Governor's Task Force on Mental Health

COMMENTS RECEIVED OCTOBER 10 THROUGH NOVEMBER 15, 2016

The Governor's Task Force on Mental Health asked that stakeholders' messages to the Task Force be circulated to them, and the messages are presented to the Task Force verbatim except in cases where identifying information was removed to protect privacy.

10/13/16

I am writing in regards to the shortage of mental health providers in rural communities. My daughter was presenting signs of mental illness and we attempted to get her into the only community mental health center in our county. We were told it would be over a four month wait. That was not an option for her with where she was mentally to wait that long. We tried to find a provider and finally found one that could see her (whose office was 45 minutes from our home). She was a national board certified music therapist who held a master's degree. We received services from her for my daughter and my daughter improved, but our insurance would not cover the services. We were told Music Therapy did not have a licensing option in MN so it would not be covered. My daughter had been to various traditional therapists over the years starting in first grade and we never saw the results we did with music therapy. She went from panic attacks almost daily to only a few a month. I feel it was the best match of mental health services for my child. She is now a full time college student living in recovery with many tools to assist her she learned from her therapist. I share our story in hopes that the task force will consider addressing expanding the definition of mental health providers in Minnesota to include a licensing process for national board certified music therapists.

Thank you for your consideration,

(Name withheld to protect privacy)

10/12/16

[This is a summary from one of the participants in the lunchtime presentation at the Task Force meeting on September 26 in Duluth]

The task force met in Duluth a few weeks ago. I attended. In Duluth, we have our own task force that has been meeting monthly for nearly a year driving toward a definition of a gap-filler for our community – some sort of triage center for mental health/substance use patients/emergencies connected to something that addresses the lack of mental health beds of various types. (We have hired Roger Meyer to help us finish the definition.) The state task force wanted to hear from our Duluth task force, and we had an hour (over lunch) to describe what we're doing and take questions. I was one of the speakers describing our Duluth/regional situation. Our other speakers were the head of OP mental health at St. Luke's, the head psychiatrist at Essentia, the ED at Center City Housing, and the chief of the Duluth police dept.

I described our role, as the only CMHC here, as our bringing to the region all of the outpatient and community-based MH programs that are funded in this state, including the new BHH program which brings care coordination and CHW and CPRS resources and will address population health for this client base. And our not being an IRTS provider, though many CMHCs in the state do operate IRTS facilities and nobody in the area applied for the DHS funding that was available earlier this year, and maybe that will be one of the outcomes of our task force work (having HDC commit to this for the future). I told them we operate an agency in Superior and how vastly inferior the funding is there. Last, I told them about my commitment to maintaining a psychiatry staff here even though it loses a lot of money because the rates are so low (using my usual line - we have a $3.5 million psychiatry program for which we are only able to bill $2.5 million), and that many of the CMHCs in the state no longer have a psychiatry team. I asked the state task force to please think very seriously about this – do you want Community Mental Health to have psychiatry or not? If you do, and why wouldn't you, then please give us rates that let us bill for the cost of a psychiatry team.

I did not go back to the table for the public testimony period, having already spoken and seeing what looked to me like a high level of interest in what we were presenting with several questions asked.

Jim Getchell
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10/14/16

The following flyer was sent to the Task Force by Beth Kangas, who spoke to the Task Force at the meeting in Rochester on October 17.

ZVMS
ZUMBRO VALLEY MEDICAL SOCIETY

invites you to a free public presentation on

Challenges in Treating the Mental Health Crisis: Law Enforcement, Courts, and Emergency Departments

Objectives include:

- To describe the effects of the current inadequate mental health resources in Southeastern Minnesota on law enforcement, courts, and emergency departments

- To recognize that mental illnesses and substance use disorders are both acute and chronic conditions

- To discuss how clinicians and communities can work together to ease the burden of mental health disorders

Panelists will include representatives from law enforcement, the legal system, and medical facilities.

To register for the community conversation, please email: info@zvms.org

October 27, 2016
6-8 pm
Auditorium
Assisi Heights
1001 14th St NW
Rochester, MN 55901
Light refreshments will be served.

For more information, contact Beth Kangas, kangas.beth@zvms.org

MINNESOTA MEDICAL ASSOCIATION

10/17/16

Hi Susan:

Thank you so much for keeping us in the loop! Now that school is back in session, it helps to have the information to be able to report to our Legislative Committee and Board. As the Task Force is completing the final stages of their recommendations, MSSWA created a document to support the work that is currently being done. Could you please share this document with the Task Force members? We hope it will help strengthen the final recommendations while ensuring that the educational perspective of mental health service delivery is embedded as a critical component in the transformative nature of the recommendations being produced by the Task Force members to enhance mental health services for children and youth. Thank you again for all of your work and dedication to this project! MSSWA is excited to see the final recommendations and look forward to sharing them with our members. If you have any questions or would like further information, please don't hesitate to contact me.

Sincerely,

Christy McCoy MSW LICSW
MSSWA Legislative Chair & Secretary; Midwest School Social Work Council Recognition Chair; SSWAA Secretary
School Social Worker
Agape High School
1037 University Avenue West
St. Paul, MN 55104

The Minnesota School Social Workers Association (MSSWA) & the Governor's Task Force on Mental Health: Improving Mental Health in Minnesota

As the representative of school social work (SSW) practice and the students, families, and schools served by SSWs across the state, MSSWA provides the following background and recommendations to support the work of the Governor's Task Force on Mental Health to improve mental health outcomes in Minnesota.

A key to this effort will involve collaboration with other sectors, such as the Minnesota Department of Education (MDE). MSSWA believes collaboration to improve the mental health services, supports, and outcomes of our students necessitates examining the specific opportunities and initiatives underway at MDE and the opportunities to further implement and sustain SSW practices across the state.

- **Improvements in Crisis Response**
    - *Current SSW Practice in Minnesota*
        - As school employed mental health professionals, SSWs are often the first-line response to mental health crises in our schools. As such, MSSWA recognizes the importance and need for collaboration between school and community providers to ensure the safety and well-being of our students before, during, and after a crisis. (4, 6, 12)
    - *MSSWA Recommendations*
        - *Enact standards for crisis services and provider.* Children and families across the state need access to reliable, intuitive, and timely crisis supports. Efforts to improve crisis responses should take into consideration ease of access by exploring options such as "one number" access, as well as expanding Text4Life options that resonate and expand our reach with adolescents. Schools would also benefit from advocacy to realign the standards to identify mental health professional's ability to authorize transportation holds. Combined these efforts help improve safety and ensure students have access to crisis care. (1)
- **Improvements in Inpatient Bed Capacity & Levels of Care Transitions**
    - *Current SSW Practice in Minnesota*
        - Educated and proficient in both the realm of education and mental health, SSWs recognize the importance of appropriate placement, level of care transitions, and discharge planning have on students obtaining mental health interventions. Equally important, SSWs recognize the connection appropriate care has impacting a student's educational experience and their social/emotional and behavioral well-being. (4,7,8)
    - *MSSWA Recommendations*
        - *Increase intensive residential treatment services.* Children, adolescents, and their families need access to a full range of options to address mental health crises. These services must provide the stabilization and supports necessary to improve functioning for children and adolescents in their home, school, and community.
        - *Strengthen housing and supports.* As advocates providing primary support for homeless children and unaccompanied youth, SSWs in

Minnesota see first-hand the academic, social/emotional, and behavioral challenges of our students qualified under the McKinney-Vento Act. As liaisons between the school and community, SSWs work to reduce barriers faced by these students by providing social/emotional and behavioral supports and interventions, as well as ensuring these students have access to the educational supports they are entitled to receive. (2)

