

# Governor's Task Force on Mental Health

COMMENTS RECEIVED 9/22/16 THROUGH 10/10/16

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10/10/16



10 October 2016

To: Governor's Task Force

From: Thrive Behavioral Network, LLC

Re: Amendment language that restricts access to MH crisis services in rural hospitals

In 2016, DHS's Vidyo initiative began collaborating with Birch Tree Center in Duluth to engage in the Vidyo initiative and be able to provide mobile crisis services via tele-health Vidyo technology. Shortly after, it was discovered that recent language was amended that prevents trained Mental Health Practitioners (MHPR) from providing crisis assessment, intervention, and non-residential stabilization via Vidyo. The language states that only a licensed Mental Health Professional (MHP), eg., LP, LPCC, LMFT, or LICSW may provide crisis assessment via Vidyo. Bear in mind, MHPRs under the supervision of an MHP, are currently allowed to deliver face-to-face crisis assessment, intervention, and stabilization services every day throughout our state. A decision was made that delivering the service via tele-medicine is significantly different, but we have not found any statistically significant data that was referenced in making this language change.

*"Mercy Hospital is attempting to treat patients when they come to us for mental health issues by utilizing community partners. Part of that care could be given via tele-mental health. Requiring tele-mental health personnel to be licensed ties our hand in getting these patients quality care especially in off hours and weekends when master's level licensed mental health professionals are difficult if not impossible to find. Since trained mental health trained practitioners are already able to give crisis care face to face, they should be allowed to give crisis help in critical off hours via tele-medicine."*

*Susan Jamros, Nursing Manager, Emergency Department, Mercy Hospital, Moose Lake, MN*

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There are several levels of mental health workers that are defined in 245A in Minnesota. We are focused on the two categories of mental health workers discussed above MHPs and MHPRs. MHPs are licensed by the state of Minnesota by various licensure boards. They include psychologists, professional counselors, marriage and family therapists, and licensed social workers. They all hold degrees at the graduate level. MHPRs by contrast may qualify through educational and/or direct mental health work experience. They hold a Bachelor's Degree in a field related to human services in addition to supervised direct care experience, or they prove qualification through having accumulated over 6,000 hours of direct experience in working with populations that have mental health challenges. These MHPRs are always supervised by an MHP and this system is condoned and enforced in a multitude of mental health services throughout the state of Minnesota including IRTS, Mobile Crisis, Residential Crisis, Eating Disorders, Assertive Community Treatment, and Adult Rehabilitative Mental Health Services.

Across the canon of psychology, in studies that examine the correlations between licensure and success in mental health interventions, it is basically shown that the longer a person has worked in mental health, the more successful the outcome of any intervention is. Therefore, we can logically assume that a BA-level MHPR that has worked in mobile crisis for 10 years could theoretically be as effective as or even more effective than a MA-level MHP that has only been in the field for a couple of years. Again bear in mind that MHPRs do not function autonomously. They are always directly supervised by an MHP who endorses or amends the conclusions that any MHPR comes to in a crisis assessment and/or intervention. Additionally, we are currently unaware of any piece of peer-reviewed statistically significant data that shows a service is causally degraded simply when it is delivered via tele-health Vidyo technically versus in a face-to-face intervention. While there are known shortcomings to MH services delivered via telephone only, primarily the loss of visual facial cues, this is not a factor in successful video-based technology with audio and visual resources.

In a draft dated 29 September 2016, the Mental Health Services Improvement Workgroup facilitated in meetings hosted by DHS published a preliminary set of important considerations. Chief among them was a multi-faceted subset of points that relates directly to the issue at hand—alliances with remotely located hospitals, especially emergency departments, for MHPRs based at Birch Tree Center in Duluth to deliver crisis assessment and stabilization via Vidyo technology—services they provide on a daily basis within a thirty mile radius of our facility in Duluth. The MHSIW outlines as follows:

**Recommendation #8: Implement Short-Term Solutions to Improve Crisis Response**

1. *Build telehealth program capacity in Minnesota to improve crisis response.*
2. Integrate CIT training in pre-service education for law enforcement students.
3. *Incorporate mental health staff where people seek initial help: critical access hospitals, urgent care centers, emergency rooms.*
4. Develop residential services for children in crisis.
5. Implement mental health/law enforcement co-responder models.

6. *Improve data-sharing and collaboration in local crisis response.*
7. *Improve standards for crisis services.*

Sub-points (1), (3), and (6) are especially germane to our conversation of how we can expand and not restrict access to crisis care in rural locations. We had been in the midst of conversations with two remotely located hospitals and the Vidyo initiative of the Arrowhead Health Alliance when this language stalled our efforts to begin formalizing collaboration and deliver services where Vidyo technology has already been installed and Vidyo-based services were about to begin. While we will continue with this technology, we will only be able to provide services when an MHP is available to directly perform this service. Not only is this restrictive since an MHP is currently only available 33% of the time that we have access to MHPs. This further misappropriates the time that the MHP has to supervise other MHPs by having to directly allocate MHP resources to performing *direct interventions*, versus providing *supervision* to a team of individuals that could have provided the same service to a greater number of individual who are in need.

*“Lake View Hospital and Birch Tree Center in Duluth have effectively partnered to provide the ability for the crisis response team at Birch Tree to utilize Vidyo to assess patients presenting to Lake View’s emergency department in mental health crisis. This technology provides our rural hospital with one more effective tool to best care for and determine appropriate placement our patients in mental health crisis.”*

*Greg Ruberg, President/CEO Lake View Hospital, Two Harbors, MN*

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We appreciate your time and consideration in this manner and hope that a language revision can be facilitated that will deliver the safe and quality services that are already being rendered face-to-face by our mobile crisis team to a population that would otherwise lack access to quality mental health care. Vidyo will only expand our capacity without degrading any quality in care.

Please direct any questions or comments to:

Ben Thompson

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October 7, 2016



October 7, 2016

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

On behalf of the Nurse-Family Partnership National Service Office (NSO), thank you for the opportunity to submit written testimony to the Governor's Task Force on Mental Health, specifically related to Health Promotion and Prevention. We applaud your commitment to paving the way towards a healthier future for Minnesota families.

Evidence-based, voluntary home visiting programs like the Nurse-Family Partnership® (NFP) are a critical component and partner in a Mental Health Continuum of Care designed to holistically support maternal health, child health and development and the promotion of safe and nurturing parenting. We strongly recommend further investment in proven prevention strategies like NFP that support healthy practices and build protective factors against mental illness.

Nurse-Family Partnership (NFP) is a targeted, voluntary, community health program that partners registered nurses with first-time mothers beginning early in pregnancy and continuing until the child turns two. The NFP model has been rigorously tested, with over 37 years of randomized control research and longitudinal follow-up studies across diverse populations and geographies. NFP has demonstrated the ability to dramatically improve pregnancy and birth outcomes, child health and development, and empower families to break intergenerational cycles of poverty.

NFP also plays an important role in providing community linkage: to crisis intervention, mental health and substance use services. In MN from June 2015 to June 2016, almost 300 NFP clients utilized mental health services across the state through government and community services. During the same time period, NFP nurses made over 650 referrals for crisis intervention, mental health and substance use for clients enrolled in the program.

Finally, NFP is cost-effective. The RAND Corporation estimates that every dollar invested in NFP yields up to a \$5.70 return on investment. A comprehensive analysis by Dr. Ted R. Miller of the Pacific Institute for Research and Evaluation projects that the total government cost savings due to NFP's outcomes in Minnesota will average \$17,445 per family served, with 55% of all government cost savings per family served accruing to Medicaid.

Thank you again for this opportunity to submit written testimony and for your continued commitment to engaging community partners in this important dialogue.

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Sincerely,



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10/6/16

Comments from William Czech

Please accept this comment to the Governor's Task Force On Mental Health, and the Formulation Group on Crisis Response. Thank You.

**EMBEDDED MENTAL HEALTH CO-RESPONDERS:  
 An Innovation To Increase Effectiveness & Efficiency**

The MN Mental Health Task force must evaluate how the state can best use its resources to improve the mental health system. This would be much easier if resources and personnel were unlimited. So, the success of the task force will inevitably be measured by its ability to provide insightful analysis and useful recommendations for needed change and innovation that creates the most efficacious use of precious resources.

Innovation comes naturally to Minnesotans. Yet, innovation might naturally be dismissed when dealing with a provider system that needs more resources and more people across the board. In such circumstances, innovative approaches might be viewed as competing with established institutions for limited resources. I urge the task force to avoid the trap of this kind of territorial thinking. I urge the task force to look closely at reforms and innovations that can fill gaps in service and add efficiency, across the “silos”, to the system as a whole. I urge the task force to recognize the Police-Based (Embedded) Mental Health Co-Responder model as the kind of innovation Minnesota needs.

This innovative approach might seem to be removed from the established systems of service, but it is not. The Embedded Co-Responder is a professional that would almost always be employed by and supervised by the county health department – the same people who provide mobile mental health crisis team services.

In fact, the Embedded Co-Responder can accurately be viewed as a specialty version of a mobile health crisis team service, created to work better with law enforcement and bring professional care to individuals in potentially life-changing incidents. This is very necessary because without an Embedded Co-Responder a law enforcement response will not evolve into a professional, on-scene mental healthcare response. Research and experience have shown that law enforcement does not utilize county mobile health crisis teams well because they have poor response time or are simply unavailable. Police also resist calling in county mobile teams because that 3<sup>rd</sup> party responder approach does not break down the walls of the two silos to achieve the needed trust and teamwork. Embedding a county mental health professional (co-responder) within law enforcement agencies has proven to be an excellent way to achieve full collaboration and achieve the best outcomes for the citizens in crisis who are contacted by law enforcement. It is about efficiency and effectiveness. Mobile health crisis teams and ACT teams are immensely important and are preferred over a law enforcement response. But, law enforcement currently responds to many more mental health related calls than do county teams and will always have contacts with persons in mental health crisis. Sometimes a law enforcement response is even appropriate. The problem is: this contact becomes a gap in care because county teams are not able to add

capacity and overcome barriers to efficiently serve as full partners with law enforcement when mental health incidents lead to a law enforcement response. This gap in mental health care, likely the largest mobile mental health care response in the state, is being filled by officers with 40 hours of training. Researchers have noted that this becomes a “substantial, unnecessary, and inappropriate burden on law enforcement.” (Helfgott, 2015) It is also an approach that falls short in terms of efficiency (systems resources) and effectiveness (consumer outcomes). In sum, this is why the Co-Responder Model is necessary in Minnesota.

