Governor's Task Force on Mental Health

COMMENTS RECEIVED JUNE 24-JULY 21, 2016

The Governor's Task Force on Mental Health asked that stakeholders' messages to the Task Force be circulated to them, and the messages are presented to the Task Force verbatim. However, DHS does not publicly reveal the identity of people who communicate their positions to us unless the position is being stated on behalf of an agency or entity. For this reason, some identifying information has been removed from some letters for this public version of the comments sent to the Task Force.

6/24/16

The Mental Health Legislative Network (MHLN) met today and they had a very brief conversation about the Task Force. This the main coalition of advocates and providers, co-chaired by NAMI and Mental Health Minnesota (formerly Mental Health Association). Here is their preliminary feedback:

- The Task Force should limit its work to a couple of key issues; there isn't time to develop comprehensive recommendations and we don't want the Task Force recommendations to hurt the ongoing legislative work of the MHLN. If the Task Force is viewed as developing overarching recommendations for the whole system then if the MHLN comes in with other things we don't want legislators rejecting those because they were not suggested by the Task Force.
- Funding – untangling how services are funded/by whom, and supporting more funding to build services.
- Workforce shortages: there is a great report with recommendations; it needs to be implemented.
- Jails and mental health (reference OLA report): There are several recommendations in the OLA report.
- Responsibility for developing services: Is the responsibility primarily on the providers, the counties/tribes, or the state?

Sue Abderholden and Shannah Mulvihill, MHLN Co-Chairs

6/28/16

I am very pleased to see the development of a task force aimed to identify gaps in services, and policies which inadvertently produce barriers to care for individuals and families experiencing mental illness or chemical dependency. I am a licensed independent clinical social worker providing direct care for patients at X Hospital's Emergency Department. Operating in a rural provider shortage area, the barriers faced by patients and providers are compounded and result in failed attempts to provide sustainable mental health care. I have conducted a formal meta-analysis as a graduate student in 2013, as well as having firsthand experience over the past 24 years, providing mental health services in several counties in X Minnesota. I would like the opportunity to present some of my findings to the committee if deemed beneficial.

Please advise.

Social worker

6/28/16

I am writing on behalf of the local Emergency Nurses Association (ENA) who are very interested in this topic as mental health patients not only use significant amounts of resources in our emergency departments, but also affect those presenting with non behavioral issues (chest pains, strokes, broken bones, etc) when our beds are filled with mental health patients that are being boarded in the emergency department, as there is no where to send them. Behavioral patients have created a great challenge for us and we are so glad this task force has been pulled together. We'd considered having members of our organization apply to be on the task force, but realized the govenor needed people with more clout than most of our members have. (however we have lots of stories) We were happy to see that the meetings would be open to the public, thus our question.......

Our question is - do we need to make a reservation, request permission, set anything up to attend these meetings? As emergency nurses, our association members have been discussing this topic and been trying to figure out how to fix this in our departments across our state. Our national organization has been trying to do same on national level. We are hoping if we are in attendance we can provide input as to what happens in the "safety net area" for health care (the emergency department). We promise to not send a mob, but are going to try to find a consistent couple of emergency nurses that can attend, if this will be OK.

thanks

Joan Somes RN, PhD, CEN, CPEN, FAEN

Twin Cities Chapter Emergency Nurses Association

Apple Valley, MN

7/1/16

Wow…..of course. [This was in response to Sue Koch asking if she wanted to be on our list to receive emails]. I see quite a committee representing all of Minnesota is on the Task Force and that is great. I have worked in children's services, adult mental health, chemical dependency and presently license homes for childcare, adult and child foster care. In nearly 10 years I have seen a lot and have heard a lot. Common feedback is that legislation and recommendations are made but providers and clients do not feel it comes from walking in the shoes of those providing services or trying to get services. So many are dually diagnosed in some respect whether it be mental health/chemical dependency, mental health/developmental delays, mental health/dementia, children with combination diagnosis', and etc. It is unfortunate that this is 2016 and tho change and progress has come a long way, there is still stereotype attitudes about mental health. I think the Task Force will be a good thing.

Thank you for asking if I would like to be on the mailing list. It is an honor of you to ask.

Have a great holiday weekend!!