- *Strengthen connections between mobile crisis teams and external settings and providers.* Mobile crisis teams must engage in work with families and integrate outreach and collaboration with educational teams. SSWs are proficient and effective managing mental health crises in the educational setting. SSWs can ensure students obtain access to mobile crisis or community services when needed while also serving as a conduit between these providers and the school to ensure the proper planning and supports for students are in place in the school. Encouraging collaboration with specialized instructional support personnel (SISP), such as SSWs, will improve the ability of mobile crisis teams to make appropriate care decisions on behalf of students and improve student safety outcomes. (4)

- **Redefining & Transforming the Continuum of Care**
  - *Current SSW Practice in Minnesota*
    - As school employed mental health professionals and practitioners, SSWs practice within multi-disciplinary teams which consist of other SISP that have unique skill sets, training and perspectives to holistically support the social, emotional and physical needs of students. According to the School Social Work Association of America (SSWAA) National Practice Model for SSW, SSWs should demonstrate advanced knowledge and technical skills to 1) provide scientifically supported education, behavior, and mental health services, 2) promote school climate and culture conducive to learning, and 3) maximize school-based and community resources. Although the roles of school social workers may vary from school to school based on student need, all Minnesota school social workers embed the above core competencies into their practice. (3, 7, 8)
  - *MSSWA Recommendations*
    - *Adopt a definition of the Mental Health Continuum of Care.* This definition should encompass the educational model of mental health that emphasizes developing the compassionate and reflective capacity of all educational staff to reduce mental distress in the children and adolescents they seek to educate. (5)

- *Prepare and support early childhood providers to more effectively serve children and families exposed to or experiencing trauma.* Ensure access to preventative and early intervention in the early childhood setting by expanding on models using SSW to guide and provide mental health interventions on social/emotional and behavioral skills for young children and their primary caregivers. (10)
- *Develop supports and education for parents of adolescents that are accessible, evidence-based, and teach positive parenting skills.* Schools are often a natural gathering place for the community. SSWs have the expertise to design, guide, and implement family engagement opportunities that capture the ability of schools to draw in the community and provide accessible opportunities for evidence-based positive parenting interventions. (5)
- *Expand transition supports for new immigrants and their families.* SSWs are often a first point of contact for new English Language Learner (ELL) families and reduce barriers for these families by providing information regarding the educational system and access to community resources that may be necessary for reducing barriers to the family's well-being and the student's academic, social/emotional, and behavioral success in school. (12)

- *Improve availability and access to mental health services and activities in the continuum.* SSWs are dually licensed by MDE and the Minnesota Board of Social Work. This unique expertise in both education and mental health underscores the ability of SSWs to prepare, plan, implement, and monitor the provision of mental health services in our schools along a continuum of care. (7, 8)
- *Build robust health promotion and prevention functions within the state.* Collaborate with efforts at MDE to implement, enhance, and sustain multi-tiered systems of support (MTSS) and positive behavior intervention and supports (PBIS) that utilize the professional skills and abilities of SSWs to enhance the mental health and well-being of our students. (9, 10)
- *Support the availability of affordable, safe, stable housing.* As leaders in the support for students identified under the McKinney-Vento Act, SSWs work directly with students and families negatively impacted by the lack of adequate housing. SSWs advocate for increased access to resources to meet basic needs, provide professional case

management to ensure students have access to the educational programs they are entitled to under the McKinney-Vento Act, and explore community resources and supports to alleviate stressors related to inadequate housing. (2)

- **Addressing the Governance Structure**
  - *Current SSW Practice in Minnesota*
    - The Task Force's example on funding for school linked mental health services captures the many angles of funding that provide financial support for the provision of mental health services in schools on behalf of students and families across the state. As part of the educational model of mental health, school linked mental health providers work in collaboration with SISP members like SSW's to effectively address the social/emotional needs of students. (5)
  - *MSSWA Recommendations*
    - While defining the governance scope to enable the mental health continuum of care, ensure that the local need of schools to have highly qualified SISP, such as SSWs is part of that definition to expand school-based mental health services as well as school-linked partnerships in our schools to provide students with access to quality mental health interventions and supports. (8)
- **Using a Cultural Lens to Reduce Mental Health Disparities**
  - *Current SSW Practice in Minnesota*
    - Guided by the National Association of School Social Work (NASW) Standards for School Social Worker Services, SSWs prioritize integrating a multicultural perspective and a person-in-environment approach to the provision of competent and ethical school social work interventions and supports. (12)
    - As mental health professionals and leaders of the educational team, SSWs support and implement mental health interventions in the MTSS framework, implement trauma-informed practices, and provide open access for all students to receive the mental health supports necessary for the development of positive academic, social, emotional, and behavioral outcomes. (13)
    - SSWs use evidence-informed practices, skills, and techniques that reflect the worker's understanding of the role of culture in the helping process. As cultural navigators, SSWs have specialized training in cultural diversity, systems theory, social justice, risk assessment and intervention, consultation and collaboration, and clinical intervention strategies to address the mental health needs of students. SSWs play a pivotal role in reducing opportunity

gaps for the diverse population of students/family's they serve to access culturally appropriate services and supports. (12)

- o *MSSWA Recommendations*
    - ▪ *Invest in prevention and early intervention.* Support the work of MDE to integrate and implement the use of MTSS and PBIS. Together MTSS and PBIS are designed to encompass the provision of prevention and early intervention for social, emotional, and behavioral needs following models of public health that address Universal/Tier 1, Secondary/Tier 2, and Tertiary/Tier 3 levels of need. Systemic planning and implementation can reduce gaps in access to care and release the influence of prevention for student well-being. (10, 11, 13)
    - ▪ *Invest in trauma-informed practices in educational settings.* Collaborate with MDE for opportunities to integrate and implement trauma-informed practices that may include SSWs leading efforts to implement systemic trauma-informed professional development, consultation, and collaboration with all school personnel working with all students. (11)
    - ▪ *Expand school based mental health supports to cover the continuum of care.* The educational model of mental health acknowledges that cultural experiences may cause families to remain apprehensive of mental health interventions, whereas school support can induce a positive element that helps reduce fears and engages families to access mental health supports when needed. SISP, such as SSWs, play an integral part of the educational model of mental health by providing mental health interventions to students, helping link families to co-located mental health services, and providing behavioral consultation and support to all staff working with students. (5, 12)
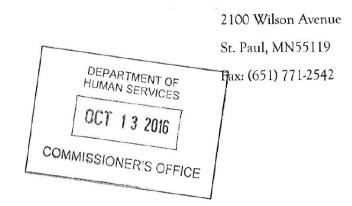
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10/13/16

St. Paul Youth Services
Turning High Risk into High Hopes

Affirmative Action, Equal Opportunity Employer

2100 Wilson Avenue

St. Paul, MN55119

Fax: (651) 771-2542

DEPARTMENT OF
HUMAN SERVICES

OCT 1 3 2016

COMMISSIONER'S OFFICE

September 19, 2016

Emily Johnson Piper
Chair
Minnesota Governor's Task Force on Mental Health
c/o Susan E. Koch, Department of Human Services
at Susan.E.Koch@state.mn.us

Dear Madame Chair,

Thank you for the opportunity to speak with the Task Force at its August 15 meeting. I am encouraged by and hopeful about the work the Task Force is undertaking, while at the same time I have, as shared at the meeting, concerns regarding the consideration of racial equity and the treatment of the traumas resulting from generational, systemic racism.

In the Task Force's Mental Health Overview it noted that "a recent report by the Minnesota Department of Health explains that disparities—population-based differences in health outcomes—are closely linked with social, economic, and environmental conditions. Moreover, structural racism, intergenerational trauma, and genocide have lasting effects on people and cultures, leading to disparities that are reproduced generation to generation" (page 2).