The Embedded Mental Health Co-Responder model is an innovation that adds efficiency and effectiveness where it is needed most. These professionals (embedded co-responders) serve a vital function for the provider system by doing on-scene assessments that can be more accurate and might enable more partnering with family and friends. These means a better assessment and more effective follow-up work. In the United Kingdom they, appropriately, call this model “street triage”. Research has consistently found that the Co-Responder model leads to “more nuanced dispositions”, better use of outpatient services, reduction in the number of transfers (traumatizing), and fewer referrals to inpatient care. Thus, the professionals employed as Co-Responders reduce burdens on critical provider inpatient services while creating better outcomes for the citizens contacted. Co-Responder teams typically perform (or coordinate) follow-up work that targets the “frequent presenters” who repeatedly initiate law enforcement responses. This follow-up work helps keep these people stable and further reduces burdens on systems including law enforcement. These results were so stark in the United Kingdom that “Street Triage” is on the verge of being implemented country-wide. In the United States, there is also increased interest in Co-Responder Teams that enable an unfortunate law enforcement response to evolve, as rapidly as practical, into a professional on-scene mental health care response.

The Governor’s Task Force On Mental Health has only a little time to do a big job. I urge the task force members to value innovation and give the Police-Based (Embedded) Mental Health Co-Responder model full consideration.

William Czech

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10/5/16

### Michael's Story

On May 31, 2016, my husband and I came home and found our 21 year old son Michael in our bed "asleep" and there were pills scattered around the floor. We could not get him awake, he was breathing but very incoherent. I called the Wellstone Center and explained what was going on and could they help me get him somewhere for help. I had explained he had been very depressed and was drinking heavily and very careless. They said to call 911.

We called 911, the ambulance came and brought him to the hospital in Hibbing. We explained to the attending PA his history with drugs and alcohol and that he had been very depressed. We were convinced he was suicidal. He had just been diagnosed with Type 1 diabetes in April and that was like a death sentence to him. When he was diagnosed in April it was because he had gone to the emergency room for carbon monoxide poisoning and they had done the test then. We believe the carbon monoxide was a failed suicide attempt.

She [the attending PA] put Michael on a 72 hour hold. We had told her many things that were going on in Michael's life causing depression. There were times when Michael would try to get help and then just give up. After being there in the ER for approximately 6 hours, they sent him upstairs to the psychiatric unit.

\*Note: when they send someone from one unit to the next they discharge them and then re-admit them. In Michael's case he was discharged from the ER and then admitted to the psychiatric unit. During this time all information is given to the attending physician/PA/CNP at that time. When there is a shift change, the shift leaving gives a report to the shift coming on. All of that patients information is also in the medical records, which they have access to, all they have to do is look! It even states in his medical records, "the parents are begging us to put a 72 hour hold on him and keep him".

On June 1, (the next day) I received a call that they were discharging Michael. I called the unit and asked to speak with his doctor. There was no doctor there, he was being "treated" by a CNP. I said I needed to speak to her about Michael. She said she could not tell me anything about him. I said she didn't have to, to just listen and I will tell you about him. I explained he needed help and his history (everything that was in his record from the PA the night before) and that we were worried he was going to hurt himself. They still discharged him.

I went to pick up Michael as I didn't want him to get a ride from anyone else. When I went up to the unit they wouldn't even let me inside. I had to wait outside in the hall. They wouldn't even talk to me. As I was waiting another CNP (the one that admitted him to the psychiatric unit the night before) walked out and I asked why are they discharging him. As she quickly walked by she said I don't know, I didn't have him today, and continued walking down

the hall. I was very upset at what I felt was a very little, if not any at all, concern for Michael, their patient. We were walked out of the building by a CNA.

On June 4, 2016 at approximately 2:00 AM, I was awakened by very loud noises coming from Michael's room. When I went in there he was falling all over the place, didn't know who he was, who we were, where he was etc. We knew he had been drinking, we could smell it, but we didn't know if he had taken anything else. Again I called the Wellstone Center and explained what had happened a few days ago. They said to call 911 and ask for a transport to detox. We explained that we had tried that in the past and when the police arrived, Michael would get disrespectful, or hide, or whatever and then they would end up taking him to jail instead of to detox or the hospital. They again advised us to call 911, which we did.

A police officer arrived first and we had explained about the 72 hour hold and the hospital releasing him after 18 hours. The officer rode with Michael in the ambulance and he placed a 72 hour hold on him when they arrived at the hospital. At approximately 9:00 AM I was called by the hospital and they said they were discharging Michael. Again I explained his history and all of our concerns. This was a different attending PA or CNP than we had the previous time. I asked her to please look at his record from the last time he was there. She said she would look and call us back.

They had Michael do an assessment over the internet. I do not understand how you can do an accurate assessment over the internet. You don't see body language, you can't see that their eyes are blood shot, or if they are anxious, etc. They said he was OK to go home and that they had set up some appointments for Michael in the future with a psychologist and that he would do a drug and alcohol screening etc.

I was called back and told that they were discharging Michael again. I told her he was just going to do it again (which she documented in his records). They sent him home in a taxi at approximately 12:00 PM. Again releasing before the 72 hour hold was up, this time less than 10 hours.

I read in Michael's record that they had sent him outside to wait for the taxi and his nose started bleeding so they brought him back into the ER and treated it. It states that he clearly had no regard for his safety and was very reckless. He was stumbling around. When he returned home he was still drunk (I can't believe they let him go in this condition) and went right to bed.

On June 5, 2016 when my husband went to check on Michael he was unresponsive. He was breathing but very shallow. The ambulance came and gave him a shot for his diabetes. His blood sugar had gone up to 30 before they left our house. We think he must have woke up early in the morning and started drinking again and gave himself too much insulin, and



maybe took some pills. He was taken to the Hibbing hospital again. They put in a breathing tube, he went into shock, he was having seizures, and he went into a coma. They flew him to Miller Dwan in Duluth. He was in ICU for 4 days. He was in very critical, life threatening condition.

On June 8, 2016 they did an MRI and found that Michael had severe brain damage. They sent him to St. Mary's Neurology ICU. He started to come out of the coma a bit, but then he started having "brain storms" and they had to heavily sedate him again. He remained at St. Mary's until July 1, 2016. They sent him to a nursing home in Superior, Wisconsin, which we were told was a recovery center. They rushed him out of the hospital at 5:30 PM on a Friday, a holiday weekend. They put him on the the second floor, they had no air conditioning, they had to go in their basement to find a bed suitable for him. They didn't have the right equipment, for his feeding tube, or for his moisture for his tracheostomy.

On July 4, 2016 Michael was brought back to St. Mary's ER. He had a temp of 106, he asparated and he had acute sepsis. He again went to the ICU for a while, and then to step down, until they found him a more appropriate facility.

On July 28, 2016 Michael was taken by ambulance to Red Wing Health Center in Red Wing, MN, where he remains today. This is a traumatic brain injury facility. We were hoping he would be closer to us, but this is the only facility that would take him in his condition. Our lives have been changed forever. None of this had to happen! If only they would have listened to us (Michael's parents) the people he lives with, the people who know him better than anyone. What is the purpose of a 72 hour hold if it is totally ignored. Not once, but twice, they could have helped and they didn't.

This has affected our lives in so many ways. This has been constant stress and heartache on our whole family. Financially (which we would do anything to be with Michael) it has been a bit of a burden for some of us. We drive to Red Wing from Hibbing, and previously we had to drive to Duluth and back to Hibbing, or spend the night in hotels. We have been doing this for 4 months now. No one is responsible for this? No one is being held accountable for this in any way? I don't understand how they can do this and nothing happens, they continue on with the same inadequate health services and incompetent mental health care employees.

On August 5, 2016, I received a call from Paula (the CNP who discharged Michael) and her superviso(?). They called to apologize! Hmmm? Took 2 months? Didn't mean anything anyways, was just another way of saying "I screwed up and don't want to get in trouble, not "I am sorry my actions caused this". She (the CNP) said that if she had known all the information I was telling her, she never would have released Michael. Well it was all in his chart! Then they asked what they could do better. I told them many things but one in particular was the

fact that PA's and CNP's are acting like real doctor's. That they should have a doctor of psychiatry in the building or on call to confere with at the very least. Someone overseeing what they (PA's and CNP's) are doing. Doctors do residencies and go to school for many years before they can evaluate people with mental illness, it seems uncomprehendable that PA's and CNP's can do this on their own. Yes, they are working under a doctor, but that doctor isn't even in the building or the town! People are being assessed over the internet?

Her reply to this was that no matter how considerable of a financial package they offer, it is hard to attract psychiatrist to the area! Well then I ask, if they don't have the professionals to do this job properly, why in God's name did the IRRRB give them money for more beds? Really?

Again now, none of this had to happen. My son is alive but I still grieve everyday, it is like he died. The Michael that we had before this is gone. Like I said he is still here, but everytime I look at him I think of who he was, and that he will never be the same. Our Michael is gone, and we are hoping to get back as much of him as we possibly can. This means we have many months ahead of us, and we are not guaranteed that Michael will not be in a permanent vegative state.

He may have no future. So while these wonderful competant employees of Fairview Range in Hibbing (sarcasm) are enjoying all the things parents enjoy with their adult children, we will be hoping Michael doesn't stay in a permanent vegative state. Michael was a very active person and would be very upset if we let him continue on in the state he is in right now. After a year, (they say if a person doesn't emerge from vegative after a year they probably aren't going to) we may have to make a very hard decision. Had we known what was in store for Michael and us, we may have made that decision on day one.

As these other parents are walking down the halls of colleges checking out which one works for them, someone will be pushing Michael down the hall to give him a bath. While these parents are pacing the hospitals waiting for the arrival of a new grandchild, we will be waiting the 7 to 10 days it takes someone to starve to death after their feeding tube has been removed. As they hold their new grandchild and welcome them into the world, we will be holding Michael's hand and telling him good-bye. Dramatic? Yes!!! You have no idea the anger I feel! ALL of this could have been avoided, if only we had appropriate mental health care providers and competent mental health care staff in northern Minnesota!

Thank you for taking the time to read this. I hope others' stories have a happier ending.

Dorothy Cencich

Comments from Dorothy Cencich - Ideas For The Task Force

How many times have you heard that mental health isn't taken seriously, or that it is not a health, or medical issue? That someone who is depressed needs to just snap out of it? Well I say go with it! Mental health shouldn't be combined with medical health in an inpatient setting. It isn't usually in an outpatient setting. You

don't go to a psychologist for an ear ache, then why would you go to a medical center for mental health? Mental health should stand on its own. By mental health I am throwing everything in there, addictions, depression, schizophrenia, bi-polar etc., EVERYTHING that can be defined as a mental illness.

**First:** Find a building. Start a pilot project. Maybe in an old school house or apartment building that isn't being used anymore. (Is Mesabi Academy in Buhl available?)

**Second:** Get funding. If the Minnesota state government can put all of that money into a football stadium(?) they should be able to invest some money into the people of Minnesota. So the government should set aside "x" amount of dollars to implement the new system.

**Third:** Use therapy that works now. Go around to facilities that have worked, whether it be mental hospital, inpatient or outpatient addiction centers. (Like Project Turnabout in Granite Falls). Take the things that were effective and worked for them and use all of this knowledge. Don't waste time or money reinventing the wheel.

