Governor's Task Force on Mental Health:
Draft Framework Document   (8/4/16)

Governor Mark Dayton established the Governor's Task Force on Mental Health to advise him and the legislature about needed changes to the state's mental health system. This document describes a framework for the Task Force's work and proposes a schedule for the Task Force meetings. If you have comments on this document or other aspects of the Task Force's work, please send them to the Task Force staff identified at the end of the document. We consider this document a draft and expect it to evolve over the course of the Task Force's work.

I.   Framework

A.   Task Force's Charge

Governor Mark Dayton established the Governor's Task Force on Mental Health in order to:[1]

1. Advise the Governor and Legislature on mental health system improvements within the State of Minnesota.
2. Develop comprehensive recommendations to design, implement, and sustain a full continuum of mental health services throughout Minnesota.
3. Make recommendations on:
   a. Developing and sustaining a comprehensive and sustainable continuum of care for children and adults with mental illnesses in Minnesota, including policies, legislative changes, and funding;
   b. Clear definition for the roles and responsibilities for the state, counties, hospitals, community mental health service providers, and other responsible entities in designing, developing, delivering, and sustaining Minnesota's continuum of mental health care;
   c. Reforms needed to support timely and successful transition between levels of care, including early intervention services and substance abuse services; and
   d. Expanding the capacity of Minnesota's mental health system to responsively serve people of diverse cultures and backgrounds.

B.   Role of the Task Force

Minnesota's mental health system provides a variety of effective services but is not yet a comprehensive continuum of care that helps people with mental illnesses to pursue wellness and recovery. The Governor's Task Force on Mental Health is one activity in a very complex system of subsystems—behavioral health care, physical medicine, social services, law enforcement, courts, education, etc.—all of which operate alongside the geographic and cultural communities that we all live in and that ground our wellness. Individuals and organizations in these systems are collaborating on dozens of projects to improve the services they provide and the coordination of those services. The success of the Task Force will lie in its ability to communicate, integrate, focus, inform, and support that ongoing work. The Task Force will strive to:

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[1] See Appendix I for the complete text of the Governor's Executive Order.

- Strengthen the **collaborative relationships** that will be needed to implement system improvements.
- Consider and propose **cross-sector solutions** to challenging system problems.
- Focus public attention on mental health system challenges and **build public support** for solutions.
- **Propose priority projects and reforms** to the Governor and Minnesota lawmakers for funding and support.

The Task Force is most likely to have those impacts if we consider it part of a larger system-change project that has already begun and that will take place over the next several years. In order to do that, we will:

- Ground the Task Force's work within all of the discussions and planning that have already taken place within mental health and related sectors.
- Inform and listen to stakeholders throughout the Task Force process in order to assure the Task Force has a full picture of the ongoing work and to build consensus around Task Force recommendations.
- Balance the Task Force's attention between big-picture system redesign and practical priority-setting.
- Staff and operate the project in a way that builds the mental health system's capacity to implement the Task Force's recommendations.

II.   Stakeholder Engagement

A 15-member group cannot possibly represent the variety of organizations and perspectives involved in mental health care, and even within the organizations directly represented there are multiple viewpoints about the best paths forward. Moreover, only some of the Task Force members will be in a position to organize input from the constituency they represent. To help ensure that the Task Force's recommendations reflect the best thinking of as many individuals as possible and that they will be supported after November 15, stakeholder engagement will be a significant dimension of the Task Force staff's efforts.

A.   State Agency Engagement

The Task Force's work will be integrated with DHS's policy work in mental health, which occurs in the Mental Health Division, Disability Services Division, Direct Care and Treatment, the Olmstead Planning department, Housing, Healthcare, Licensing, CECLC, Compliance, and other departments. It also will be integrated with work in other agencies, including MDH, MDE, DEED, MnDOT, DOC, the Office to End Homelessness, the Ombudsman for Mental Health and Developmental Disabilities, the Governor's Diversity and Inclusion Council, and the health-related licensing boards (like the Board of Psychology and the Board of Nursing). To help ensure this engagement, the Task Force staff will do the following:

1. **State agency support team**: Identify subject matter experts in each agency who can serve as lead contacts for the project. These people can help with creating the stakeholder mailing list, briefing Task Force staff about policy trends and recent legislative reports, providing subject matter expertise, identifying relevant data, and reviewing draft documents.