Once this is acknowledged and accepted, our collective response to these effects must be in proportion to the enormity of the conditions which created them. In order to respond adequately, we also must acknowledge that our understanding of the complexities of these issues, the conditions that created them, and their impact is limited and biased.

Just as St. Paul Youth Services is turned to for its mental health expertise in working with youth, we, as a community of care givers, should be turning to an expert in racial equity and social justice to inform our thinking as we build an equitable mental health care system.

In one document, the Task Force laudably discusses not maintaining the status quo, but in another it uses language that is precisely that – status quo – terminology that has been around for some time. An example is "resilience": unless this is applied to the "system" in terms of *its* ability to adapt to the changing needs or crisis of our community members, it has no place in mental health services for youth. We can not condition our youth to adapt to discrimination, to poverty, to unequal opportunities. We can not tell them to be stronger and work harder to overcome these "barriers". We must do better than this. A racial equity expert can bring a critical eye to the language we use and the narrative framework upon which we construct Minnesota's mental health system.

For forty years, St. Paul Youth Services has been a leading provider of early intervention and behavior services for youth. In addition to being a direct service provider, we train those who interact with youth

in order to elevate their understanding of youth's psychosocial development and teach them skills for building healthy relationships with and positive outcomes for youth.

Today St. Paul Youth Services works with 1,200 children and young adults ages 5 to 18, along with their families. We focus on keeping our youth healthy, educated and free, and draw on the diverse wisdom of our community, youth and their families, and outside experts in various fields to help us rewrite the rules of youth engagement.

Once again, I encourage this Task Force to add to its collective experience by seeking expertise in racial equity and social justice and, equally importantly, to understand this as fundamental to any change of the mental health system in our community. In the end, this can help all of us elevate our thinking and increase our capacity to address these issues.

Thank you for considering my concerns and I welcome any questions you might have. Please don't hesitate to contact me at 651.252.6251 or tasberry@spys.org.

Onward together,

Tracine Asberry, Ed. D.
Executive Director

10/26/16

Dear Ms. Koch:

Kindly accept my input for the Task Force.

Minnesotans receive limited psychopharmacological treatment because of the refusals of insurance companies to pay for many medicines, both old and new.

A law requiring insurance companies to pay for three months of any psychotropic medication prescribed by a board-certified psychiatrist, without the large burden of step therapy or prior authorization, would have an immediate impact on the quality of care for the large number of Minnesotans whose illnesses are best treated with medication. Persons suffering from many serious and persistent mental illnesses respond uniquely to antipsychotic medicines, antidepressant medicines, and other psychotropic agents.

The cost of care and extent of disability should decrease.

Sincerely,

Floyd Anderson, MD
Distinguished Fellow, American Psychiatric Society

10/28/16

Dear Susan Koch,

I was sent the material by MPS and had the opportunity to read much of the Task Force work and have been very impressed by the materials. I was Head of Psychiatry at U of Minnesota and have been very concerned about care in our community and the State. I want you to know I have worked in other places and helped get the Public Academic Liaison (PAL) program going in Ohio and wished it could have started here. It is very successful in Ohio. I will make a list of comments about issues I have been concerned about and comments on the Task Force work.

1. Having worked at the University and communicated with other hospitals, I feel it is important to increase the residency programs in the State. This can increase the number of psychiatrists to help these issues. Also, many of the psychiatrists are older so it is important to start soon. This should include Child and Adolescent Psychiatry. There were some good points made by Dr. Brian Johns in this area.

2. From my view, as there is importance in team approach to the patients, there should be more teaching for the nurses and social workers. Many of them are very good, but more knowledge is needed for initial career.

3. People Inc. started housing for significantly ill schizophrenia patients and this worked very well for them. So now I believe more of these type of houses should be created. Just two houses in the Twin Cities.

4. I worked on the Schizophrenia ward at NIMH and got good training for those patients. I think we need to perform special training for the seriously ill and children as well. I did start a Schizophrenia Fellowship at the University and more can be initiated and extended to bipolar disorder and other significant illnesses.

5. A very good point to increase and incorporate mental health staff at the ERs. In my experience, many staff in an ER for many hours or a couple of days.

6. In the material written by William Czech, he made good points about improving resources and personnel.

7. At the Jewish Family services meeting last Sunday there was much communication to increase people knowing about mental illness. An excellent lecture by Ken Barlow about this. He did note that it was many years before he was given psychiatric care.

8. A very good point for the need to treat homeless seriously mentally ill. There are many people living outdoors who need help and many have a serious diagnosis.

9. I agree that telehealth is a very good step. WE were doing a pilot program in 1989 at the University and it really helped the patients who had been to the U, but lived far away.

10. In treating the seriously ill patients - mostly schizophrenia - there has been a recent study showing how well the patients do on LAI medication. In the UCLA article the patients who took the LAI only 5% relapsed in a year compared to 31% who took oral medication.

11. We need to be aware that 25% of people with schizophrenia are non-responders to first line medication. In the US there is low use of clozapine. Minnesota can work on establishing a good clozapine program.

12. There are good points about bed capacity and important to provide care. After cut back of support about 1990 there is short stays which is difficult for the seriously ill. It takes a minimum of 2 weeks for a person with schizophrenia to respond to medication.

13. The government has been supporting First Episode Psychosis and they have noted the importance of the team - psychiatrist, nurse/social worker, personnel for school and work, and a well knowledged doctor for prescriptions.

Thanks for letting us contribute and I am happy to talk if needed or visit a meeting.

Chuck Schulz

10/28/16

This email was sent to a Task Force member and is being shared with the rest if the Task Force

I think it's important for the committee to understand the importance of Domestic Violence is included in the policies around 72 Hour Holds. Gaslighting is a tactic and strategy that the abuser uses to gain control of the victim. Gaslighting begins to happen and surround the victim when the abuser tells colleagues, friends and families that the victim is crazy.

As mental health assessments get done in the 1st 72 hours, it's important to look at the context of what the victim has been through that got the victim there to begin with. A domestic violence advocate, or someone who understands the impact of trauma on the brain should be included in the first 72 hour assessment.

11/1/2016

I am a medical director for 6 adult psychiatric units at UMMC. We face numerous challenges that have increased in the 7 years I have been practicing here, including the length of time it takes to get patients placed in residential treatments (IRTS) and at Anoka RTC (this is virtually impossible since the 48 hour rule was established). This has caused our throughput to decline and we now have 6-10 patients waiting in the ER every morning for a psychiatric bed. When there are no state beds for committed patients, what happens over time is that the standard of care for severely ill patients declines to the point that many are deemed "too ill" to commit. I saw this happen in Florida, where I completed my

training. There, the most severely ill patients are discharged as soon as they show any improvement or as soon as they ask to leave, and they are often a safety risk for the community and often end up in jail.

The most pressing problem, however, is aggressive patients. For the most aggressive patients, striking the right balance between getting them the treatment they need but also keeping our staff safe and engaged (so that they can be there to care for the 99% of our patients who aren't aggressive) is one of the most difficult aspects of running a mental health unit these days. My feeling is that it can't fall on community hospitals to bear the brunt of this violence; the state and law enforcement has to do more, even when the aggression is clearly related to mental illness. When Anoka RTC is inaccessible, and MI and D commitments are so difficult to get, patients will need to go to jail. The legislature needs to understand that this is the trade-off. If community hospitals must bear the brunt of the violence, they will get out of the mental health care business altogether, as has happened in other metropolitan areas (e.g. Denver).

I'd be happy to discuss these and other aspects of the mental health care system from my perspective.

Thanks for the opportunity to provide this feedback.