County Social Worker

7/6/16

Thank you for sending to me this highly important correspondence on Governor Mark Dayton's Task Force on Mental Health. There is an additional aspect to the work I hope you will consider, please allow me to elaborate:

1. In-patient care at our hospitals often will find a lack of availability for individuals with acute mental health needs. I was part of a group that worked with the three hospitals in a major urban area in Minnesota to assess how best to address the demand for in-patient beds relative to the need that often found people on wait lists for such care. In my role as President of a behavioral health institution that was a Rule 29 and Rule 43 licensed facility, I had worked on a coordinated care for behavioral health clients in which it was a multi-payer model and was a convergence of a medical model, behavioral health model within a community care framework. That worked helped to informed me on how to address the in-patient crisis. The most significant disconnect we discovered with regard to the in-patient crisis and lack of beds for the demand by people requiring such assistance in our work with the hospitals was that there was little contact between discharging the in-patient client with their support system. Our experience at our behavioral health institution was that it was not uncommon to have an Emergency Response Vehicle pull up in front of our facility and release an in-patient client and tell them to go into our facility. In addition we assessed that there was very little connection between in-patient services and Rule 29 facilities. A one payer model was as much a prohibiting factor as was the scope of what the system saw as their responsibility, and what was not their responsibility.

   In my view a coordinated care model that truly is person centered will reframe from silos to an integrated platform in which there is seamless care between providers from inpatient, outpatient care and community supports. Better coordinating such care has the possibility of enhance client stability in community, thereby reducing the potentiality of cycling back into in-patient care. Hospitals are generally part of a larger corporate entity, and the corporate entity itself has to own its relationship in community by community and for community with regard to person centricity and enhancing added value for advancing client wellness and their commitment to community support. Lastly why should this become part of the conversation? Because both private and public providers operate within a broader context that needs to be defined as an ongoing public health concern so that all are part of a broader organizing principle and therefore accountable to the citizenry to whom they serve.

2. The Task Force has the opportunity to consider a scope of concern regarding the prevalence of individuals with mental health issues who find themselves within the criminal justice system and the judiciary. Here again there could be opportunities between the executive branch, legislative branch and the judicial branch to assess how are youth and adults faring in the criminal justice system? Like the issues with hospitals mentioned above, what can we do in Minnesota to think about a person centric platform that can help to stabilize individuals in community thereby reducing recidivism within the criminal justice system? Minnesota has among the best systems by which people with mental health issues are addressed within our courts. The opportunity is to build upon the gains made and the Governor's Task Force given the scope of work the Task force is charged with, has the extraordinary opportunity to form a goal statement for this area and involve individuals from Minnesota's Judiciary as well.

Please let me know if I may be of assistance with regard to the work of the Task Force and also with regard to the aforementioned areas.

Sincerely

Executive Director of Advocacy Organization for People with Disabilities

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7/6/16

The county jails are having to hold and deal with the mental health problems since the state has a broken system and hasn't addressed the issue and no representative from this area.

WOW!!

Great job,   I can see that this is going to be group that gets nothing right or done!!

County Sherriff

7/7/16

Task force members,

Typical scenario that happens thousands of times a year in the state of MN. Law enforcement gets a call of a person that is acting strangely, acting out against others, family members or they may have committed a crime. Upon arrival at the scene person is taken into custody and taken to the hospital to get evaluated. Once at the hospital person becomes agitated and violent because of their mental state, this state maybe caused from numerous things. Now that they are violent no one will take this person, so they are transported to a county jail where county jail staff have to deal with this person.

We are now holding this mentally ill person who doesn't belong in jail, but because of their actions and the lack of beds and resources in the state. We are the states only answer to making sure he doesn't injure himself or other because of his mental state. This person then continues to act out while we are holding them. The staff at the jail is not trained to handle these types of people for several days to weeks or months but are forced to. The states two locked facilities are under tremendous pressure to help the jails out and as of late have not always been able to do this.

Rural Minnesota jails are in even a worse position since our resources are even more limited than those in larger population areas. Sometime we find that a bed was available but has now been taken by someone from the Seven County metro area or other areas of the state. It is not uncommon to travel for more than 5 hours or more away from the county hoping to get this person the help they need.

The state closed down its out state regional sites that were staffed and able to deal with these types of people. It shifted it to the Community based plan which is a failure for many Minnesota residents.

Unfortunately the jails have become the mental health answer for the state. We are ones left holding and dealing with people that don't belong in jail and shouldn't be in jail.

A task force is created to study the problem and come up with answers and hopefully solutions, but strangely one of the largest players in the mental health puzzle is left out??? So you are now left with a very incomplete picture of what is really happening with the mental health problem in the state.

So you can see why I'm skeptical. Looking to see what comes out of this task force endeavors.

County Sherriff

7/8/16

I am attaching the comment that the nurses of the Minnesota Emergency Nurses Association would like to share with the mental health task force. It briefly outlines the several of the issues we have identified and offers to provide any assistance we can. thank you for this opportunity and we are in process of scheduling a member to attend the meetings. If the rooms/times should change please let us know.