2. **DHS support team**: The Task Force staff will rely heavily on DHS staff to help with drafting documents, assembling and analyzing data, setting up speakers or field trips, if needed, and reviewing draft documents. The DHS departments to be involved include:
   - Adult mental health policy
   - Children's mental health policy
   - Mental health data analysis
   - Alcohol and Drug Abuse Division
   - Olmstead Implementation
   - Housing
   - Deaf and Hard of Hearing Services
   - Aging and Adult Services
   - Healthcare
   - Direct Care and Treatment
   - Disability Services Division

As the Task Force's priorities are established, the makeup of both the state agency team and the DHS support team could shift to focus on particular subject areas.

B.   Stakeholder Engagement

There are many organizations and individuals who are eager to work with the Task Force to plan improvements in the mental health system:
- **People who receive mental health services:** People with mental illnesses play an active role in planning the state's mental health system, both directly as participants in planning bodies and indirectly through advocacy organizations.
- **Counties**: Minnesota's mental health system is a state-directed, county-administered system, so Minnesota counties partner with DHS to administer the majority of the publicly-funded mental health services in Minnesota.
- **Tribes**: American Indian tribes in Minnesota provide or support health and social services for their members.
- **Insurers:** Insurers determine what mental health services are reimbursable for most people in Minnesota. About one-third of the population is covered under Medicare and Medicaid and almost two-thirds are covered by commercial insurers or self-insured companies.
- **Healthcare providers**: Providers of mental health services include community mental health centers, outpatient clinics, hospitals, residential service providers, jails and prisons. These include both community-based and government-operated providers.
- **Support service providers**: Providers of services that are related to mental health, including housing agencies, disability services, vocational and employment agencies, law enforcement and corrections, courts, schools, faith organizations, and other civic organizations.

To ensure that all of these stakeholders are informed about Task Force activities and have opportunities to provide input to the Task Force, engagement activities will include:

1. **Stakeholder contact list**: Staff will create a stakeholder mailing list that includes contacts from the relevant sectors: health care, social services, education, law enforcement and corrections, courts, and civic organizations. Stakeholders who want to be informed about Task Force work, help prepare and review documents, answer

substantive questions, and provide background data should contact Task Force staff to be added to the list.

2. **Task Force website**: The Task Force website will support communication with stakeholders by being a one-stop location to find notices of meetings, requests for input, draft documents, and other messages: https://mn.gov/dhs/mental-health-tf/

3. **Frequent consultations**: The Task Force's timeline is very short so stakeholders will have fairly narrow windows for answering questions and reviewing drafts. The Task Force staff will issue frequent requests for such help, explain how the input will be used, and try to make the provision of input as easy as possible.

4. **Presentations at meetings**: Task Force staff will try to honor stakeholder groups' requests to host presentations about the Task Force's work. These presentations can be used to gather input to inform Task Force draft documents and the final recommendations.

5. **Public comment**: A public comment period will be scheduled during all Task Force meetings.

III.   Principles

A.   Principles Governing the Mental Health System

The Task Force's work will be shaped by a set of governing principles being developed by the Task Force members. At their July 25th meeting, the Task Force suggested a few additional changes to the revised list. Those changes have been incorporated into this draft; changed sections are marked with an asterisk.

1. **Prevention and early intervention based**: It is better to help someone avoid illness or address symptoms early than to wait until their condition has become more acute to provide services. Primary prevention (preventing a mental illness from occurring); secondary prevention (identification and screening of people with high risk factors or low protective factors for mental illness); and tertiary prevention (halting or slowing the progress of an illness that has already been diagnosed) are all essential strategies. The system should employ a full range of effective health promotion and prevention strategies, including education of the general public about mental health and their role in supporting people with mental illnesses.