Steve

Steven Miller MD
Interim Executive Medical Director, Behavioral Health Services
University of Minnesota Health

11/2/2016

Hi Susan

After reviewing the documents, MSSWA is requesting that the task force add school employed mental health professionals listed on the chart that identifies the 6 categories of services under the continuum of care. It is critical that the educational model of mental health service delivery is embedded as an additional category. Schools are a pivotal place where children and youth receive prevention services and interventions to address mental health needs. Schools continually intersect with community mental health providers offering ongoing support and interventions in collaboration with one another. Please pass this along to the appropriate work group.

The Minnesota School Social Work Association appreciates the commitment of the task force in their efforts to ensure that the final recommendations are comprehensive which must include licensed school employed mental health professionals and practitioners.

Thank you for your consideration.

Christy McCoy MSW LICSW
MSSWA Legislative Chair & Secretary; Midwest School Social Work Council Recognition Chair and

SSWAA Legislative Chair & Secretary
School Social Worker

11/3/2016

Hi Susan-

Thank you for latest updates. I wanted to share feedback but I need to stay anonymous in order to not jeopardize my position. I license homes for child care, child and adult foster care. I work very closely with child protection and children's mental health. I used to work in the adult mental health and chemical dependency world. I have a lot of conversations with corporate adult foster homes. It sounds harsh but what the real need is a state hospital that can serve children, adults and seniors. It does not have to run like St. Peter or Anoka or like any of the hospitals that were torn down. It is a fabulous idea that everyone deserves to live in the community but reality is there is a huge population that cannot function in that capacity. So many times placement is needed for a child whose mental health and behaviors are over the top but do not meet criteria for hospitalization (which by the way few options exist for a hospitalization) and a foster home will not take because of safety to other children in the home. Adults who have mental illness and developmental delays who live in a group home might have an incident where they get violent, cops are called, cops arrive and ask the home what do you want us to do with them, if person is not suicidal they do not meet criteria for psych eval. Or hospitalization. Homes are forced to keep people and put other persons and staff in the home at risk because there is nowhere to go. Coming from the adult mental health field, I can recall several clients I worked with that truly a locked facility would be the only place to keep them safe from themselves or others.   The clients I speak of "are as good as they will get" basically. They just need a place that can meet their needs and keep them safe so they are not continuously victimized or continue to victimize.   Jails are not mental health facilities. But there really needs to be a holding facility where people can go to when truly no other options or if it is short-term to get back on track so can return to the home. CBHH's have long waitlists and are only supposed to be short-term. Many times people need more than short-term and there are not enough step down programs. There is a huge shortage in the state and especially in the north there is little to no resources without traveling several hours. I heard Anoka RTC does not have beds filled at capacity. I do realize staffing statewide is a problem in the mental health field but maybe Anoka could be looked at a repurpose goal of its empty beds. Or better yet, something in the north that can better meet the needs of those needing placement.

Thanks for listening,

County Social Worker

Minnesota Health Care

Safety Net Coalition

TO: Members of the Governor's Task Force on Mental Health   November 4, 2016

Dear Task Force Member,

On behalf of the Minnesota Health Care Safety Net Coalition (SNC) I would like to express support and additional information for your consideration regarding the current recommendations produced by the Governor's Task Force on Mental Health. While many challenges exist in the current behavioral health system, the SNC commends the task force for considering feedback from the SNC and other stakeholders to better understand the barriers for patients, providers and other stakeholders within the current system.

The SNC is unique and brings together nonprofit health care organizations that serve primarily low-income, uninsured and racially or culturally diverse patients with complex social, cultural and economic challenges from multiple sectors in health care including primary care, behavioral health, oral health and safety net hospitals.

The SNC supports the current recommendations produced by the task force, but we believe there are key opportunities the Task Force could highlight in order to ensure health equity in behavioral health reform efforts. Without conscious and intentional attention to the potential impact of policy changes on racial and cultural groups who experience health disparities today, and the providers and agencies who serve them, policy proposals may actually have the unintended effect of perpetuating or worsening disparities. To prevent this requires both careful analysis of possible consequences and full engagement of the communities themselves in assessing the expected impact on them. To be sure the recommendations achieve the dual goal of improving behavioral health and reducing health disparities, we recommend the following:

Completing an *Equity and Inclusion Impact Statement* for each recommendation.
Starting with the 2017 budget, the Governor has requested that state agencies develop an equity impact statement for *each* budget proposal. To align with the Governor's request, and to implement recommendations in the Minnesota Department of Health's *Advancing Health Equity Report*, it is recommended that the task force answer the following questions for each of the recommendations to ensure health equity:

- What groups are impacted by the proposed policy or budget item? (Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans) What is the nature of the impact? Have representatives from these groups been consulted and collaborated with in order to determine how to address these impacts?

- Is the proposed item submitted to reduce or eliminate any disparities for Racial and Ethnic groups, Lesbian, Gay, Bisexual and Transgender groups, Persons with Disabilities and Veterans? Please explain how implementation of the proposed item(s) will reduce or eliminate these disparities.
- Are there potential positive or negative impacts on the identified groups? Explain those impacts. If negative, please adjust the proposal to achieve a more equitable outcome.
- Can the policy or budget idea be sustainably successful? Discuss the on-going funding, implementation strategies/opportunities, and performance measures/accountability mechanisms.

Completing this analysis will not only improve the Task Force's recommendations but it will also be required if the recommendations are to be considered as state agency and Governor policy and budget proposals.

Additional opportunities to improve health equity within the behavioral health system include:

Enhancing cultural lens to include additional social determinants of health. As recommended by the task force, cultural lens should be considered in behavioral health system reform, but we believe additional social determinant of health factors should also be considered. Multiple reports and research studies have agreed that many variables affect health beyond clinical treatment including, but not limited to, cultures and beliefs. The task force should consider expanding the cultural lens to include social determinants of health and the affect they have on health outcomes. The Safety Net Coalition recommends that the task force use the following reports to include additional social determinants that affect health outcomes:

- Minnesota Accountable Health Model – SIM Minnesota: Data Analytics Subgroup Phase Two Report[1]; Section: Essential Data Analytic Elements Related to Social Determinants of Health

- National Academies Press Report[2]: A Framework for Educating Health Professionals to Address the Social Determinants of Health

- National Academies Press Report[3]: Accounting for Social Risk Factors in Medicare Payment – Data

Improving quality measurement and payment systems to achieve health equity. In primary care, existing measures of quality can negatively impact safety net providers

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[1] http://www.dhs.state.mn.us/main/groups/sim/documents/pub/dhs-289330.pdf
[2] http://www.nap.edu/21923
[3] http://www.nap.edu/23605

because they do not take into consideration the social determinants of health that affect scores on existing standardized quality measures. As behavioral health quality measures are developed and implemented, it is vital to consider the patient population providers serve and the measures should be adjusted based on socio-economic complexities of the patient population. From more accurate quality reporting measures that consider social determinants of health, fair payment methodology can be implemented that will direct scarce resources to accurately reflect patient needs and better serve the most complex and difficult to treat patients.

Legislation passed in 2014 and 2015 (Minnesota Statute 62U.02[4]) requires the Minnesota Department of Health and Department of Human Services to modify the quality measurement system and payment methodology to account for the social determinants of health. It will be important that Task Force recommendations also reflect these policies to ensure that clients, patients and communities experiencing disparities have the support, resources, and opportunities to receive the care they need at the time they need it.

The Safety Net Coalition appreciates the opportunity to review and respond to the Governor's Task Force on Mental Health Recommendations.