**Fourth:** Implement a new program. I would set up a facility something like this . . .

**Intake Phase:** I would have an area where the nurses and doctors are and call it the Intake Phase. Here patients would be evaluated and a personal care plan would be created, then they would be sent to the proper Phase they belong in. This area would also be used for detoxing alcohol and drug users. They could be easily monitored by the nurses and doctor. When they have detoxed then they would go to their Phase they belong in. This is also the area where all patients would go to get their medication. Therefore only 1 nurse 24/7 and maybe a doctor Monday-Friday and on call 24/7.

**Phase 1:** Some of these people may be here for a very long time and have severe mental problems. This would be a very secure area of the building. (6 month to ? stay). I would have one female and one male security person 24/7.

**Phase 2:** Some of Phase 1 patients may progress and aren't such a threat to themselves or others, so they move up. These are also patients who have come in and need acute care, have displayed behavioral problems maybe due to not taking meds etc. (3 to 6 month stay).

**Phase 3:** When people in Phase 2 have progressed they now move up to Phase 3. Phase 3 is also for people who are maybe newly diagnosed, or need to be diagnosed. They can function well out in the community, they just need some tools for coping, or living life as a recovering addict (any addiction) or with a mental illness. (1 to 3 month stay)

**Phase 4:** Half way house. Patients are now out in the community, they have a job (even if it is part-time) they have minimal supervision. Maybe they "check in" every week, month, whatever. If need arises they can come back to intake and spend a day or two to "regroup".

**Fifth:** If this works after a year, then start more facilities around the state. Keep mental health out of the medical systems. Work to eventually have mental health facilities in every region of Minnesota. If there is a medical issue such as bleeding, overdose, anything that is an immediate medical issue, have it dealt with and as soon as the patient is medically stable send them to a Mental Health Facility. The reason for this is that most of the time a person spends in a hospital setting, they see more medical workers than they do mental health workers. You hear of these workers getting frustrated and burnt out, it isn't a matter of not enough staff it is the wrong type of staff. If I couldn't hammer a nail with a spoon, and I got another person to hammer with a spoon along with me, did the nail go in yet? It doesn't matter how many nurses and CNA's you have, if they aren't trained in mental health they won't be very effective. Try to stay out of a "regular" hospital setting. You are wasting money on "medical personnel" in a mental health facility when it should be hiring "mental health personnel".

**Sixth:** There would have to be some sort of legal language, where these patients, if they are bad enough to be brought to a hospital or mental facility, then they should get the proper treatment they need. They should **HAVE** to at least be held for 72 hours, no exception. No one can release a patient before 72 hours. It has to be a state

law. Maybe if these people were kept for 72 hours that might give them enough time to get out of their system whatever they have consumed and can think more clearly and maybe take a look at themselves and decide they want to stay and get help.

**Seventh:** Advocates for both the patient and for their loved ones. Help should be easy and quick, not just for the patient but for the people who are trying to get help for them.

**Eighth:** Literature etc. should be readily available for people right in the ER or doctor's offices. Numbers to call, advocates, information about mental illness, anything to help.

I just wonder how many homeless people out there have a mental illness. Maybe they have no family to advocate for them. How many people in prison have a mental illness and rather than being helped, they are being punished for it? Have we taken our human rights so far that we can't legally help people? Physician assisted suicide is NOT legal in Minnesota. By turning away these people and not insisting they get the help they need and deserve, is that not assisted suicide?

How many re-admissions are there in the hospitals we have now because patients didn't get the proper care to begin with? Maybe they were handed a prescription, maybe they drew a pretty picture in therapy, maybe they lied and said they were fine, maybe they were good at manipulating staff (especially with addictive personalities) and were sent on their way, no follow-up? Who knows. All I know is mental health care in Minnesota is very sadly inadequate to say the least.

Dorothy Cencich

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9/30/16

Comments received from Patti Cullen, Care Providers of Minnesota

To: Governor's Task Force on Mental Health  
 From: Patti Cullen, President/CEO, Care Providers of Minnesota  
 RE: Continuum of Care Issues  
 DATE: September 30, 2016

Care Providers of Minnesota is a membership association with nearly 1,000 members across Minnesota represent non-profit, for-profit, and government-owned organizations providing services along the full spectrum of post-acute and long term services and supports. As you prioritize your issues and recommendations for the Governor's Task Force on Mental Health we want to be sure the unique mental health needs of the elderly are included in the discussions. There are two general areas of concern: ensuring access to training and services; and appropriateness of placement.

While many transitions of care for seniors are smooth transitions, with positive outcomes, that is often not the case for seniors (or "near" seniors) who have co-morbidities that could include mental or chemical health needs. Over the past few years, as other available options become scarce, especially in rural communities, long term care facilities (nursing facilities and/or senior housing/assisted living) have become the placement options for seniors with mental and/or chemical health needs. While the majority of the placements in our settings are appropriately made due to physical/medical issues, the challenge for the providers is how to best address their corresponding mental and chemical health needs in addition to their physical needs.

At times the nursing facility or assisted living setting admits individuals with undiagnosed mental illness, and their mental health treatment needs only manifest themselves after we have already admitted them. Many of these placements are individuals who are far younger in age than the typical nursing facility resident (who are in their mid-80s). So, not only are we concerned about making sure we can address both physical and mental health needs for these new admissions, we also need to be sure all of the other residents/tenants, who are frail seniors, are not at risk. Compounding these issues, community nursing facilities also feel pressure from their community hospitals to accept admissions because the hospitals are feeling the financial pressure due to delayed discharges. These discharge delays of seniors/near seniors are frequently due to challenging behaviors, complex co-morbidities, non-compliance with treatment, active substance use and/or lack of payment.

**Suggested Recommendations:**

1. Since we already are experiencing significant workforce shortages, requiring additional staff or stringent training will have negative consequences. Rather, make available on-call consultation and on-line training to guide staff in our buildings. Make workforce training grants available via an RFP process.
2. Revise the critical access nursing facility program to focus on higher rates for those community facilities who choose to provide "niche" mental and chemical health services.
3. Make tele-health services available using psychiatrists/behavior health specialists.
4. Strengthen the discharge planning process so mental and chemical health needs are clearly identified prior to discharge into the community.
5. Remove any size or setting barriers that limit the community choices for Minnesotans with mental health needs, in particular any % restriction for assisted living settings.
6. Revise payments under Elderly Waiver program to reflect additional service and staffing needs of recipients with chemical and mental health needs.
7. Streamline care coordination functions and communications, especially for Medicaid recipients, who could have up to seven care coordinators overseeing their services after an acute episode.

Questions/comments can be directed to: Patti Cullen, [pcullen@careproviders.org](mailto:pcullen@careproviders.org), 952-851-2487.

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9/30/16

Comments received from Cary Zahrbock, Regional Vice President, Medica Behavioral Health

Hi Jen,

Hope you are well! During Thursday's DHS MH Improvement workgroup, Sue Koch shared the Governor's Task Force draft recommendations with the group. I understand you are leading the IP bed capacity formulation group, thus I'm reaching out to you with my concern.

Following are the recommendations under IP bed capacity shared with us today:

**Recommendation #7: Implement Short-Term Solutions to Inpatient Bed Capacity Problems**

1. Establish an ongoing body to coordinate and oversee work on inpatient bed capacity
2. Increase Intensive Residential Treatment Services (IRTS)
3. Strengthen housing and supports
4. Increase capacity of competency restoration
5. Make small changes in the Civil Commitment Act
6. Support efforts to reform addiction treatment
7. Adopt previous recommendations on discharge planning
8. Temporarily increase capacity at the Anoka Metro Regional Treatment Center?

My concern is the notable absence of the impact of the 48 hour rule on IP bed capacity planning. From my perspective, the 48 hr. rule (which was implemented without MH stakeholder feedback) has had the single most significant negative impact on IP bed capacity during my MH career. I suggest that adding mental health services to serve individuals in jail who have mental health concerns, rather than moving them into the mental health delivery system be considered by your workgroup.

Following are some of the impacts I see from a health plan perspective and from the perspective of stakeholders we work with (hospitals, CCBHC's, Anoka, Care Coordinators, TCM's to name a few).

1. There is limited to no access to Anoka RTC for anyone who is not coming in from corrections, so individuals who would traditionally benefit from Anoka no longer have access.
2. Safety concerns have increased at Anoka, both for staff as well as individuals with mental illness in Anoka as the population has become significantly more violent and predatory.
3. Community IP MH hospitals are backed up with people waiting for admission to Anoka, so IP MH access is severely limited for all Minnesotans seeking MH care due to the 48 hr. rule.
4. The severity of individuals placed in CCBHC's due to the 48 hr rule have also increased safety concerns for other patients and staff.
5. Individuals who are predatory criminals are now taking MH treatment resources in treatment settings, rather than receiving MH treatment in an environment appropriately controlled through corrections.

My concern is that no amount of focus on IP bed capacity will have an effective impact while the 48 hour rule remains in place. I respectfully request that this issue be incorporated into the Governor's task force formulation subgroup focused on inpatient MH capacity.

Please let me know if I can be of any assistance in your work. Thanks!

Cary Zahrbock, MSW, LICSW

Regional Vice President  
 Medica Behavioral Health  
 Telephone: 952-205-2794 Fax: 952/205-3716

9/26/16

Comments received from Teresa Briggs, Koochiching County

Susan

I am writing on behalf of Koochiching County to provide our perspective in regards to providing for our mental health population. Koochiching County sits on the northern border and is remote. Travel distance to a larger service city is two plus hours, that being Virginia or Bemidji. Through our local health resources, we are working on the creation of a Crisis Response Team and short term treatment beds to assist those in need here at home. However, our unsolvable problem is the unavailability of beds in the region for higher need treatment. Our Sheriff's Department on a weekly basis is transporting persons to and from treatment facilities for court appearances as well as transporting persons from our hospital to treatment facilities. There are no beds available in our regional facilities so the transports the last couple years have been to Fargo (4 hours one way), Rochester area (7 plus hours one way) and more recently, the Twin Cities (5 plus hours one way). In a given day, the Sheriff is sending transports to the cities to bring the person to court and after a few minutes of court, returning them back to the treatment facility, and multiple times a week. Though we understand the business dilemma in holding beds open, we need available beds in the region to not only reduce the burden on the County but also to provide for a closer to home facility for the person in need and for the family to visit them. And understanding the person's right to appear at their court hearing, if the hearings could be done by interactive television or at the location of the treatment facility it would reduce the travel stress on the person as well.

Below is a summary of the miles traveled by the Sheriff Department for transporting persons to regional treatment facilities as reviewed above.

<u>New Report - Sheriff Transports - Treatment Facility</u>	
Year 2015	52,748 miles traveled with 1,115 hour of travel.
Year 2016 thru 9/13/16	60,000 miles traveled with 1200 hours of travel.
	In addition hotels, gas, meal reimb.