2. **Resilience and recovery-driven**: The goal of mental health services is resilience (children) and recovery (adults). Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress. Recovery is defined by the Substance Abuse and Mental Health Services Administration (SAMSHA) as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[2] For some people resilience and recovery involve freedom from the symptoms of mental illness; for others, they involve effective management of symptoms in order to live a satisfying life. In any case, resilience and recovery are about striving toward maximum participation and performance in appropriate life activities including school, work, family life, civic engagement, spiritual practice, recreation, and socializing.

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[2] "SAMHSA Announces a Working Definition of 'Recover' From Mental Disorders and Substance Abuse Disorders," SAMHSA News Release accessed on December 22, 2013 at http://www.samhsa.gov/newsroom/advisories/1112223420.aspx

3. **Person-centered and family-centered**: Recovery is best achieved by person-centered, person-driven, and family-centered strategies and care, which means that each person and their family directs their own recovery to the greatest extent possible. The approach is summed up in the "Nothing about us, without us" motto. Family and friends can play a crucial role in helping ensure that decision-making and care are driven by the preferences of the person as much as possible.

4. **Autonomy**: There is a fundamental tension between involuntary civil commitment as a means to ensure safety and treatment and the curtailing of civil liberties. The mental health system should be designed to prevent or reduce the use of civil commitment whenever possible, and to ensure that individual autonomy is only constrained when absolutely necessary.

5. **Anti-stigma**: The stigma surrounding mental illnesses is very powerful discrimination that isolates people, prevents them from seeking treatment, and dramatically complicates recovery. It also misleadingly links mental illness with violence. It is important to fight stereotypes and misleading information about mental illnesses and to educate society about the reality of these illnesses. Education should also prepare people to respond appropriately when encountering someone with a mental illness or experiencing a mental health crisis.

6. **Community-based**: As much as possible, mental health services should be accessible in local communities so that people can pursue resilience and recovery while remaining integrated in their communities. The system of services in each community should reflect the community context and the strengths of that community.

7. **Commitment**: Policy makers and regulators should commit to following through and implementing the recommendations of the Task Force. This could require additional financial or human resources.

8. **Access to the right services, right place, right time**: People experiencing mental illnesses should be able to find the right services in the right place at the right time. Just like what we expect when we break our arm or experience a heart attack, people with mental illnesses should have timely access to services that meet their needs in a convenient location. They should also receive services in the least restrictive and most integrated community setting of their choice.

9. **Consistency of services regardless of payer**: The healthcare system should provide consistent and appropriate services regardless of whether the person's insurance is publicly or privately paid. There should also be mechanisms to assist people as they move between public and private insurance to ensure smooth transitions.

10. **Public-private partnerships:** The mental health service system relies on effective collaboration among a host of government-operated and private entities. The roles of each organization should be clearly understood and there should be adequate support for the joint planning, collaboration, evaluation, and redesign that is necessary for continuous improvement at a system level.

11. **Public and private insurance:** The mental health service system is funded by both private and public insurance, so any planning for changes to the service system should consider 1) the needs of all people no matter their source of the funding of their services; and 2) the impacts on the services funded by both public and private insurers.

12. **Integration**: Mental health services should be integrated to assist a person to transition easily between service locations and levels of care. Mental health services can be integrated with other health and social services, including substance use disorder treatment,

primary and urgent care, disability services, housing, income supports, law enforcement and corrections, education, etc.

13. **Coordinated**: Where mental health services are not actually integrated, they should at least be coordinated so that the person and family receiving care do not "fall through the cracks" between providers or levels of care.

14. **Multi-dimensional**: Mental illnesses and substance use disorders are medical conditions that have emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual dimensions. To support recovery, the healthcare, social service, education, and employment systems should help the person—with their family and community—to address all of these dimensions in flexible ways.