Sincerely,

Michael Scandrett
Executive Director
Minnesota Health Care Safety Net Coalition

Minnesota Health Care
Safety Net Coalition

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[4] https://www.revisor.mn.gov/statutes/?id=62U.02

ARRM leads the advancement of community-based services that support people with disabilities in their pursuit of meaningful lives.

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ARRM

November 4, 2016

Members of the Minnesota Governor's Task Force on Mental Health:

ARRM is a nonprofit association of more than 200 providers, businesses and advocates dedicated to leading the advancement of community-based services that support people living with disabilities.

As the Vice President of External Affairs for ARRM, I have attended two of the task force meetings and have reviewed the documents available on the website. I would like to share some information and comments regarding the issue of services to people with mental health issues as it relates to the services provided by our members.

The Task Force membership includes providers of services, but ARRM feels that there has been a lack of representation of community providers who support people with mental health issues, yet are not identified as mental health service providers. A majority of our members provide services to people who have a primary or secondary diagnosis of mental health issues. Because of this I would like to share some information that might be helpful as the final report is completed.

One of the primary concerns for ARRM members is the lack of resources to support people in the community when they experience a mental health crisis. Because of a lack of support to community providers, people in crisis often shift back and forth from ER/hospital and community residential settings (formally known as corporate foster care).

When providers get to a point where they feel that they can no longer meet the needs of the person, a next step is often to give a notice of discharge. A 60 day notice of discharge, unless in an emergency situation, is given to the individual. ARRM recently did a survey of its members. The survey was sent to 160 organizational members and 87 providers responded. The survey results showed that there were 137 notice of discharge given by those 87 members from January 1, 2016 to October 1, 2016. Of those 137 people, 28 (20.4%) of them remained in their residential living situation beyond the 60 day notice limit. The average number of days beyond 60 was 41 days.

Community providers have limited options on what to do when they are providing services to someone in crisis and do not have the resources needed to meet the needs of the individual. There are providers who have been given direction from counties to take the individual to the ER and drop them off, this recommendation has also come from some doctors. On the flip side, there have been hospitals that have told providers that if they did not pick the person up, even

when the provider did not feel that they could safely serve the person, that they would be reported for abandonment and neglect.

I would also like to comment on #10 on page 49 of the draft report. My concern with the paragraph is that it seems to indicate that individuals are ready for discharge and community providers simply refuse to accept them back. The reality is that in many of these situations the person is not stable, but there is an urgency to free up the bed. With the proper additional support to the community provider many of these people could be returned, but there is a lack of resources to assist with the transition back.

Thank you for your consideration of these comments. You may contact Barb Turner with any questions. 651-291-1086 ext. 3 or bturner@arrm.org

Sincerely,

Barb Turner

Vice President of External Affairs

ARRM

November 4, 2016

Task Force Chair,

I have recently been informed by the MN POST Board that your task force has made draft recommendations (October 13, 2016) for a 40 hour CIT course to be taught to pre-service (Professional Peace Officers Education – PPOE)students rather than in-service officers (current working experienced officers) based on cost reasons as stated. I would like to take a moment to inform the task force that the MN POST Board has already mandated over 500 new learning objectives (over a 200 % increase from current number of learning objectives) for the MN PPOE schools to implement by Fall 2017. Designated categories in these learning objectives are specific to training in CIT and Mental Illness.

I have attached the MN POST mandated learning objectives that are required for all MN PPOE schools to fully implement by Fall 2017. Please refer to Category Two – Part II (pages 25-27, 31, and 43) for the learning objectives that address Crisis Intervention and Mental Illness. You will see that an extensive amount of new learning objectives are already committed to this area of need.

I have also attended a recent MN POST Board Training Committee meeting where representatives from MN Crisis Intervention Team (MNCIT) presented information on CIT training and did NOT recommend that a 40 hour CIT course be taught to students in a PPOE program as it better aligns with in-service officers that have experience in the field.

If a 40 hour CIT course is mandated for PPOE schools to provide to students it would lead to additional cost for students, additional time to complete degree, and no guarantee the student will be offered a peace officer positon with an agency. This could also have the potential for making the process more challenging for students from diverse backgrounds to be successful in a PPOE program.

Please take this information into consideration prior to making further recommendations for PPOE schools.

Best Regards,
Michael Ardolf, Law Enforcement Coordinator
Rasmussen College Eagan Campus

Attachment

11/6/16

Dear Susan,

I learned about the existence and work of the Governor's Task Force on Mental Health on November 4 when I attended a Minnesota Public Health Association forum on mental health. So I realize this is late for submitting comments. I have read through the current draft available on the web site.

As a parent of an adult daughter who has lived with bipolar disorder and has accessed mental health services in the metro area, I have several responses/comments.

1. The task force report is very comprehensive and considers a systems perspective, which I think is very important. It is also very large in scope. I am wondering how priorities of where to start and what to emphasize as most important will be determined.

2. I have a concern about adequate housing for persons living with mental illness. I see this issue is addressed in Recommendation #7, which I was very glad to see included. I agree that as a social determinant for mental health that housing is absolutely critical. My daughter, age 43, has had frequent hospitalizations, and is currently living with my husband and I, because she cannot find housing. She has a housing voucher with Bridges, a housing support person working with her, and a case manager. She has been turned down for 3 housing applications in the tenant screening process, for unfair reasons that I believed are related to discrimination toward people who have housing vouchers. In one situation, the rental company had a fax that was not working and missed the rental manager's deadline for receiving my daughter's rental history who then rented the apartment to another tenant. In a current situation, my daughter had her application denied because she had incorrect dates for move in and move out for her last two apartments (off by a few months). When she completed the application she was not sure of the dates so she guessed. We are appealing that decision. My daughter has always paid her rent on time but is facing huge barriers in the apartment rental market. Glen Andis, from Medica, who was on

the panel at the MPHA event on Friday, said there are many more vouchers available than there are housing opportunities.

I believe that future policy should address the discrimination/stigma issue held by apartment rental companies toward persons living with mental illness and would like to see adequate, safe housing as a priority in action steps.

Parent of a person with mental illness

11/6/16

From: Mary Vukelich [mailto:Mary.Vukelich@century.edu]
Sent: Sunday, November 06, 2016 2:28 PM
To: *DHS_DHS MentalHealth <dhs.mentalhealth@state.mn.us>
Cc: Mary Vukelich <Mary.Vukelich@century.edu>; rseurer@ci.savage.mn.us;
sabderholden@namimn.org; Gove, Nathan (DPS) <Nathan.Gove@state.mn.us>
Subject: Mental Health Crisis Standards / Pre-Service Recommendation

Good morning. I apologize for my delay in sending this email earlier than the day before your next meeting. That being said, I wanted to share a few thoughts and pose a few ideas to ponder before a motion is made to move forward with the existing recommendation surrounding Pre-Service Crisis Intervention Team Training as Required Training for Law Enforcement.

For those who don't know me, I am a former Minnesota police officer and former 911 dispatcher who currently teaches pre-service training for Law Enforcement students at Century College. I am also a family member who has walked beside a sibling with multiple diagnoses of serious and persistent mental illness and had many, many contacts with law enforcement. In addition, I have walked beside other family members who have struggled with mental illness, diagnosed and undiagnosed. Several years ago, prior to the existence of the Memphis model of CIT teams and training, I traveled around the State of Minnesota providing training to law enforcement and other first responders on this very topic. I share all of that to say that I am very passionate on this topic and support the need for action. My concerns are in implementation.

Minnesota has a very unique model of education for the aspiring law enforcement officers, as we require a 2 year degree, where other states have an academy style. The bulk of the curriculum that has existed in the objectives provided by the Minnesota Peace Officers Standards and Training (POST) Board was similar to what existed at its inception except for legislative changes that were mandated.