We would greatly appreciate your consideration of our comment as you move forward on your task to improve the delivery of mental health services in the State.

Thank you.

Teresa Briggs

County Administration Director  
28-283-1152

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9/26/16

Comments received from Michael Trangle, Health Partners

Hi Sue,

I would like to make 2 recommendations to the task force for consideration:

- 1) If we are talking about transformation and starting to make changes that will get us to a best practice that improves access, quality of care and saves money, we should consider setting a goal that all mental health crisis services throughout MN should include the capacity to quickly provide evaluations/intakes, crisis stabilization services AND rapid access to a trained psychiatric prescriber (psychiatrist, psychiatrically trained NP, PA, or CNS). I've attached results of a study that highlights the cost effectiveness of such an approach. The East Metro Adult Mental Health Crisis Alliance has data confirming very good patient satisfaction with this approach. The latest data from that group shows that when a crisis therapist is involved about 18% of clients avoid going to their local emergency room and that when they see a psychiatric prescriber 31% avoid going to their local emergency room.
- 2) The recent MN Hospital Association study highlighted the number of PAD (potentially avoidable inpatient psychiatric days- days where psych patients were not safe to go home but could have gone to an intermediate care program or facility had a bed been available) throughout MN on a regional basis. Unfortunately that is where the analysis stopped. For each region to KNOW and then begin taking ACTION on this data further analysis is required which is easily accomplished (and has already been done for the East Metro Region under a previously funded grant). Then DHS, the counties and local providers will know the exact number of beds/programs needed and can begin to work to increase their IRTS, foster home, residential chemical dependency providers, nursing homes etc. beds truly required to meet the needs of their region. The expense would require \$2500-\$5,000 depending on the specifics.

I have more details available if that is required.

Michael Trangle

Attachment:



## The impact of community-based mental health crisis stabilization

### » Background

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Mental illness affects millions of American each year. Using estimates from SAMHSA, it is estimated that 245,800 adults living in the east metro had a mental illness in the past year. An estimated 59,300 adults in the east metro had a serious mental illness, and 49,170 had a substance abuse problem in the past year. Serious mental illnesses (SMI) are diagnosable mental disorders that interfere with or limit one or more major life activities for adults. Conditions include bipolar disorder, dual diagnosis, major depression, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder, and schizophrenia.

#### *East metro services*

The east metro of the Twin Cities metro area offers a robust service delivery system for adults living with SMI, including crisis services. Community-based crisis stabilization is one available service, which provides short-term, intensive support, education, and treatment to address a specific mental health crisis. Individuals are supported until they are linked with community resources to address longer term needs.

### » Current study

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The Mental Health Crisis Alliance was interested in exploring the impact of community-based crisis stabilization services on healthcare utilization. Specifically, to what extent does use of outpatient mental health services, inpatient hospitalization, and emergency department use increase or decrease following crisis stabilization. In addition, the current study explored the impact on the costs associated with inpatient hospitalization for patients who received crisis stabilization services. Wilder Research was contracted to obtain claims data from the Department of Human Services, and conduct the study on behalf of the Mental Health Crisis Alliance. The scope of this report is limited to claims data provided by DHS, which includes patients who were enrolled in state Medical Assistance (MA) programs between January 2008 and April 2010.

- The impact on service utilization was investigated for the overall patient population served during the identified time period, as well as those patients who were identified as “high-frequency” users. High-frequency emergency department patients were identified as those patients who had five or more emergency department claims in the six months prior to crisis stabilization. In contrast, low-frequency users are those who had fewer than five emergency department visits, including those who had no emergency department visits, in the prior six months.
- This study was approved by the DHS Institutional Review Board (IRB) in October 2011, and renewed in September 2012. A detailed methodology is available at [www.wilderresearch.org](http://www.wilderresearch.org).

*continued*

For more information contact Roger Meyer, Project Director, at 651-338-5318 or [roger@meverconsulting.org](mailto:roger@meverconsulting.org)

## » Key Findings

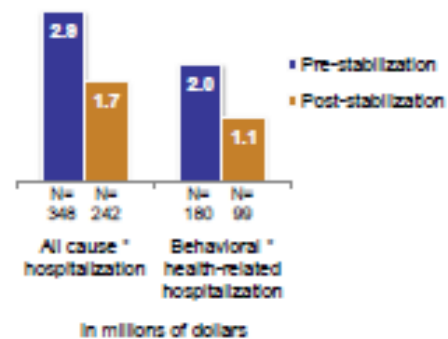
- Emergency department utilization decreased significantly post-crisis stabilization for all patients, including “high-frequency” patients.
- Use of outpatient mental health services increased significantly for low-frequency patients following stabilization; no statistically significant change in utilization was observed for high-frequency patients.
- All-cause inpatient hospitalization decreased significantly for all patients, including high-frequency patients. In addition, significant decreases in mental health-related admissions were observed for patients as well.
- A cost-benefit analysis found that for every one dollar spent on Crisis Stabilization services, there is a savings of \$2.00 - 3.00 in hospitalization costs.

### Inpatient hospitalization: prior to and following crisis stabilization



## » Cost implications

- Total costs for all-cause inpatient hospitalization decreased from \$2.9 million prior to crisis stabilization to \$1.7 million post-stabilization. This decrease was statistically significant.
- Total costs for mental health hospitalization decreased from \$2.0 million prior to stabilization to \$1.1 million post-stabilization. This decrease was statistically significant.
- The net benefit for all cause hospitalization patients after receiving mental health crisis stabilization services is nearly \$0.3 million, with a return of \$2.16 dollars for every dollar invested. Patients with mental health related services generate a little over \$0.3 million in net benefits with a return of \$3.19 for every dollar invested.



9/26/16

Comments received from John Dinsmore, Director, Otter Tail County Community Services Division

Sue and Jim,

Thank you for all of your excellent work in coordinating this important effort. Attached you will find a set of comments and recommendations for you and the Teams to consider. This seven-page document has attempted to provide feedback and recommendations in a format that addresses the key issues identified by each of the Formulation Teams:

- Pages 2-3: Immediate Improvements in Inpatient Bed Capacity and Levels of Care Transitions
- Page 4: Redefining and Transforming the Continuum of Care
- Page 5: Addressing the Governance Structure
- Page 6: Immediate Improvements in Crisis Response
- Page 7: Using a Cultural Lens to Reduce Mental Health Disparities

Please know that the ideas proposed represent “one voice” only and do **not** purport to represent the views of Otter Tail County, MACSSA or AMC.

Please distribute and post as you deem appropriate. If you have any questions, please feel free to contact me at the phone numbers or addresses listed below.

Thank you for your time and consideration.

John W. Dinsmore, Division Director  
Otter Tail County Community Services Division  
505 South Court Street  
Fergus Falls, MN 56537  
218-998-8172 (desk)  
218205-5476 (cell)  
[jdinsmor@co.ottertail.mn.us](mailto:jdinsmor@co.ottertail.mn.us)

Attachment:

## Minnesota Governor's Task Force on Mental Health: Proposed Solutions to Explore

Developed by  
John W. Dinsmore, Director  
Community Services Division  
Otter Tail County

Sunday, September 25, 2016

Thank you to the Task Force and the comprehensive work you have accomplished in a very short timeframe. I commend Sue Koch and all at DHS for the professionalism, responsiveness and comprehensiveness you have demonstrated in coordinating this process.

The timely [website](#) postings of Task Force and Formulation Team documents have been impressive and mindful of the importance of educating and informing all stakeholders of your progress and deliberations. I have been particularly grateful for the following:

- Mental Health Overview Presentation;
- The Overview Document and Appendices;
- The Summary of Task Force members' rankings of challenges facing the mental health system;
- The hyperlinks to 54 Past Reports (in the Additional Resources tab) plus the links to 10 reports from other States, and most recently;
- Formulation Team documents and meeting summaries

The following comments/proposed solutions (beginning on page 2) are based on a variety of experiences gained and on roles in which I have served: (1) as a member of MACSSA's "kitchen cabinet" who has been advising Ramsey County Commissioner Jim McDonough; (2) former member (2000-2007) of the MN State Advisory Council on Mental Health; (3) my above mentioned role with Otter Tail County; (4) my 30+ years of providing community based mental health services, and (5) my respective "life" roles as a son, brother, uncle, husband, father and grandfather.

I acknowledge that my following comments represent the views of only one person; however, they have been informed by the perspectives referenced above and by my review of the Task Force and Formulations Team's documents to date. I have formatted my feedback in response to the five Formulation Teams' areas of focus and the work they have produced as of this writing:

Pages 2-3:	Immediate Improvements in Inpatient Bed Capacity and Levels of Care Transitions
Page 4:	Redefining and Transforming the Continuum of Care
Page 5:	Addressing the Governance Structure
Page 6:	Immediate Improvements in Crisis Response
Page 7:	Using a Cultural Lens to Reduce Mental Health Disparities

Thank you again for your time and consideration, and for this opportunity to provide this input.

## Immediate Improvements in Inpatient Bed Capacity and Levels of Care Transitions

Comments address two areas: Inpatient Capacity Need/Formula & Safety Net: Definition and Roles

### Inpatient Capacity Need/Formula

Based on the data contained in the 29-page, 07-20-16 "*Draft Mental Health Overview*" and the 13-page 09/06/16 "*Immediate Improvements in Inpatient Bed Capacity and Levels of Care Transitions: Proposed Solutions*" documents, please discuss these considerations:

- Minnesota's 2016 population is 5,541,669<sup>1</sup>. Within the next 20 years, our statewide population is projected to increase by nearly 10% to 6,089,935
- Today, 45 Minnesota hospitals<sup>2</sup> currently provide 1,424 inpatient mental health treatment beds for adults and children/adolescents
- The MN Department of Human Services has approved six providers to develop and additional 150 Psychiatric Rehabilitation Treatment Facility (PRTF) beds by July, 2018
- 2008 Treatment Advocacy Center's Report<sup>3</sup> recommends 50 public inpatient psychiatric beds for every 100,000 population
- Today, Minnesota provides 25.7 inpatient psychiatric beds for every 100,000
- Based on the assumptions referenced above, Minnesota would need to add 1,347 inpatient beds for a total of 2,770 beds to achieve a ratio of 50 beds for every 100,000 population.

The above referenced reports also cite SAMSHA statistics that project the number of state residents who may be considered at "higher risk" of inpatient psychiatric treatment services, i.e.,

- 221,000 (5.4%) adults experience Serious Mental Illness (SMI)
- 103,038 (2.6%)<sup>3</sup> adults experience Serious and Persistent Mental Illness (SPMI)
- 110,354 (9%) school age children (5 to 21) experience Severe Emotional Disturbance (SED)
- 17,625 (5%) of preschool children (birth through 4) experience SED

### Request of Task Force

1. Analyze Minnesota's current continuum of services and current supports and develop estimates of "at risk" residents who may need hospital level of psychiatric service at some point throughout a calendar year.
2. Based on this analysis, and assuming Minnesota's needed level of inpatient beds per 100,000 is between 25.7 (current) and 50, identify level of need.
3. Develop recommendations for Minnesota State Legislature, DHS, Counties, MCO's and the Minnesota Hospital Association to update medical and non-medical supports & resources required to address the needs of persons experienced mental illness.