15. **Safety net**: The mental health system should ensure that anyone who needs mental health services can access them, regardless of ability to pay, high intensity of illness, symptoms including aggression, history of legal involvement, or other reasons. Even in a community-based system with multiple providers and funders, there should be well-understood responsibility, accountability, and capacity for "no rejections" providers who serve those whom no one else is willing to serve. The safety net function should be clearly spelled out on a local, regional, and statewide basis and funding should be allocated to match responsibility.

16. **Sustainability and cost-effectiveness**: The system should be based on a sustainable and affordable financial framework with rational incentives.

17. **Suicide prevention**: Suicide can result from inadequately-treated mental illness. Suicide is preventable and the mental health system should invest in proven suicide-prevention programs.

18. ***Stewardship**: The mental health system should reflect responsible stewardship of public and private funds, ensuring that funds are used efficiently to have maximum positive impact on health outcomes.

19. **Understandability**: The system should be easily navigated by people with mental illnesses and providers because it operates in efficient, understandable pathways.

20. **Cultural responsiveness, competence, and specificity**: The system should respect cultural and social norms of people who might have alternative conceptualizations of mental health and mental illness. As much as possible, services should be responsive to the needs of people from the range of cultural and ethnic groups in Minnesota (culturally responsive and culturally competent) and/or specifically targeted to the needs of a particular cultural or ethnic group (culturally specific). Education about various cultural perspectives should be delivered to create better understanding and awareness.

21. **Accessibility**: Mental health services and information need to be available in multiple formats and languages to meet the needs of the range of people living in Minnesota. Printing documents in multiple languages and formats is a good start, but assuring that follow-up resources are also available in multiple languages or responsive to the needs of linguistic/cultural subpopulations will also be necessary.

22. ***Housing**: Stable, safe, affordable housing is key to pursuing recovery in the community. The mental health services system should collaborate and coordinate with housing services to prevent homelessness where possible and to quickly address the need for housing—with appropriate services—to avoid or ameliorate mental illness or mental health crises. The system should also identify housing gaps and request resources to fill those gaps, as well as providing up-to-date, useful information about the availability of safe housing and the processes and funds for accessing housing.

23. **Transportation**: Transportation is a key dimension of access to services: if a person has no way to get to appointments, the treatment may be available but it's not accessible. Humane and safe transportation is also especially important during a mental health crisis. The mental health system should include, or coordinate with, transportation services to ensure that people with mental illnesses can access services with safety and dignity.

24. ***Employment**: Employment is one key to maintaining independence and self-identity, which makes is an important factor in recovery. The mental health service system should coordinate with employers and vocational services providers to ensure that people receive the support they need to prepare for and maintain stable employment. It should also work with employers to increase understanding about mental health and mental illnesses.

25. **Prevent, reduce or eliminate criminal justice involvement**: The mental health service system should be set up to prevent, reduce or eliminate criminal justice involvement by people with mental illnesses whenever possible.

26. **Evidence-based**: The system should support evidence-based interventions and treatment to produce the desired outcomes. Where evidence has not yet been developed for a particular treatment or sub-population, research should be initiated to test the intervention and cultural leaders should be consulted about the most appropriate way to proceed. Some people prefer the term "evidence-informed" to acknowledge the importance of cultural differences and the fact that evidence gained about one cultural group may not generalize to other cultural groups.

27. ***Capacity**: The system should have ample capacity of staff and programs to meet the needs of all Minnesotans with mental illnesses and emotional disturbances.

28. **Accountability**: The rules and incentives governing the service system should clearly define accountability among all parties.

29. **Data-driven and continuous improvement**: The mental health system should have a transparent system for setting quality goals and measures, gathering data, assessing outcomes against measures, and implementing improvements. Changes to the system should be driven by this data and analysis.

B.   Vision for the Mental Health System

The principles presented above indicate that our vision for the success of Minnesota's mental health system cannot focus narrowly on the effective treatment of mental illness. Our vision should be comprehensive enough to capture the general wellbeing described in the World Health Organization's definition and the range of health and social service systems that affect prevention, resilience, and recovery. This proposed vision for Minnesota's mental health system will be presented to the Task Force, which will refine it over the course of the project.