Over the past 3 years a comprehensive revision has taken place of the objectives required to be taught to pre-service law enforcement students. These objectives were derived from patrol

officers sharing what it is they do on a daily basis. I am proud and relieved to say that over 20 learning objectives specific to responding to people in crisis and/or with a mental illness are now in the learning objectives and will be taught in every Minnesota college and university who offers a law enforcement degree beginning Fall 2017, if not sooner.

I testified on this topic at the legislature over 10 years ago as a family member and a police officer. This has been a long journey.   That being said, I would like to ask each of you to look at the objectives that are about to be deployed statewide and see if they don't meet the spirit of your recommendation? Through their implementation, faculty will be required to assess and evaluate student's learning. By mandating the 40 hours of CIT training at a pre-service level, we are left with many questions. Forty hours is the equivalent of 3 credits of coursework. Is the legislature ready to increase the LE degree from 68 credits to over 70 credits? Who will be teaching the CIT content? Are we referring to copyright materials or specific topics and methods that could be recommended as the newly revised objectives are implemented? If they are topics and methods that could be recommendations in our current integration of the new objectives, then faculty may have already incorporated them into the current degree length. If not, there will not be room for an additional 40 hours of teaching without a longer degree.   If the content has to be taught by specific people, will the colleges (and therefore the students) be paying the people? If so, will they also be doing the required assessing that the students are learning?   What if students need remedial assistance?

Please don't get me wrong. I truly support a response at a statewide level for law enforcement getting more education on responding to crisis calls and/or people with mental illness.   I have been a part of asking for it, as a family member and a police officer, for the past 20 years. I now ask as an instructor, that before your recommendation is finalized with language that may leave little room for reasonable implementation, that you consider how to move forward realizing that there may be logistics and/or room for interpretation by others that could prevent this from being as effective as it could be for people with a mental illness diagnosis, those in crisis, the law enforcement officers it is intended for and the family members of all of those groups.   I wish I could be present at your meeting on November 7, but it is not possible for me. Please don't hesitate to contact me by email or phone with any questions. I can be reached at 651-230-4512. Thank you for your consideration.

Respectfully,

Mary Vukelich

PS - The additional attachments illustrate a course currently being offered at Century College. In addition, an academic certificate being pursued by faculty to take our students knowledge and skill set to the next level.

Attached: **Learning Objectives related to Crisis Response and Mental Illness**

Existing Course: HSCI 1100 Behavioral Health: Implications and Interventions currently offered to LE and other technical program students
Letter of Support for Century College Mental Health Certificate from White Bear Lake Police Chief Swanson
Learning Objectives contained in proposed Mental Health Certificate

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11/6/16

RE: Wadena County Mental Health Task Force Recommendations

Since December 2015, representatives of 14 local organizations have been meeting in Wadena County to find creative, local solutions to the current crisis in managing acute mental health situations in our state.

We know that we can come up with local solutions eventually. However, we need legislation that can help us right away. There are three initiatives that have broad, statewide support from multiple stakeholder and advocacy groups. We need your help to pass them.

The three 2016 legislative actions that can most assist our task force are:

- State support to fully fund and staff more beds at the Anoka Metro Regional Treatment Center and the various Community Behavioral Health Hospitals around the state.
- State support to fund additional competency restoration services.
- Support for the Excellence in Mental Health Act.

We ask for your help in voting for these three actions. They appear in the legislative agendas of the Minnesota Hospital Association, Minnesota Association of County Social Service Administrators, the Association of Minnesota Counties, the Minnesota Sheriffs Association, the Mental Health Legislative Network, the Minnesota Association of Mental Health Providers, the findings of the Office of the Legislative Auditor, and other advocacy groups.

Here is additional information about each one:

- <u>State support to fully fund and staff beds at the Anoka Metro Regional Treatment Center and the various Community Behavioral Health Hospitals around the state.</u> This will allow for more placement options for our local citizens in crisis situations, thereby reducing the need to inappropriately house these individuals in our local county jail, where despite the 48 hour rule, they often reside longer than mandated by present state law. This also will reduce the equally inappropriate housing of the individuals in the local community hospital in either an inpatient setting or the emergency department. In both cases, the individuals are in incorrect settings where they are not receiving the required professional mental health care counseling, treatment, and other services appropriate to their mental illness. This initiative is addressed in Senate File _____ and House File _____.

- State support to fund additional competency restoration services. This will reduce the backlog of patients held at Anoka Metro Regional Treatment and the Community Behavioral Health Hospitals, and thereby create additional bed capacity to address the same inappropriate housing of individuals in the county jail or the local community hospital mentioned earlier. This initiative is addressed in Senate File _____ and House File _____.

- Support for the Excellence in Mental Health Act. In 2014, federal lawmakers passed this act, creating a national demonstration project to transform how community mental health services are delivered. Minnesota is one of 23 states competing for 8 slots to participate in this national demonstration project. This will improve the way Minnesotans access mental health and addiction treatment by creating a "one stop shop" model of a certified community mental health clinic that will provide comprehensive, coordinated and integrated care to children and adults with complex mental health and chemical health conditions. Significant federal matching dollars will accompany a small state investment, but we must first pass the authorizing legislation and fund the state match. This initiative is addressed in Senate File 2549 and House File 2609. An additional note of importance on this project that the local community mental health provider, Northern Pines Mental Health Center, is working on its own initiative to be a part of this demonstration project if Minnesota is selected, which will create near term assistance to our citizens that suffer mental illness and chemical dependency concerns.

As you will see the list of organizations identified in the signature section of this letter, this is a significant cross representation of Wadena County. We are **UNANIMOUS** in our support of the initiatives identified above as the best and most effective means to help resolve immediate mental health needs in our communities. First and foremost, these initiatives will help to assure that the citizens of Wadena County will get appropriate care for mental health needs in a timely manner and in an appropriate setting. They will also have a great impact on reducing crowding in the Wadena County Jail which will reduce taxpayer burden. They will also reduce the burden of unnecessary and costly emergency room visits at Tri-County Health Care as well as inappropriate inpatient stays where patient are not getting the necessary mental health treatment they require. Additionally, they will provide relief of the many administrative burdens to multiple organizations as we presently attempt to manage these untenable situations to find appropriate placement. This includes but is not limited to enhancing the efficiency and effectiveness of efforts by agencies such as Wadena County Human Services, the local judicial system, and Northern Pines Mental Health Center. It will also allow for more efficient and effective provision of services by the Community Behavioral Health Hospitals, Anoka Regional Treatment Center, and other state operated services.

We thank you most sincerely for your efforts to improve the care of Wadena County citizens that are in mental health crisis situations and require appropriate and necessary mental health treatments. The current crisis is a situation that we cannot and should not allow to continue and the initiatives identified above will aide in our work here in Wadena County.

We would be happy to discuss these issues further with you and greatly appreciate your support in this important work. If you require further information please contact Joel Beiswenger, CEO of-Tri-County Health Care at 218-631-7489 or joel.beiswenger@tchc.org; or any of the individuals or organizations noted below. Thank you.