7-10-16

Dear Members of Governor Dayton's mental health task force

The Minnesota Emergency Nurses Association (ENA) wants to share that we have great interest in the assigned work of this task force. As the often noted "safety net" for health care -emergency departments across the state of Minnesota have been greatly affected by the increasing number of mental health patients being seen and boarded in our departments. Those of us who work in the

emergency department feel we are on the front line and have a large stake in this process. Emergency nurses have identified several concerns.

The most obvious involves patients with mental health issues. We recognize they need more in-depth care than the typical emergency nurse is trained to do. Emergency nurses are good at initial assessment and emergent stabilizing care, but our forte is triaging patients to the correct resource. (Many emergency nurses are taking on additional training, but the patient with mental health issues is only one of the myriad types of patients we treat that require additional specialized training.) Referring mental health patients to the appropriate resource is becoming more and more difficult to arrange. Habitually, we come to work each morning to find mental health patients that have been boarded in our emergency rooms overnight, and often for days on end. These patients are receiving only basic care and not the definitive care they need. Frequently we need to transfer these patients out of their community and across/out of state in order to obtain their mental health care. This transfer also takes our emergency medical services personnel out of the community. Prolonged confinement while waiting for disposition often leads to agitation, outbursts, and injuries to staff and even the patients themselves. Outbursts, when they occur, create fear in other patients in the emergency department who hear, and potentially witness, the patient out of control.

It should be noted that the non-mental health patients are affected in other ways as well! With emergency department beds filled with mental health patients waiting for disposition, other emergency patients cannot be roomed for treatment. Patients with chest pain, shortness of breath, stroke, broken bones, severe pain, sick children, and other medical conditions have to wait for an empty emergency department bed, or are being treated in hallways because the mental health patients needs to be kept in a "safe space" - thus filling the treatment rooms. This makes it challenging to treat all patients in a safe, timely, and private manner.

Emergency nurses recognize this is a nationwide problem. Our national organization (ENA) has been attempting to identify solutions. We have been documenting, testifying, and lobbying for national legislation related to this problem for several years. We are realizing this is not something the emergency nurses can fix alone. We need to partner with other providers of care for those with mental health issues.

Minnesota emergency nurses have been working on this problem as well and were excited when the formation of this task force was announced.

Minnesota ENA is committed to send at least one of our members to each meeting.

We also offer to:

~ seek out testimony from our members across the state who deal with this daily

~ share any research our organization has developed/published

~ be a resource to the best of our ability

We look forward to partnering with other providers of mental health, as we often do in the emergency department and carrying messages back to other emergency nurses.

Thank you for your work and dedication to this need

Joan Somes RN, PhD, CEN, CPEN, FAEN, NAEMTP
Chair - Institute of Quality, Safety, and Injury Prevention
Minnesota Emergency Nurses Association

7/8/16

Hi Sue –

I work on GRH policy in the Housing division. It's late in the day and I was just able to review the task force PDF. Thanks for sending it for review.

Overall, it's very comprehensive and the underlying principles certainly resonate with me. I'm sure they will for others as well. My natural inclination is to look at everything through a housing lens, so I'd like to advocate from that perspective for a moment.

My background, prior to working in housing, was in mental health case management. I cannot over-emphasize how fundamental housing was (and is) to client stability. Beyond the obvious benefits for the client, having stable housing allows a person to focus on other issues like consistent healthcare and

Long story short, I would love to see **more and more discussion about housing being a solid platform from which people can address many of the other challenging issues they face.**

Thanks for your time and for the opportunity to provide feedback!

DHS staff person specializing in Housing services

7/14/16

Thanks for the information [on how to provide input to the Task Force]. Hopefully I will be able to do one or more of these things although I'm not sure my point can be made in 5 minutes.

I'm a big picture person and I'm particularly focusing on the very first contacts people make with the mental health system. Unfortunately, this is where I've known many people to fall through the system and eventually even end up in the legal system, hospitals, homeless, or even in prison. If we can catch people at this stage it will relieve a lot of the concerns we have today. I'm particularly focused on these items, in order:

- Lack of specialization. The insurance mental health provider networks do not take into consideration the need to include specialties. Mental health is not a 'one size fits all' condition. There are many kinds of therapy and some work much better for particular diagnoses.
- Lack of accurate or even any diagnosis. I don't believe there was ever any attempt to diagnose me except for 'chronic depression'. I only received an accurate diagnosis after being in the system for 15 years. Even then, I only found it by accident; no one ever told me. Knowing my diagnosis was freeing and powerful for me. Knowing what type of therapy best worked for it even more elating. Most people do not have my determination to stick it out that long.
- Incompetence. There has to be better education of mental health workers. I know this sounds dramatic but I truly believe that 90% of mental health workers do not have the proper education nor the seriousness and understanding of their jobs. Therapists and doctors have agreed with me on this. If you need to talk to someone about a death or relationship breakup, they can handle it. Beyond that, if you don't get a proper diagnosis in advance and referred to someone with the appropriate expertise, you WILL fall through the cracks. Usually people are just left

with the therapist assigned, getting nowhere, until they give up. Fortunately for me, after my diagnosis, my fourth therapist knew she didn't have the expertise nor the time to learn it and encouraged my desire to move to someone who did.