<sup>1</sup> See: <http://mn.gov/dhs/minn/demographics/data-basics/correlation-data/cor-relations/>

<sup>2</sup> Includes: 34 community hospitals, 7 CBHT's (soon to be 6) – 16 beds x 6 = 96 beds, AMRTC: 175 licensed beds, CABHS: 16 beds, 2 VA Hospitals

<sup>3</sup> In 2016, 3,963,019 adults between the ages of 22-100. 103,038 represents 2.6% of adult residents

### Safety Net: Definition and Roles

As the Formulation Team has written, the State of Minnesota has historically served as the safety net provider (for historical perspective, see: Minnesota State Planning Agency's 1985 Report, "[Minnesota's State Hospitals](#)"). During the past 30 years, however, a variety of policy changes ("deinstitutionalization, financial incentives, and the Olmstead decision") have helped move Minnesota's mental health and substance use disorder treatment services delivery system to a community-based care model.

Although our delivery system's inpatient capacity need/formula does need to be re-evaluated and updated (see page 2 above), Minnesota should **NOT** abandon our community-based care model. In fact, it needs to be expanded and should continue to guide our delivery system policies.

The Team has posed the following questions (see page 7, Section I (E)) in need of answers. Please consider these responses as you continue your research and develop your recommendations:

Inquiries	Responses for Your Consideration
What are the expectations of community providers?	<ul style="list-style-type: none"> <li>• Providers serve as the foundation of our community based delivery system</li> <li>• Funding and resources of the continuum of services should be targeted to expand the role of community providers.</li> </ul>
What are the expectations of the state?	<ul style="list-style-type: none"> <li>• Eliminate DC&amp;T's central pre-admission process and return decision making to facilities</li> <li>• DHS's Direct Care and Treatment Administration's role as a provider should be limited/reduced to serving persons who are MI &amp; D and sex offenders</li> <li>• CARE, CBHH and CABHS services should be transferred to community providers over the next five years</li> </ul>
What level of involvement should law enforcement play in responding to calls about a person in a mental health crisis?	<ul style="list-style-type: none"> <li>• Continued CIT training for all first responders</li> <li>• Expand crisis mobilization teams, crisis stabilization units and 24/7 on-call systems and make their "4<sup>th</sup> Response" as "credible" and viable as police, fire, and EMS systems</li> </ul>
Where does the county fit into the equation?	<ul style="list-style-type: none"> <li>• Counties should continue their role as the local mental health authority (See: <a href="#">MS 243.466</a> and <a href="#">MS 243.4873</a>)</li> <li>• Led by county government partners, Adult Mental Health Initiatives and Family Service/Mental Health Collaboratives should serve as the local and regional leaders in developing mental health and substance use disorder service delivery systems</li> <li>• Over the next five years, Care Coordination and Targeted Case Management should be assumed by community providers via Accountable Care Organizations (ACO's), Integrated Health Partnerships (IHP's) and/or Certified Community Behavioral Health Clinics (CCBHCs)</li> </ul>
How difficult questions are intertwined with issues of funding and liability.	<ul style="list-style-type: none"> <li>• Funding of Managed Health Care (MCO's) organizations and health care service parity should be enhanced</li> <li>• Streamline and redirect funding to our primary health care payers, i.e. MCO's</li> <li>• Develop a 21<sup>st</sup> century public health care funding model that expands our health care benefit set and uses only federal and state allocations to fund Medicaid &amp; MCO managed services</li> <li>• Analyze how DHS, DEED, MHFA, MDE, DOC and county funds can be prioritized to fund our non-medical continuum of support services.</li> </ul>

## Redefining and Transforming the Continuum of Care

The Redefining and Transforming the Continuum of Care Transformation Team identifies how Minnesota's current continuum of services is incomplete. Please consider these responses as you continue your research and develop your recommendations:

System Short-Comings	Responses for Your Consideration
Insufficient resources are allocated to our continuum of services	<ul style="list-style-type: none"> <li>• Funding of Managed Health Care (MCO's) organizations and health care service parity should be enhanced</li> <li>• Streamline and redirect funding to our primary health care payers, i.e. MCO organizations</li> <li>• Develop a 21<sup>st</sup> century public health care funding model that expands our health care benefit set and uses only federal and state allocations to fund Medicaid &amp; MCO managed services</li> <li>• Analyze how DHS, DEED, MHFA, MDE, DOC and county funds can be prioritized to fund our non-medical continuum of support services.</li> </ul>
A disproportionate amount of funds are allocated to treatment versus prevention/early intervention AND recovery/resilience	<ul style="list-style-type: none"> <li>• Community providers via Accountable Care Organizations (ACO's), Integrated Health Partnerships (IHP's) and/or Certified Community Behavioral Health Clinics (CCBHCs) should identify what funds can be targeted for non-treatment activities.</li> <li>• Engage Minnesota's non-profit foundation community to support and fund prevention/early intervention AND recovery/resilience services</li> </ul>
A disproportionate allocation of resources is devoted to SPMI level services	<ul style="list-style-type: none"> <li>• DHS's Direct Care and Treatment Administration's role as a provider should be limited/reduced to serving persons who are MI &amp; D and sex offenders</li> <li>• CARE, CBHH and CABHS services should be transferred to community providers over the next five years</li> </ul>
The continuum of services defined are not equitably available everywhere	<ul style="list-style-type: none"> <li>• Led by county government partners, Adult Mental Health Initiatives and Family Service/Mental Health Collaboratives should serve as the local and regional leaders in developing mental health and substance use disorder service delivery systems</li> <li>• DHS provides guidelines and minimum service standards</li> </ul>
Service design flexibility is lacking	<ul style="list-style-type: none"> <li>• Led by county government partners, Adult Mental Health Initiatives and Family Service/Mental Health Collaboratives should serve as the local and regional leaders in developing mental health and substance use disorder service delivery systems</li> <li>• Analyze how DHS, DEED, MHFA, MDE, DOC and county funds can be prioritized to fund our non-medical continuum of support services.</li> </ul>
Publicly funded continuum only serves 1/3 of people eligible for these services	<ul style="list-style-type: none"> <li>• Funding for Community providers via Accountable Care Organizations (ACO's), Integrated Health Partnerships (IHP's) and/or Certified Community Behavioral Health Clinics (CCBHCs) should include marketing and education allocations</li> <li>• Require Minnesota's Medicaid, MCO and commercial health insurance products to provide comparable benefit set for behavioral health care and substance use disorders.</li> </ul>
Natural supports are under-supported and under-addressed	<ul style="list-style-type: none"> <li>• Analyze how DHS, DEED, MHFA, MDE, DOC, county and non-profit foundation funds can be prioritized to fund our non-medical continuum of support services.</li> </ul>

### Addressing the Governance Structure

In their 08/30/16 scoping document, "Creating A New Governance Structure – Issue Overview", Formulation Team writes that "the Task Force can probably only formulate these issues and lay out a process for tackling them. There isn't time to convene the meetings that would allow for robust recommendations on a new governance structure. Therefore, the Task Force could develop principles, tasks and a vision for a concerted state-wide planning effort to redesign the governance system for the mental health continuum of care."

Based on the set of scoping issues and questions posed by the Team, please consider these responses as you continue your research and develop your recommendations:

Scoping Questions & Governance Issues	Responses for Your Consideration
Define what specific aspects of governance/continuum of care to focus on	<ul style="list-style-type: none"> <li>• Support development of Service Delivery Authorities (SDA's) in a manner that promotes the work of AMHI's, Collaboratives and/or Criminal Justice Advisory Councils/Committees</li> </ul>
The use of data for continuous quality improvement	<ul style="list-style-type: none"> <li>• DHS needs to provide counties and MCO's with greater access to data warehouse information to enable local and regional data analytics.</li> <li>• Work closely with the Human Services Performance Management Council in analyzing data.</li> </ul>
The importance of providing mental health services that are driven by local need.	<ul style="list-style-type: none"> <li>• Counties should continue their role as the local mental health authority (See: <a href="#">MS 245.466</a> and <a href="#">MS 245.4873</a>)</li> <li>• Led by county government partners, Adult Mental Health Initiatives and Family Service/Mental Health Collaboratives should serve as the local and regional leaders in developing mental health and substance use disorder service delivery systems</li> </ul>
How best to design a governance structure of publicly-funded mental health services. Does the state-directed, county administered system still make sense?	<ul style="list-style-type: none"> <li>• Counties should continue their role as the local mental health authority</li> <li>• Led by county government partners, Adult Mental Health Initiatives and Family Service/Mental Health Collaboratives should serve as the local and regional leaders in developing mental health and substance use disorder service delivery systems</li> </ul>
How can the governance system better coordinate—or integrate—between child and adult services?	<ul style="list-style-type: none"> <li>• Increase legislative and financial support of AMHI's and Collaboratives</li> </ul>
How could governance changes create more incentives for integration (between mental health and substance use disorder services, between behavioral health and primary care, between behavioral health and community support services, etc.)?	<ul style="list-style-type: none"> <li>• Reinforce/promote community providers to collaborate and develop Accountable Care Organizations (ACO's), Integrated Health Partnerships (IHP's) and/or Certified Community Behavioral Health Clinics (CCBHCs)</li> </ul>
How to develop robust mechanisms for collaboration with related sectors (education, law enforcement, corrections, courts, transportation, housing, employment, etc.)?	<ul style="list-style-type: none"> <li>• Led by county government partners, Adult Mental Health Initiatives and Family Service/Mental Health Collaboratives should serve as the local and regional leaders in developing mental health and substance use disorder service delivery systems</li> </ul>
What are the statutory changes needed to implement changes, including changes to the Mental Health Act, the Commitment Act, etc.?	<ul style="list-style-type: none"> <li>• Legislatively empower AMHI's (<a href="#">MS 245.466</a>) and MH &amp; Family Service Collaborative (<a href="#">MS 245.493</a> &amp; <a href="#">MS 12-6D.23</a>) to expand and tailor delivery system to local needs</li> <li>• CARE, CBHH and CABHS services and state appropriated funding should be transferred to community providers over the next five years</li> </ul>



### Immediate Improvements in Crisis Response

Based on the work done by the Crisis Formulation group as described in their 09/15/16 background document, please consider these responses as you continue your research and develop your recommendations:

Models for Examination	Responses for Your Consideration
Use of telehealth to support community hospitals without dedicated psychiatric resources	<ul style="list-style-type: none"> <li>• Replicate Region III's "Collaborative Integration in Person-Centered Services: Integrated Behavioral Health Arrowhead Telepresence Coalition" Vidyo and expand statewide</li> <li>• Expand DHS's Vidyo network from current 2,600+ user sites (desktop, laptop, tablets, smartphones) to statewide and system wide coverage</li> </ul>
Co-responder or embedded mental health professional with law enforcement	<ul style="list-style-type: none"> <li>• Expand and embed Trauma-Focused Cognitive Behavioral Therapy trained mental health professionals to be available 24/7 in each county</li> </ul>
Pre-service police training on CIT, during coursework. Paired with refresher courses at a regular interval.	No responses developed
Adaptation of CIT for other responders. Paired with a forum or process for building shared understanding and trust between crisis teams and other responders	<ul style="list-style-type: none"> <li>• Expand crisis mobilization teams, crisis stabilization units and 24/7 on-call systems to all serve all counties</li> <li>• Make their "4<sup>th</sup> Response" as "credible" and viable as police, fire, and EMS systems</li> </ul>
Centralizing resources in a trusted location. Psychiatric ERs, Urgent Care (Ramsay model), colocation with existing urgent care for physical conditions.	<ul style="list-style-type: none"> <li>• Via AMHI's and Collaboratives, expand Trauma-Focused Cognitive Behavioral Therapy training to ensure residents of all MN counties have access to services</li> <li>•</li> </ul>
Research and root cause analysis. What data or study would be necessary to better understand the preconditions of crisis, and outcomes evaluation for interventions?	<ul style="list-style-type: none"> <li>• Utilize Resources on <a href="#">Child Trauma for Educators and Helping Professionals</a> resources to guide research and root cause analysis</li> <li>• As our State's citizenry of New Americans grow our population, we must expand on the work began in 1985 by the <a href="#">Center for Victims of Torture</a> to serve those in need from countries in conflict</li> <li>• Work closely with the MN National Guard and the U of M's Anbit Network to ensure we are providing state-of-the-art PTSD treatment to veterans and their families (see: <a href="#">A Veteran's Guide to Talking With Kids About PTSD</a>)</li> </ul>

### Using a Cultural Lens to Reduce Mental Health Disparities

As cited by the Formulation team: "Applying a cultural lens to Minnesota's mental health system could lead the Task Force to develop recommendations on multiple levels." Please consider these responses as you continue your research and develop your recommendations:

Cultural Lens Topics	Responses for Your Consideration
An overview of culturally-informed services, programs, and models from other states, counties, and SAMHSA.	<ul style="list-style-type: none"> <li>• Consult/review DHS's "Cultural and Ethnic Community Leadership Council <a href="#">2016 Legislative Report</a>"</li> <li>• See Ramsey County's 2015 "<a href="#">Culturally Informed Clinical Practices for Healthy Home Lifestyles</a>"</li> <li>• See: Improve Group's 2014 "<a href="#">Mental Health Services Needs Assessment: Assessing the Successes and Gaps of Mental Health Services Provided in a Nine-County Region</a>"</li> </ul>
An overview of what culturally-informed work is already going on in Minnesota in relation to mental health care and what is being planned for implementation.	<ul style="list-style-type: none"> <li>• Review DHS's Health Care Research and Quality Division's findings of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.</li> <li>• Consult with the Roy Wilkins Center for Human Relations and Social Justice Health and Human Services</li> <li>• Consult with the University of Minnesota's Program in Health Disparities Research</li> <li>• Consult with the Wilder Foundation's "<a href="#">Speaking for Ourselves</a>" project</li> <li>• Southeast Asian veterans culturally specific mental health services appropriation.</li> </ul>
A list of policy/issues areas that the Formulation Team has identified for further development into possible recommendations. We picture that this would be a list of 5-10 items. The Task Force could then choose which of these items that the Formulation Team would work on further in order to develop options for recommendations.	<ul style="list-style-type: none"> <li>• Task Force should consult with DHS's newly formed Community and Partner Relations Administration's four areas of concentration: Community Relations, County Relations, Office of Indian Affairs, and Equity and Performance Development – to seek their respective lists of priorities</li> <li>• Study and best practice solutions are needed to better understand and reduce the following: Out of home placement for African American and American Indian children were, respectively, 4x's and 1.5x's more likely to be placed out of home compared to white children.</li> </ul>

9/25/16

Comments received from William Czech

Greetings,  
Please accept this comment for the task force.  
William Czech

The Minnesota Governor's Task Force on Mental Health  
Comment on Crisis Response

**Filling A Gap: The Embedded Mental Health Co-Responder Model**

The Embedded Mental Health Co-Responder Model is a proven police best practice for responding to calls that likely involve mental illness. It pairs appropriately trained police officers with embedded mental health professionals, as a permanent team, which responds to mental health related calls. Though based at the police department, the embedded co-responder is always an employee of a partner provider organization, such as county mental health services. Using co-responder teams enables an unfortunate law enforcement response to a mental health related incident to evolve, as rapidly as practical, into a professional on-scene mental health care response. The State of Minnesota should do much more to support and encourage the use of this best practices model in the state.

The embedded co-responder model is an evidence based best practice. It came into being over 2 decades ago in Los Angeles and has been shown through research and experience to provide better outcomes than CIT-alone. This model has seen much wider implementation in the past two years as law enforcement agencies seek to enable real collaboration in response to increasing numbers of mental health related calls. More specifically, the model is becoming more popular because experience and research has proven that this model reduces use-of-force (liability), reduces the number of mental health calls (via more appropriate dispositions for "repeat presenters" plus follow-up), saves taxpayer money (by reducing arrests, transfers, and the number of ER visits or holds), and provides better outcomes for those in crisis. Research ("*Evaluation of Seattle ..*", Helfgott, Hickman, and Labossiere, 2015) has consistently shown that the co-responder model at creates more nuanced, appropriate, and less disruptive dispositions for consumers. (see also: "*Crisis averted: how consumers experience a police and clinical early response team...*", Eloisa Evangelista, *IntJ Mental Health Nursing*, (2016) 25,367–376). This affect is even seen when the co-responder is introduced to agencies with strong CIT programs. The Duluth Police Dept. was the first Minnesota agency to implement this best practices model. The resultant cost savings and improved outcomes are lauded by Duluth's police administrators, who are eager to expand their program. In April of 2016, the Duluth PD was awarded the 2016 Innovation Award by the Minnesota Chiefs of Police Association for bringing this very successful model to Minnesota.

Embedded mental health co-responders create highly effective collaboration where bureaucracy, logistical considerations, and organizational cultures would otherwise promote "separate silos." Having an embedded clinician is a game-changer. Research and experience has shown that embedding the clinician – having them work within precincts and co-respond – promotes trust and helps the clinician become "part of the team." ("*Outcomes achieved and police and clinician perspectives...*", Lee, Thomas, Doulis, , *IntJ Mental Health Nursing*, 2015, Aug. 27) Embedding the clinician also solves the difficulties law enforcement agencies report when they attempt to collaborate by asking health care organizations to meet them on-scene. Research and experience has shown that law enforcement severely underutilizes there partner organizations in this scenario. In particular, law enforcement experiences a capacity and systems problem that result in unacceptable response times and availability of the un-embedded mental health professionals. (Example finding: *Steedman, 2000*) Without on-scene collaboration, law enforcement officers often become de-facto mental health care workers. Research in Seattle reported that their pilot co-responder program, "is relieving an otherwise substantial, unnecessary, and inappropriate burden on law enforcement officers." ("*Evaluation of Seattle ..*", Helfgott, Hickman, and Labossiere, 2015) This burden on the officers comes at a cost for the person in crisis and the tax payer. In a recent article about a co-

responder program in Cheshire, UK, the authorities noted that dispositions chosen by police officers without on-scene clinician partners, “often make decisions based more upon resource demand and risk aversion rather than a robust assessment of individual needs.” That article reported that adding co-responding clinicians reduced the number of transfers by 89%. (RCNi News, online, Elaine Cole, Apr. 2015) Making better use of outpatient services and avoiding unnecessary transfers is a common research finding. (See also: “*Evaluation of Seattle ..*”, Helfgott, Hickman, and Labossiere, 2015, and “*Evaluation of Overland Park PD Co-Responder Program*”, Alex M. Hoslinger PhD, UMKC).

Currently, the State of Minnesota does not provide adequate recognition and support to local efforts to implement this valuable mental health crisis response model. State agencies can do much more to facilitate the partnerships (i.e. between county government and municipal police) needed to create co-responder programs. Too often, these partnerships are desired by city and police leadership, but create a demand on the would-be partner county’s health care budget. That is a recipe for hindering collaboration. Because, the embedded mental health co-responder model effectively addresses a major existing gap in mental health services, the state should create a dedicated funding stream to support co-responder projects. Also, the implementation of co-responder projects is hampered by state statutes that effectively prevent medical assistance and private insurance from covering the co-responding clinician’s services. The co-responding clinician is a licensed professional, employed by the county health department and teamed with a highly trained specialty officer. Unfortunately, this best practice model that is highly effective in other states, can be denied insurance coverage based on short sighted Minnesota state statute language. The Minnesota Legislature should alter existing statutes to recognize the embedded co-responder model as an appropriate mobile crisis response where mobile health crisis teams are inappropriate or unable to effectively fill this sizeable gap in mental health care services.

One can describe both a moral and legal (parens patriae) imperative to promote proven best practices, such as a co-responder program, which insure the police response to mental crisis related calls is guided by persons with adequate training, expertise, and experience. The embedded mental health co-responder model, with a mental health professional based within the departments, can accomplish just that for Minnesota.

Submitted By:  
William Czech  
1962 Knob Road  
Mendota Heights, MN 55118

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9/23/16

Comments received from Brian Johns, North Memorial

Dear Susan,

To keep it short and simple, I see two primary problems with mental health services in Minnesota:

1. Not enough providers. Residency slots desperately need to be added to the three residency programs currently in Minnesota, plus incentives to keep graduating psychiatrists in the state. Additional programs for nurse practitioners and fellowships for physician assistants could also be of benefit. (Out of my last three hires, two psychiatrists came from out-of-state and one from a local NP program.)
2. Not enough beds. I cannot recall a time when this hasn’t been a major problem in mental health. The state hospital’s extremely limited capacity creates a “log jam” throughout the entire

health care system, with patients waiting for days in emergency departments across the state for mental health care.

Thank you very much for the opportunity to comment on the Governor's Task Force on Mental Health. Feel free to contact me with questions.

Best regards,

Brian Johns, MD, MFA, ABPN  
Medical Director, Mental Health and Addiction Care  
North Memorial Health Care

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9/21/16

Comments received from Sandra Lewandowski, Superintendent, Intermediate District 287

Susan,

Thank you for the reply. I have attached our proposal for consideration by the task force. If possible, we would also appreciate being able to address the task force during public comment. Please let us know if that is possible.

Many thanks.