Yours in service to Wadena County,
Kindest Regards,

Bill Stearns

Bill Stearns, Commissioner
Wadena County

Tanya Leskey, Director
Wadena County Human Services

Mike Carr, Wadena County Sheriff
Wadena County Sheriff's Office

Joel Beiswenger, CEO
Tri-County Health Care

Glenn Anderson

Glenn Anderson, Executive Director
Northern Pines Mental Health

Naomi Plautz, Chief of Police
Wadena Police Department

Cindy Pederson, Director
Wadena County Public Health

Lee Westrum, Superintendent
Wadena-Deer Creeks Schools

Sally Robertson

Judge Sally Robertson
Wadena County 7th Judicial District

Jode Freyholtz-London
Executive Director
Wellness in the Woods

Kathy Langer, Director
Todd-Wadena Community
Corrections

Angela Sonsalla

Angela Sonsalla, Assistant County Attorney
Wadena County Courts

Mary Marana, Executive Director
Crisis Line & Referral Services

Cheryl Turcotte, Regional Ombudsman
MN Office of Ombudsman for Mental Health &
Development Disabilities

11/6/16

Presented by: Community Coalition
Mental Illness in Douglas County

What types of things do we have the patience to wait for in our day to day lives that take 25 minutes or less? A Cup of coffee, lunch from a fast-food restaurant, bank drive through, response on someone's text message or email a few things that we all encounter on a regular basis. You can also expect that within 25 minutes of arriving at the Douglas County Emergency Room while exhibiting symptoms of a heart attack you will be on your way to being administered tests, drugs or meeting with a specialist to reduce or reverse the symptoms of your heart attack before you die.   There are doctors, nurses and specialists in place at every hospital to take care of you within those 25 minutes if you are having a heart attack because it is a life threatening medical condition. A person presenting to the ER with heart attack symptoms are a top priority. Medically, culturally, and socially we expect that people having a heart attack are treated quickly. Protocols have been developed by the American Heart Association along with committees internally to make sure response times are quick and fine-tuned to be effective.

What situations and services do we find to be acceptable if we have to wait for 6 hours to maybe days? Approval on loan applications, dry cleaning, cable TV installation, receiving online purchases. In 16 hours you can fly to Australia or the Middle East. This is a typical wait for people that have mental health related problems that need emergent care.   These patients, also called consumers," are sitting in our hospitals and law enforcement holding areas waiting to be accepted into a mental health treatment facility. It is apparent that our system does not support fast and efficient service for people experiencing a mental health crisis. Mental health and treatment is being treated as a social problem and not a medical condition in the State of Minnesota.

In 2006 a new model of delivery for diagnoses and treatment for people who were homicidal / suicidal. The State of MN closed the state run facilities in areas such as Fergus Falls, Willmar and Brainerd.   These facilities were operating under an "Institutional Model". It does not appear that anyone took into account or attempted to recognize the trends that the system may experience when you start educating police officers, nurses, doctors and mental health evaluators. There were grants for police officers to attend trainings in order to better understand and work with consumers. These classes offered education as to what certain disorders are and what to expect, how to safely de-escalate and defuse mental health crisis situations, focusing on safety for consumers and officers. The response to consumers is focused more on empathy rather than control

Along with a new method of delivery, mental health services, and education to public safety, we were given a very methodical process for getting consumers to emergency rooms for diagnosis. At the end of 2006 law enforcement in Douglas County (Alexandria Police Department, Douglas County Sheriff's Office and Osakis Police Department) responded to 152 cases that related to mental health. This includes suicidal situations and escorts to mental health facilities. This was the start of the shift from an institutional model of delivery for consumer to a local, more personal level of service model; keeping consumers in the regions where they live and work. Initially we were able to place consumers in the

Community Behavior Health Hospital (CBHH) in Alexandria. Consumers spent less time waiting in the emergency room and were able to be admitted to CBHH with fewer hurdles.

Year	# Mental Health related Cases Law Douglas County Law Enforcement Cases
2006	152
2014	286
2015	299
2016	327 (08-16-16)

What happens when you train public safety and give them tools to deal with people in crisis? They become very efficient with their tools. We now have consumers who are willing to seek treatment rather than being forced by police officers and ER staff into a system because the consumers didn't have a choice. As a matter of fact, public safety employees across our state have seen a significant increase in the number of consumers being brought into the system. The statistics tell the whole story here. In the fall of 2013 the State changed the CBHH system from accepting consumers placed on 72 hour holds to only accepting consumers already under a commitment. We no longer had the ability to have our local consumers suffering from mental health crises and get them to the Alexandria facility. The following reflects the number of Douglas County residents admitted to the Alexandria Community Behaviors Health Hospital. This data was provided by the Alexandria Community Behavioral Health Hospital.

Year	Number of Admissions to the Alexandria CBHH	
2012	24	
2013	24	(end of year changed to only taking committed consumers)
2014	8	
2015	3	
2016	1 (beginning of May)	

The change that was done affected public safety officials, emergency medical facilities, health and human services, and the court system. These changes were done at the state level and little to no information was provided at the time. Local organizations received no guidance from the state on how to adapt to the new situation. Consumers and those in crisis have shouldered the burden that has been created. These people sit and wait in emergency rooms and police facilities for hours and sometimes days before they can begin receiving the help they need at an appropriate facility. The Alexandria CBHH has a total of sixteen beds but due to budget limitations, only has ten available. In early May, when this group met, I was made aware of over 60 people that were on signed commitments but did not have an available bed. This does not account for the consumers waiting in emergency rooms across the state waiting for placement on a 72 hour hold.

The chart below reflects Douglas County's Emergency Room's mental health patients since 2012.

Patients with Mental Illness	2012	2013	2014	2015
Total patients	413	377	465	429
Avg. Length of stay (hours)	2.95	3.23	3.07	3.42
Total Charges	826,526	886,965	1,091,051	1,120,809

Consumers who need services are spending too much time in emergency rooms awaiting placement. We need to consider the potential liability of not taking action. Consumers who are homicidal and/or suicidal are going to be sent home after waiting for hours instead of receiving the treatment they need. Our system is failing the mentally ill. We have already started to see trends that indicate doctors are sending these people home in order to get them out of the ER faster. If they sign them to a hold they take up nursing and security staff time as well as disrupt other patients care. Meanwhile, staff attempts to contact dozens of mental health facilities with limited success. These facilities usually have protocols that won't accept patients that are violent, on probation, under the influence of drugs or alcohol, or have been treated before. Locally, we had a situation in which a person in crisis was in ER for an extended period of time. She became very disruptive and officers finally made the decision to arrest her and bring her to jail. She clearly needed mental health assistance, but due to the broken system she was taken to jail; a decision that brought further challenges with the local jail.

We will start seeing police officers not bringing consumers to ER for evaluations because the doctors are turning them away and sending them home. We have come a long way since 2006 in identifying and working with mental health situations more appropriately. We are on the verge of going backwards because our system is not capable of dealing with the volume of people we are identifying as needing help.

The service providers in Douglas County need your help and support in advocating change at the state level to better help citizens of our communities receive the timely help they need. If we start identifying and prioritizing mental health as a seriously as we take heart attacks we can change people's lives instead of adding to their pain.

Thank you for your support

Community Coalition, Douglas County

Bill Klein	Lakeland Mental Health
Jennifer Westrom	Alexandria Community Behavioral Health Hospital
Kesha Anderson	Region 4 South
Chad Larson	Douglas County Attorney's Office

Michelle Clark	Douglas County Attorney's Office
Carl Vaagenes	Douglas County Hospital
Margaret Kalina	Douglas County Hospital
Lori Rosch	Douglas County Hospital
Linda Vickstrom	Douglas County Hospital
Kelly Helmbrecht	Douglas County Hospital
Rick Wyffels	Alexandria Police Department
Scott Kent	Alexandria Police Department
Troy Wolberson	Douglas County Sheriff's Office
Brad Lake	Douglas County Sheriff's Office
Jackie Notch	Douglas County Sheriff's Office
Laurie Bonds	Douglas County Social Services
Sandy Olson	Douglas County Social Services
Tabitah Krenmin	Douglas County Social Services

Attachment

11/7/16

Comment for MH Taskforce

Please look into handicap accessibility at all MH facilities from big to small

****also - a big need to ***integrate medical and MH care

---Chronic illness - what if people are using MH services because of stress of chronic illness, and MH providers are not including awareness of or treatment of chronic illness in their treatment - sometimes resulting in making things much worse?