We envision a time when there is no stigma associated with mental illness. Minnesotans understand mental illness and know how to support someone experiencing difficult emotions, mental illness, or a mental health crisis.   Minnesota invests in a robust, integrated, culturally-sensitive, community-based system of assessment, health promotion, prevention, early intervention, treatment, and supports that promotes resilience and recovery and helps all Minnesotans reach their full potential. Minnesotans can access this system through multiple doors, and mental health service providers collaborate with a variety of other sectors to make sure that services are available when and where needed.

C.   Principles Governing the Task Force Process

1.   Role of Members

Members are encouraged to fully participate in all meetings and to articulate their views and the views of their constituencies. They are also encouraged to keep their constituencies informed about the deliberations and to actively seek their input. Additionally, members are encouraged to strive to bridge gaps in understanding, seek creative resolution of differences that integrate the needs of all stakeholders, and commit to the purpose and principles agreed upon by the members.

2.   Decision Making

The group will operate by consensus, and every effort will be made to meet the interests of all of the participating stakeholder groups. The group will reach consensus on a recommendation when it agrees upon a proposal and each member can honestly say:

- I believe that other members understand my point of view.
- I believe I understand other members' points of view.
- Whether or not I prefer this decision, I support it because it was arrived at openly and fairly and it is the best solution for all involved at this time.

Members should not block or withhold consensus unless they have serious reservations with the approach or solution that is proposed for consensus. If members disagree with the approach or solution selected by the rest of the group, they should make every effort to offer an alternative that satisfies all stakeholders.

3.   Internal Communication

In order to facilitate an open and collaborative discussion, members agree to:

- Represent their interests and concerns; don't just restate positions
- Look for areas of common interests
- As needed, respectfully agree to disagree
- Be mindful of how long they speak for the purpose of ensuring that all voices are heard
- Listen when others are speaking rather than plan a rebuttal
- Be open to changing their minds
- Assume the best of each other
- Take risks by sharing what is really important to them

4.   External Communication

Members are encouraged to keep their constituencies informed about the deliberations and to actively seek their input. Members can also assist Task Force staff in engaging stakeholders.

IV.   Draft Timeline

The timeline below indicates the major milestones for the Task Force. This timeline does not show all of the stakeholder engagement activities that staff will fulfill, including attending meetings to communicate with stakeholders, circulating documents for comments, and revising drafts based on comments.

Week	Activities	Documents Completed
July 11-15	First meeting, July 11: Agree on scope, goals, principles, and conceptual framework. Presentations on mental health system and adjacent systems.	Overview document circulated before first meeting.
July 18-22	Staff revises documents and plans second meeting. Continues work on Issues Document.	
July 25-29	Second meeting, July 25: Finish overview of MH system. Identify system issues.	Issues Document: Challenges in the mental health system and adjacent systems
August 1-5	Staff revises Issues Document and begins working on Policy Options document	
August 8-12	Staff work on Policy Options document and plan third meeting	
August 15-19	Third meeting, Aug. 15: Review issues and choose priority issues.	
August 22-26	Staff work on Policy Options document	
Aug. 29 - Sept 1	Staff work on Policy Options document	
September 5-9	Plan fourth meeting.	Policy options document
Sept. 12-16	Fourth meeting, Sept. 12: Explore policy options for priority issues and discuss recommendations	
Sept. 19-23	Plan fifth meeting	
Sept. 26-30	Fifth meeting, Sept. 26: Review and revise draft recommendations	Rough draft of recommendations
October 3-7	Revise draft recommendations and plan sixth meeting	
October 10-14	Sixth meeting, Oct. 12: Review and revise draft recommendations	
October 17-21	Revise recommendations	Revised draft of recommendations
Oct. 31-Nov. 4	Revise recommendations and plan seventh meeting	
November 7-11	Seventh meeting, Nov. 7: Ratify final recommendations. Discuss communications plan and next steps for the TF.	Final draft of recommendations
November 14-18	Staff finalizes recommendations and sends them to Governor	
November 21-25	Staff implements communications plan and next steps	

V.   Task Force Staff

Task Force staff welcome your questions and feedback. You can reach us at:

- Susan E. Koch, Department of Human Services: susan.e.koch@state.mn.us (651) 431-2325
- Mariah Levison, Minnesota State Office for Collaboration and Dispute Resolution: Mariah.levison@state.mn.us (651) 539-1409

Appendix I: Governor's Executive Order

STATE OF MINNESOTA
EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 16-02

Establishing the Governor's Task Force on Mental Health

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, more than 200,000 adults and 75,000 children in Minnesota live with a mental illness;

Whereas, people wait an average of ten years between first experiencing mental health symptoms and accessing treatment;

Whereas, over 50 percent of children and adults in Minnesota who experience homelessness live with a mental illness;

Whereas, Minnesotans who seek mental health services experience gaps in the current mental health system, leading to inappropriate placement in mental health services, or to not receiving care altogether;

Whereas, adults with a serious and persistent mental illness are dying, on average, 25 years earlier than the general public due to heart disease, lung disease, diabetes and cancer;

Whereas, numerous reports have highlighted the cross-sector challenges faced by Minnesotans in need of mental health care, and recommended developing and implementing a more comprehensive continuum of mental health services; and

Whereas, Minnesotans who live with serious mental illnesses can live healthy and productive lives when high-quality and effective mental health services are available to them.

Now, Therefore, I hereby order that:

1. The Governor's Task Force on Mental Health is created to advise the Governor and Legislature on mental health system improvements within the State of Minnesota.

2. The purpose of the Task Force is to develop comprehensive recommendations to design, implement, and sustain a full continuum of mental health services throughout Minnesota.

3. In addition, the Task Force will make recommendations on:
    a. Developing and sustaining a comprehensive and sustainable continuum of care for children and adults with mental illnesses in Minnesota, including policies, legislative changes, and funding;
    b. Clear definition for the roles and responsibilities for the state, counties, hospitals, community mental health service providers, and other responsible entities in designing, developing, delivering, and sustaining Minnesota's continuum of mental health care;
    c. Reforms needed to support timely and successful transition between levels of care, including early intervention services and substance abuse services; and
    d. Expanding the capacity of Minnesota's mental health system to responsively serve people of diverse cultures and backgrounds.

4. The task force shall consist of members appointed by the Governor, including:
    a. The Commissioner of the Department of Human Services;
    b. 4 individuals or family members of individuals with lived experience of mental health issues;
    c. 2 mental health advocates;
    d. 2 representatives of community mental health services;
    e. 2 representatives of hospital systems;
    f. 2 representatives from law enforcement;
    g. A representative from the counties; and
    h. A representative from the judicial branch.

5. The task force shall include four ex-officio leaders from state agencies, who shall be appointed by the Governor:
    a. The Commissioner of the Department of Health;
    b. The Commissioner of the Department of Corrections;
    c. The State Director to Prevent and End Homelessness; and
    d. The Ombudsperson for Mental Health and Developmental Disabilities.

6. The task force shall include four ex-officio legislative members, who shall be appointed by caucus leadership:
    a. A Member of the Majority Party in the Senate;
    b. A Member of the Minority Party in the Senate;
    c. A Member of the Majority Party in the House of Representatives; and
    d. A Member of the Minority Party in the House of Representatives.

7. The chair of the Task Force will be the Commissioner of the Department of Human Services.

8. The Task Force will report to the Governor's Office, the Legislature, and the public by November 15, 2016.

9. The Commissioner of the Department of Human Services will provide general administrative and technical support to the Task Force.

10. The Task Force will make its meetings open to the public and provide opportunities for public comment.

This Executive Order is effective fifteen days after publication in the State Register and filing with the Secretary of State, and shall remain in effect until rescinded by proper authority or until it expires in accordance with Minnesota Statutes, section 4.035, subdivision 3.

In Testimony Whereof, I have set my hand on this 27th day of April, 2016.

Mark Dayton
Governor

Filed According to Law:

Steve Simon
Secretary of State

FILED
APR 2016
(MN) SECRETARY
OF STATE