Sandra Lewandowski, Ed.S.  
Superintendent  
1820 Xenium Lane North  
Plymouth, Minnesota 55441  
Intermediate District 287

Attachment:

# Children's Mental Health Proposal

*submitted by*

Intermediate School District

287, 916, and 917

*September 2016*

*presented to the*

Governor's Task Force

on

Mental Health

# Setting 4.5

## The challenge



Students with disabilities who lack access to community mental health resources can present **major challenges** for the most well-equipped **special education** staff.



The current educational structures do not accommodate students who have little or no external support for **severe mental and behavioral health needs**.



The intermediate school districts are uniquely positioned to see how diminished funding for out-of-school placements is **creating a crisis** for Setting 4 schools



Schools do not have the resources to address a growing group of students who show **aggressive** and **dangerous** behaviors, **complex** pharmacological profiles and/or multiple developmental, cognitive and neurobiological **disorders**.

This combination of challenges **disproportionately** and **negatively** impacts communities of color and American Indians.

## The solution

**Setting 4.5** would shift us from adding school-based services to constructing more comprehensive school-led interventions designed into the school day for students from pre-K through age 21, helping meet Olmstead Act requirements.

### Critical services



- School-led **mental health** funding
- **Partnerships** with mental health agencies
- Dedicated **hospital beds** and teams for patients experiencing psychiatric crises
- In-school psychiatric help for students who cannot access traditional services
- Dedicated, co-located **county staff** to assure access to county services
- Partnerships with agencies to provide access to short-term **crisis homes**



### Staff readiness and school accountability

- Staff and program development for **school partners**
- Program development for **intermediate school districts**
- Program **accountability study**



### Remove operational and funding barriers

- Increase **mental health** funding
- **Intermediate lease aid**
- Fund **cross-subsidy** at the state level
- Allow **access fee** for students who open enroll
- **Equalize funding** for students in area learning centers



### Integrative delivery model with powerful outcomes

- **Improve** student academic and mental health outcomes
- **Assure** least restrictive environment (LRE) for students
- **Reduce** staff injuries
- **Align** resources to reduce costs
- **Equity** in access to services



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Intermediate School District | 916  
*partners in education*

Intermediate District 287  
RESPONSIVE. INNOVATIVE. SOLUTIONS.

## Setting 4.5

### An Adaptive Solution

#### The Problem

When the federal setting levels for special education were established, Setting 4<sup>1</sup> was designed to educate students who could benefit from a separate school site with related services to help students meet their individual education plan (IEP) goals. Higher settings on the continuum, known in Minnesota Rule as Care and Treatment options, were established as well. This was done with the understanding that school based settings could not provide the extent of mental and physical health services some students need.

Over the years, however, there has been a shift of responsibility for many services previously provided in Care and Treatment settings. Students in need of these expansive medical and mental health services are increasingly placed in Setting 4 sites, but without the crucial resources or designated responsibility to provide them. Decreased funding and support for day treatment, hospital, residential, and even corrections placements have left schools as the primary entity addressing a growing group of students' aggressive and dangerous behaviors, complex pharmacological profiles, and a myriad of developmental/cognitive and neurobiological disorders.

Our current school-based model for educating students with extreme mental and physical health needs is not only educationally insufficient, it is creating a public safety emergency. Schools are becoming the state's de-facto mental health system, but the extent of our educational resources and authority is currently limited to Setting 4. While Setting 4 does offer a separate site and usually some additional resources, these schools are based on the same operational framework used for general education. We start with our common picture of what we all consider to be a school day and then sprinkle around the edges resources such as school-based mental health providers and behavior specialists. Even with a few important extras, we fundamentally maintain the general academic model that is not fully supported by or integrated with the therapeutic services necessary to meet some students' needs in a school setting.

School districts that operate Setting 4 programs using this general academic model struggle to address the needs of some students with the most challenges in a timely, safe or effective manner. When mental health and behavioral crises arise, parents and school staff find limited and emergency-based options that are often (1) contrary to the least restrictive environment, (2) much more costly than public school settings, and (3) sometimes have dubious educational and health benefits. Furthermore, even if a Care and Treatment placement is available for a child or adolescent with significant

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<sup>1</sup> Federal Definition of Setting 4: "[In Setting] 4. Learners receive education programs in public separate day school facilities, including students with disabilities receiving special education and related services in public separate day school facilities for more than 50 percent of the school day. Note: This must be a specially designed facility/program for special education students only." From *A Guide for Minnesota Parents to the Individualized Education Program (IEP)* (2014 ed.), Pacer Center. <http://www.pacer.org/parent/plus/PfIP-a12.pdf>



behavioral and mental health needs, he or she can be, and are, discharged due to aggressive, violent, sexually predatory, and/or destructive behaviors. In contrast, due to the considerable protections afforded to students in special education, school districts are legally obligated to allow students to return to school the same day they are deemed “too dangerous to serve” by their current placement and discharged. Schools can virtually never say “no” to admitting/readmitting a special education student back into public school who is mentally ill or dangerous. We are the one system that cannot dismiss students due to our inability to serve them safely.

The intermediate school districts have a unique vantage point to both understand this problem and propose a proactive solution. Collectively we operate sixteen Setting 4 sites for high needs special education students from our member districts and surrounding areas. We have some of the most experienced staff and specialized facilities in the area, but still our injuries are high: District 287 recorded 335 injuries last year. NE Metro 916 recorded an average of 300 injuries per year over the last several years. Another data set that exemplifies the environment is the recording of critical incidents. Last year, critical incidents at District 287 numbered 225, with 49 ambulance calls to transport students in a mental health emergency. At 916, critical incidents are defined as when a student is removed from school either by police, the SRO or at the request of an evaluator at Diagnostic Evaluation Center (DEC) from Behavioral Health Providers. Last year at 916, 115 calls were made to 911 or to the SRO for emergency assistance and 15 calls were made to DEC. Of these 130, 53 were transported to the hospital for a full mental health evaluation.

We have become regional spokespeople for the plight of schools with the enormous responsibility of meeting the increasing needs of students. However, we often are hamstrung to best address these students’ needs. The structural limits of our ability to coordinate services and centralize resources prevent our being able to use our energy and apply our knowledge in the most effective way. We are offering a solution that unbinds these limits and allows us, with partners, to transform the current fragmented and insufficient system.

### **The Solution**

We are calling for a new setting not based on simply adding more of the same--more dollars, more people, or more services. We are calling for the opportunity to structure a new daily response to students with increasingly complex mental health and other needs. We are calling for “*Setting 4.5*.” Although not an official Federal Setting, this name calls out how the current continuum is not adequate for these students.

- “Setting 4.5” would be a shift in operating that would take us from adding school based services to constructing more comprehensive school led interventions. With this new model, schools, parents and students would have a new option on the setting continuum. It would consolidate mental health and transition services, offering a less restrictive setting for those otherwise being considered for more restrictive settings--homebound, hospital, day treatment or corrections--as well as those for whom appropriate care and treatment placements are not available. The chilling consequences of our state’s current lack of placements with mental health support was told in a recent

[StarTribune story](#) revealing how hundreds of Minnesota teens with mental health problems are winding up in juvenile detention. The current disjointed and often ineffective model would be replaced with a model that would improve the linkages between many partners, with the goal of increasing the access and effectiveness of services for students in a more cost effective way.

- **“Setting 4.5” would leverage high intensity interventions designed into the school day for students aged PK-21 and would support the collaborative commitment to meet the requirements of the Olmstead Act.** The Olmstead Act reflects the state of Minnesota’s commitment that people with disabilities experience lives of inclusion and integration in the community – just like people without disabilities. The vision is that “people with disabilities have the opportunity to live close to their families and friends and as independently as possible, to work in competitive, integrated employment, to be educated in integrated schools and to participate fully in community life.” One specific goal of the Olmstead Act is to increase the percent of children who receive mental health crisis services and remain in their community to 85% or more. The proposed Setting 4.5 would also support Goals Four and Five under Positive Supports of the Olmstead Act. Goal Four states “by June 30, 2017, the number of students receiving special education services who experience an emergency use of restrictive procedures at school will decrease by 316.” Goal Five states “by June 30, 2017, the number of incidents of emergency use of restrictive procedures occurring in schools will decrease by 2,251.” During the 2015-16 school year, District 287 reported the use of 634 restrictive procedures on 140 of our students who receive special education services. Put another way, this figure demonstrates that 18% of our highest needs students were restrained one or more times by school staff for engaging in dangerous, aggressive, and/or self injurious behaviors. Most often these students are black and brown. In order to reverse this trend, we desperately need to change our current model to a more effective one outlined in this paper.

- **“Setting 4.5” represents an adaptive solution that recognizes we need more than mere technical change to address this problem.** An adaptive solution requires change on many fronts and across organizational boundaries. This new model intends to align the various parts of a now fractured system of care as well as provide an improved level of communication between all the parts of this system. By (1) Dedicating access to critical services through partnerships, (2) Assuring staff readiness and school accountability to meet the demands of a new model, and (3) Removing operational and funding barriers for intermediate districts, “Setting 4.5” is designed for student success, improving outcomes through more efficient use of resources.

## **The Inputs**

### **1. Dedicating access to critical services through partnerships**

- **Dedicated School-Led Mental Health Funding**

Currently, school-linked mental health services are covered under a grant program provided by the legislature. School districts cannot initiate the request for proposals (RFP) process, however, and this limits our ability to facilitate a district led collaboration model with mental health service providers, to develop and manage plans for co-located or school-linked mental health services, and to access the

funding necessary to sustain the collaboration. Our request, therefore is to allow school districts to initiate the process as well as to have the ability to use grant dollars flexibly for school-linked mental health services, especially for those services that do not fit neatly within Medical Assistance (MA) requirements or other billing structures. For example, these funds would allow for flexibility to wrap services around the student in the school setting by subcontracting with respective agencies that provide those services, e.g., dollars to pay for a county worker to be a case manager, not unlike the School Resource Officer (SRO) model by which school districts contract with local law enforcement agencies for school resource officers. In essence, this would flip the current Care and Treatment model from one where school services are delivered into a non-school setting to one where support services are “pushed” into the current intermediate setting.

In order for staff in the school partner programs to be able to work with schools to design and operate a program grounded on the best knowledge and effective practices, we request Department of Human Services school-based mental health grants equivalent to \$50 multiplied by the total of the total member district adjusted pupil units (APU). This funding would go to mental health partners of intermediates and their Greater Minnesota counterparts allowing school and treatment providers to partner directly without barriers on such essential program elements as:

- ◆ Trauma Informed Care
- ◆ Restorative Practices
- ◆ Development new treatment modalities to provide community experiences allowing students to practice how to manage mental illness outside of the school building
- ◆ Therapeutic Teaching Model
- ◆ Parent/Family Engagement
- ◆ Trauma Coaches
- ◆ Child Protection Workers
- ◆ County Social Workers
- ◆ Critical Incident Team
- ◆ Psychiatric Support
- ◆ Behavior Aids

Access to any therapeutic services offered within the *Setting 4.5* would be based on parental consent, apart from the services described in an IEP and outside the context of an IEP team decision. One of the rationales for offering access to therapeutic services co-located in a school setting is for the ease and convenience of families who may otherwise attempt to seek services in the community, and who may not have access to such services because of provider availability or other factors. Community-based services are optional for the family and are not school-based services in IEPs.