---Our population is growing older
There are many people with hidden are more clearly identifiable disabilities

---Being handicap- accessible is something I feel has been very much overlooked in MH facilities.

******Does anyone know why this happened - please look into it before finalizing report: examples...

----Why in one part of a hospital, ADA is followed, yet in the MH section, it is not?

-----Or why many different types of MH facilities are not required to be handicap-accessible.

----****So in essence, this is very much discriminating against those who have a disability. It certainly messes with Olmstead goals re being able to stay in community. There is a shortage of facilities to choose from - imagine trying to search for an accessible one - even smaller group.

****There are ways to make things safe (such as MH facility-compliant grab bars)

****Many times, MH staff may not have training re disabilities (other than MH), and often do not know that patients with disabilities can ask for accommodations due to their disability.

---Things that are examples are: none, or not enough handicap-accessible bathrooms

****Lack of training, including safety

***Requesting that top leadership ensure all MH facilities become ADA aware and compliant.

---*******most importantly: that people with disabilities who ask for accommodations due to a disability be treated with respect, have someone on staff that will assist them (calling an Ombudsman takes too long due to the backup re their workload) and no retaliation for asking for an accommodation.

***having an ADA coordinator at each facility - counseling office to hospital, community program to in home service - would ***greatly help

Please look into this
It can and will help so many people

Thank you
Kim Pettman

11/14/16

Dear Benjamin Ashley–Wurtmann,

We are writing to you in response to your Crisis Formulation Group meeting notes, for the Governor's Task Force, entitled: "Background and Agenda for 9/12/2016". At the end of your meeting notes you inquired about additional crisis services in the state of Minnesota. We thought it would be helpful to inform you about the crisis work that Behavioral Healthcare Providers (BHP) has been providing for the past 14 years.

BHP is a taxable, non-profit, wholly-owned subsidiary of Fairview Health Services. Since 1995, the work we have developed has been guided by our mission statement: "dedicated to enhancing behavioral health through innovation". In 2002, BHP developed the Diagnostic Evaluation Center (DEC) due to an increase in behavioral crisis patients presenting in local emergency rooms, as an innovative solution. In 2012, we began delivering this service via telehealth to

better serve critical access hospitals and rural areas in the state of Minnesota. To date, we have completed over 100,000 behavioral crisis assessments and partner with over 20 hospitals in the following care systems: CentraCare Health (1 site), Children's Hospital (2 sites), Fairview Health Services (6 sites), Glencoe Regional Health Services (1 site), Mayo Clinic (10 sites), Mille Lacs Health System (1 site), and Northfield Hospital & Clinics (1 site). In addition, DEC services are utilized in assisted living facilities and over 170 schools in the metropolitan area.

DEC patients receive a comprehensive assessment (6-8 pages long), by an independently licensed mental health professional, who provides diagnosis and treatment recommendations. Once an appropriate level of care is determined with the care team, our professional assists with locating available inpatient beds, and/or provides follow-up support to patients who are not admitted. Patients also receive appointment scheduling services through our SchedulR and/or resource identification, follow-up calls, and other care coordination activities conducted by our staff. Our partners have reported decreased inpatient admissions, a reduction in lengthy wait times for patients presenting in Emergency Departments, and a better workflow for ED staff. The result is better care for the patient and more support for the care team.

DEC services are generally covered through payer billing. Our business model has been successful for over 14 years. We respectfully ask you to include the work we have created and implemented as a successful solution when treating behavioral patients in crisis. We welcome the opportunity to meet with you, or any other task force members, to discuss our services. Thank you for your time.

Respectfully submitted,

The Business Development Department:
Sally Olson, Director of Business Development
Nicole Bauer, Account Manager
Jordan Winberg, Account Coordinator

Behavioral Healthcare Providers (BHP)

11/15/16

Susan,

I found your request for "input, questions and feedback" on the task force website after being prompted by the Chris Serres front page Star Tribune report last week.

My reaction is that a lot of attention and effort is being given to what I would consider operational complications attendant to a poorly designed underlying system. The parity endeavor is trying to force a retrospective insurance framework for services that do not conform to being an insurable risk. If I may use a metaphor, a rope is much better for pulling than pushing. Acute care medicine is usually an insurable risk. Chronic health care, including behavioral health, is like using a rope to push behavioral health through a system designed for insurable risks that have interrater reliability on diagnosis,

treatment plans and what it takes to satisfy a claimant – which is different than an outcome. Any insurance type program for behavioral health is not going to meet goals related to outcomes and efficiency. Why is nobody dealing with the strategic issues?

With much less elaboration and specificity than I could give if making a presentation, I would summarily state:

1. Insurance is always to provide financial compensation in the event of loss, never to achieve a goal. Mental and chemical health are goals and thus incompatible with insurance. When I go to a clinic and am asked for my insurance card, I know they are focused on disease or loss rather than health and a goal. With insurance quality has to do with compliance rather than outcomes. What outcomes does a life insurance company track? What outcomes are tracked by the payers of behavioral health services? If there are outcome data, how is it constructively used? The payment system undermines the nature of the services required and the noble intent of public policy and providers of care.
2. Insurance is always for events over which I have no control. We have moral hazard when insuring manageable events. When I go to a clinic and am asked for my insurance card, I'm being told there is nothing I can do to influence my health status. Behavioral health services paid through a parity insurance system in effect say that the provider will fix the passive patient. That may happen for acute care but not for chronic conditions including behavioral health which get slighted because of the insurance paradigm. Even if the medical part of diagnosis and prescriptions are insurable, the support services are not. Very seldom do we have a complete cure, which would make a clean criteria for a claim.
3. By definition, insurance has underwriting that matches premiums to actuarial risk. If underwriting is prohibited such as in ACA, we have entitlements and not insurance. Adverse selection is an issue for entitlements, never for insurance with appropriate underwriting. So what is a person entitled to? The issue goes back to defining services in terms of needs versus rights, which when Social Security was created in the 30's resulted in our seniors today living on a rights based system and playing cards in Mesa while our needy children were given a needs-based system and many live in poverty. Behavioral health is hard to define on a rights-based system.
4. The purpose of insurance is for cost to not be a concern when a financial catastrophe occurs. The function of insurance is to pay according rights defined by the policy. Insurance is not about prudent purchasing or reigning in costs. Insurance limits costs by appropriate underwriting and by selling stated benefits and then curtailing coverage when claims are a matter of judgment. Services are inadequately funded because the financing mechanism doesn't facilitate prudent purchasing.
5. Insurance requires objective criteria for claims. Chronic health conditions are incremental in nature, not definably solved and subject to varying appraisals by different providers as to the condition and required remedy. Chronic health conditions do not conform to being an insurable risk. Behavioral health services need to be managed rather than be insured with claims determined by a third party.

I would like to contribute to designing a system that is not perversely shaped by incumbent financial interests and political loyalties. When I was at Honeywell Corporate I set up pilot programs in four states to manage the procurement of uninsurable risks related to behavioral health. For ten years after that I made a living by writing, speaking at conferences and consulting with major buyers and providers

of behavioral health services across this United States. My Ph.D. program in Social Work was designed around these issues. I designed, wrote and sold software that administered the management of behavioral health services through the case manager. I think I could contribute at the strategic level in getting the premises right and in building a solid foundation for an optimal system.

I would welcome any opportunity to talk further, make a presentation, or sit on a task force. My master's degree was in social group work. I have served on many non-profit boards, and been chair of several. I believe I could contribute both as to content and process.

Thanks for your attention in these busy days.

Lee Wenzel