I would appreciate you sending this on to the task force and if it doesn't fit into one of their current topics perhaps they will understand the need for discussion of this topic and form a panel. I could maybe even help with suggesting a therapist to be on the panel. I know a therapist who has begun to formulate and teach classes at the U that bring students more in touch with the realities of being a therapist.

If we let people fall through the system from the very beginning, we may not see them again until they reach the hospitals, jails, and streets.

Thank you,
Stakeholder

7/14/16

Good Afternoon

I have been designated the facilitator of an informal group of people that are very concerned about the mental health care issues for people in X County and told you should be our first contact. Early this spring the CEO of X County Hospital called for a meeting because of growing frustrations with the system delivery at the X County Emergency Room. X County Emergency took care of a person on a commitment hold for over 17 hours before being transported to court and another 10 hours before the person was transported to a facility. After a tense hour of discussion we realized that we simply didn't understand the scope and responsibilities of law enforcement, ER, social services, County Attorney, Hospital and treatment facilities. We have educated one another, shared our frustrations and most importantly we have collected data on the issues that we are dealing with in X County.

We have continued to meet approximately every 3 weeks and members consist of the CEO, Chief Nursing Officer, Director of ER from the X County Hospital, X County Sheriff, County Attorney, Director of Social Services, City Police Chief, representatives from the local community mental health center, the Adult Mental Health Initiative, and the local Community Behavioral Health Hospital. This is a group of problem solvers and "think tank" people. We want is best for people in our community suffering from mental illness.

We as a group are finalizing a report and a presentation to present to our local elected officials in August. We are in the process of getting on agendas to the X County Board of Commissioners, City Council and will reach out to our local legislators and share the information we have comprised.

We are asking for your guidance on how to share our information with the Governor's Task Force on mental health or the Department of Human Services. Members or our group are very passionate about entering into dialogue for a problem solving approach for not only X County and City of X but also the state wide issues related to the emergent care of those suffering from mental health.

We have members that are willing to travel to share our story and certainly willing to host in X city.

Thank you for your time and look forward to hearing from you.

Local law enforcement official

7/14/16

Hello Susan:

It was nice to officially meet you Monday during the first task force meeting. Nancy Van Horne, President of the Minnesota School Social Workers Association and myself are interested in providing testimony at one of the upcoming task force meetings regarding school based mental health supports as part of the continuum of care from an educational perspective. I am also attaching a document titled Understanding the Scope and Practice of Minnesota School Social Workers as well as a document from our national School Social Work Association (SSWAA) regarding the role of School Social Workers in addressing mental health needs of students and increasing academic achievement. While listening to the concerns and hopes of the task force members and other stakeholders in the audience, one element that was missing was the importance of school based supports which is why we want to ensure that our knowledge and expertise is integrated into the task force's decision-making.

Would you be able to share the attached documents with the task force and is there a possibility of getting on the schedule for the July 25th or August 15th meeting to provide testimony? We appreciate your assistance. Thank you for your time and including the Minnesota School Social Workers Association in this process.

Christy McCoy MSW LICSW
MSSWA Legislative Chair/Past President, Midwest SSW Council Recognition Chair and SSWAA Secretary
School Social Worker
Agape High School

7/21/16

I wanted to send this early "save the date" regarding an event that may be of interest to the Governor's Task Force on Mental Health.

On Friday, February 24, 2017, Mitchell Hamline School of Law will welcome Stacey Tovino and Sara Gordon from UNLV Law. They will present their work on mental health law as described (preliminarily) below.

PROFESSOR SARA GORDON

"The Use and Abuse of Mutual Support Programs in Specialty Courts."

Professor Gordon will discuss the evolution of AA/NA and how drug and other specialty courts incorporate AA traditions and approaches to the treatment of addiction. She will describe evidence-based approaches to the treatment of addiction that are available, but not often used, by courts. Her presentations will be accessible to both legal and lay audiences.

PROFESSOR STACEY TOVINO

"Essential Mental Health and Substance Use Disorder Benefits"

Professor Tovino has been studying mental health benefits particularly for people with gambling disorder. She will review Minnesota's benchmark plan and coverage of mental health services. To make her presentation even practically relevant to this audience, Professor Tovino will incorporate recent data from the Minnesota Department of Commerce.

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