Proposed Language to expand the scope of Minn. Stat. 245.4889 CHILDREN'S MENTAL HEALTH GRANTS to school districts and their subcontractors (e.g. mental health service providers), as well as an expansion of the services covered by the grant is available at [Proposed Mental Health Changes](#)

- **Dedicated hospital beds and teams for crisis placement.**

A very critical need for students served in the intermediate school districts is the lack of dedicated psychiatric beds for students who have high mental health needs and often significant aggressive behaviors. These students are often in crises in our school programs and are in danger to themselves or others. This need was recently recognized through an RFP issued by DHS for opening beds called "Psychiatric Treatment Residential Facilities" which could have helped to fill this gap for students served in the intermediates. However, no providers in the metro area responded to the RFP. This means that access to this service will not be readily available to students experiencing ongoing, daily crises in the intermediate school districts. Instead, these students will continue to be sent by ambulance to a local hospital and return to school the next day with no plan for their ongoing emotional and psychological health. Without a model for crisis treatment and transition back to school for students in the intermediate districts, students are set up to recycle through the existing, inadequate system throughout childhood and adolescence, and then move into the adult system that lacks capacity to meet the growing number of young people with very complex needs.

State aid should be provided to *incentivize partnerships* between metro hospitals and intermediate school districts to dedicate beds in a short term 30-60 day stabilization/acute care unit. Key to the use of this aid would be to develop a successful model that would meet the medical and educational needs during the psychiatric stay and develop a collaborative plan for the successful transition back to home and school. These partnerships would allow proper identification and triage treatment for students in need of acute care. The partnerships could include both a mobile team to deploy to the school site and a hospital team that would work with the school team through a dedicated technology pathway to determine necessity for a crisis placement in the hospital. This partnership would further allow the school to transport the student via ambulance to the hospital the day of the in-school crisis and the hospital would be ready to provide treatment immediately upon arrival.

- **Access to short term crisis homes**

Partnerships with agencies or companies that provide crisis placements would assure access to short-term (30 day minimum) placements in therapeutic group homes to receive necessary treatment and services. This would be similar to those already available to adults. Such placements would allow students to stabilize and return to school with the support of a case coordinator who facilitates the transition back to the community and school.

## 2 . Ensuring staff readiness and school accountability to meet the demands of a new model

- **Staff and Program Development for School Partners**

In the 2016 legislative session, intermediate school districts and other cooperative school districts operating Setting 4 programs received professional development grants for "activities related to enhancing services to students who may have challenging behaviors or mental health issues or be suffering from trauma." These grants, in the amount of \$1000 per full-time licensed staff, are limited to three years. Our request is for ongoing funding to assure adequate preparation and execution of all the points above, especially the critical need to embed trauma informed practices in all work and to provide staff support due to the compassion fatigue that can be the result of

indirect/non experimental traumatic stress disorders, secondary traumatic stress, vicarious trauma, and burnout.

- **Program Development for the Intermediates**

The opportunity to apply what we are calling “Setting 4.5 Intermediate Cooperative Revenue Aid” to our programs would allow us to supplement the rising cost of designing an educational program. This aid, in the requested amount of \$15 per APU would cover five additional professional development days. These days are critically needed to assure adequate program time for learning and developing essential knowledge, skills, and processes.

- **Consultative Program Development Support**

We request additional revenue from the legislature to provide consultative program development and support to build or improve services in non-member districts. Many times we are asked to provide assistance to non member districts who struggle to provide services to a similar student population. We, however, do not plan for program development and support for non-members and would need secure funding in order to hire the necessary leaders and staff for this service. This would allow the Intermediates to have greater reach outside our members to expand expertise in the region without the current members having to take any risk to support this service model. This recommendation was developed but not funded for the state Restrictive Procedure Work Group. We suggest the funding take the form of grants for planning and staffing consultation services that would then be paid for by the receiving district once the services were established. The grant dollars would cover any un-reimbursed costs incurred by the intermediates to provide the service to non-member districts so there would be no costs to the intermediate and its member districts.

- **Program Accountability Study**

In order to assure program accountability and identify success factors for replication, we request Setting 4.5 programming and students be the subject of a ten year longitudinal study. This study would identify dependent and independent variables as well as risk and resilience factors that are tied to student outcomes. We also request resources for providing shorter term evaluation studies that would monitor program procedures, partnerships, and costs in the hope of providing clarity for mid-course correction and replication with other constituencies. As a member of the Center for Applied Research and Educational Improvement (CAREI) District Assembly at the University of Minnesota, we would access their well-respected supports and researchers in the planning and implementation of studying the Setting 4.5 programming.

### 3. Removing operational and funding barriers for intermediate districts

- **Intermediate Lease Aid**

Increasingly, intermediate districts have found the need to design and construct specialized facilities that allow our school environment to address the very complex needs of students who enter our doors. Our member school districts have shouldered the funding for new facilities via the lease levy. We assert that local taxpayers should not shoulder this full responsibility. Rather, we recommend a lease

aid revenue equal to half of the current lease levy used by each intermediate be provided from the state be initiated to remedy this growing issue.

- **Partnership costs beyond per pupil funding are borne by the state**

For this truly to be a new model, there must be no significant cost disincentives to enroll students. Put another way, there must be no major penalty to individual school districts when students can benefit from this type of setting. Currently students may not get referred by a district because a district fears the cost of using an intermediate placement. In addition, some districts wait until a student's behaviors are severe it is a crisis and only then will the district refer the student. This runs counter to the idea of getting to the issues early. Therefore, our request is to provide state-level assistance to pay for what is currently a cross-subsidy of special education from sending districts' general funds to mitigate the costs of these students--costs that are already huge and are escalating because of so many needs being addressed primarily at the school level and only after crises have erupted. Essentially, the state would implement a cross-subsidy reduction aid for students placed or open enrolling into an intermediate setting. This new model cross subsidy reduction aid would be equal 25% of the non-reimbursable special education costs.

- **Recovering Costs through Non-Member Access Fee for Open Enrolled Students**

Currently MDE does not allow the intermediates to charge an access fee to the resident school district for a student who has open enrolled to a member school district in order to access the Setting 4 special education programs. Our understanding is this rule employed by MDE rose out of a challenge by Pine City around 1999 regarding the access fee assessed by 916 to Pine City. At the time, the number of students with these extraordinary needs were not like the current environment where the numbers are growing rapidly. And so, a growing challenge for the intermediates' capacity to plan for and serve our members is that advocates are openly recommending to parents to open enroll their children to a member of one of the intermediate districts if it is felt that inadequate services are being made available to the students. This shows up most clearly in the result of diminished classroom space for resident students from the member districts.

We request the ability to charge the non-member access fee for students who have open enrolled from a non-member to a member district specifically with the intent of moving to an intermediate district program. This would help equalize the risk and long term financing members have taken on to insure that specially designed facilities are available for their students. An access fee could be applied to the debt service costs for the intermediates which the member districts support, thus reducing the financial burden for member districts for facility costs for students who use open enrollment in this fashion. Components for developing this access fee could include lease levy, safe schools levy, and referendum aid and levy the student generates.

- **Students may qualify for services based on Graduation Incentives criteria (Minnesota Statutes, section 124D.68.)**

Although our current concept of federal settings as part of a continuum of service applies to special education, we envision *Setting 4.5* as housing critical services that should also be available to certain

students who qualify to enroll in an Area Learning Center (ALC). These students often attend the ALC programs run by the intermediate districts because they are considered higher need than those who attend programs run by other K-12 districts. This is further documented in our [legislative request](#) from 2016. Many of these students have unidentified special education and/or unmet mental health needs. Some have signed their consent to no longer receive IEP services. These students range from pregnant and parenting teens to youth returning from the juvenile justice system to homeless adolescents that are a growing group of high needs students for the intermediates.<sup>3</sup>

The ALCs also encounter students receiving drug and alcohol treatment as well as those who should be receiving treatment but cannot due to limited or no insurance. For these students, often those of color, we see an increasing use of the criminal justice system as an intervention. It should be noted the intermediates have been key in writing and testifying for current legislation that establishes sober schools. Although we are being considered to run a regional sober school, the promised funding has been cut significantly. It is our hope that this new model would allow us to apply one of the requested, dedicated school based mental health grants to running a sober school. The additional funding would allow for the needed support services for this population.

Furthermore, we request that high needs ALC students be allowed access to the array of services identified within this document. To fund this access, we request (1) per pupil funding to be equalized to the average of relevant group of member districts and (2) transportation costs in excess of what is received by the member districts in order for transportation to be fully funded.

### The Outcomes

We believe the creation and operation of *Setting 4.5* will have the following positive outcomes.

- Better student academic and mental health outcomes. The educational and mental health needs of school children are so intertwined that an integrated delivery model is critical for positive outcomes. A school program designed with this in mind, one that is neither school-based with mental health added nor hospital-based with schooling added, is the best solution for better academic as well as mental health outcomes.
- Assuring the least restrictive environment (LRE). Our special educational laws and beliefs are firmly rooted in the notion we should be providing LRE. As students are being considered for placement at the upper end of the settings continuum, we are increasingly faced with the dilemma of how to best provide LRE. Setting 4 would give students a public school option with a greater chance of providing successful supports than we have currently.
- Reduced use of restrictive procedures. Through adequate supports and training, schools will have the ability to meet the Olmstead plan goals for positive supports.
- Reduced staff injuries. With sufficient training and supports, the dramatic increase in staff injuries will be stemmed and reduced.

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<sup>3</sup> In fiscal year 2016, District 287 enrolled 100 homeless students, 66 of whom had IEPs, 34 of whom attended the ALC, and 70 of whom were black or brown.

- **Cost efficiency.** By providing an alternative to higher cost settings on the continuum that are the only alternative now, we can keep students in school, providing more effective services while also saving costs.
- **Equity.** Through the provision of a continuum of appropriate supports and services comprehensive enough to adequately address the needs of our most challenging students within a zero-reject public school environment, we combat the access gap to mental health treatment that exists between families and communities of color and their white counterparts.

### **In Conclusion**

As student needs have increased, schools, their partners, and the legislature have responded in many ways to add resources or services to existing models. These efforts have given us a glimpse of what might be possible but also the understanding that adding to an insufficient model does not address the root problems. With *Setting 4.5*, we propose a transformative model not built on doing more of the same. Through a combination of (1) Dedicating access to critical services through partnerships, (2) Assuring staff readiness and school accountability to meet the demands of a new model, and (3) Removing operational and funding barriers for intermediate districts, *Setting 4.5* is designed for student success.

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