

Governor's Task Force on Mental Health

COMMENTS RECEIVED JULY 22-AUGUST 8, 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.

7/22/16



Comments on Governor's Task Force on Mental Health

The Minnesota Leadership Council on Aging (MNLCOA) is a champion, thought leader, planner and educator that advances positive system change for older adults, their families and caregivers. MNLCOA's organizational members represent older adults, providers, advocacy and trade associations, as well as organizations committed to improving the care of older adults.

Mental health and aging is a public health crisis. For example, approximately six million people live with late life depression, but only a fraction receive treatment. Further, comorbidity of physical and mental conditions in adults "represents a significant and costly portion of the population." In fact, the average total monthly costs for a person with a chronic disease and depression are \$560 more than for a person without depression. (RWJF Research Synthesis Report No. 21 on Mental Disorders and Medical Comorbidity, 2011).

Unfortunately, Minnesota's mental health support system is fragmented and primarily focuses on crisis rather than prevention and early intervention. As noted in the biennial Gaps Analyses conducted by Minnesota's counties, mental health services are consistently rated as top gaps for seniors and people with disabilities across the state.

We support efforts to ensure a network of mental health services exists across Minnesota. We support the Task Force's identified principles, particularly:

- Cultural responsiveness. We believe seniors have the right to culturally appropriate services.
- Person-centered and family-centered. We believe in embedding a culture of person-centered care and include caregivers in decision making.
- Choice. We believe the services must be delivered in the manner and location of the person's choice.

We believe initiatives that explore the mental health system should include:

- The right to age with dignity and autonomy, including the right to take informed risk.
- Systems, regardless of payer source, must be integrated, holistic and flexible to support the diverse, growing and changing needs of people as they age.
- Communication strategies across health care, long term care and community based care sectors.
- A notion of individual and community responsibility and capability. Each person should understand his/her role.
- Structures that can implement change within the mental health systems. This includes policy changes and reimbursement that support evidence based interventions, collaborations across providers and systems, and continuous improvement.
- Access to a full array of mental health services throughout the state so individuals can receive services they need in their home communities whenever possible.

We look forward to continued conversations about specific changes related to mental health services. Questions can be addressed to Rajean Moone, MNLCOA Executive Director, at (651) 235-0346 or rajean@mnlcoa.org.

7/24/16

Input and Ideas for Task Force:

[Minnesota city] is [close to the border of two other states]. Our small hospital has limited resources. When the Police Department takes a person having a mental health crisis in to the Emergency Room, technically the Officer has fulfilled the obligation and should be free to get back on the street. However, as most outstate hospitals do not have security guards, etc., the Officer usually has to stay with the person in crisis. Time frames range from 3 hours up to 24 hours. As we are a three Officer Department, and our resources and manpower are very limited.

So, my point is, Minnesota has a FAILED mental health system. I hope to see the day that once a person is placed on a Doctor's 72 hour hold, a facility or open bed would be located within one hour time frame instead of our very long drawn out 4-10 hours we currently wait to locate a bed. Many times the patient is sent home with instructions to take their medication as no beds are available. Not acceptable in my opinion. MN obviously needs many more beds for these patients. And I am old enough to remember the State Hospital in [Minnesota city] where an Officer delivered a person in crisis and was back on the road within ten minutes. We need change!!! My two cents...

Chief of Police
[Minnesota City]

7/25/15

Madame Chair, members of the Task Force, thank you for the opportunity to be here and speak with you today.

My name is Virgil Sohm. I'm a member of the Lake Superior Band of Ojibwe, Bois Forte tribal member, and co-Chair of the American Indian Mental Health Advisory Council (AIMHAC). The Advisory Council is comprised of 13 individuals representing tribal and urban American Indian mental health programs in Minnesota. I'm also a tribal representative to the Region 3 Adult Mental Health Initiative.

The American Indian Mental Health Advisory Council met late last week and had a lengthy discussion about the Task Force. We feel it is important our voice be heard by the Governor's Mental Health Task Force.

Our cultural ways have mental health prevention, intervention and after care interwoven throughout them that *we know work* for our communities. The way our system is set up for reimbursement as a western medical model does not always honor our healing ways as legitimate. I can only assume this might also be true for other cultural communities. We would like to propose expanding our State Plan to include cultural advisors for reimbursement and have demonstration grants to show that fully integrating culture and language into mental health treatment leads to better outcomes.

Also, we would like the Task Force to consider that more housing and transportation resources are needed, as these issues directly correlate to how someone experiences their mental health symptoms.

Greater Minnesota defines the rural and reservation areas outside of the concentrated Metropolitan area. Since the number of American Indians is small compared to other communities, our communities are often overlooked for funding. We would propose funding set-asides for tribal programs and communities. Funding is needed for professional staffing and facilities.

We are requesting 30 minutes on the next Task Force agenda to talk with you in more detail about these issues. Miigwech for your consideration.

Virgil Sohm

8/5/16

[Minnesota County] just transported an individual from that was placed in [neighboring state] to [Minnesota city] for mental health reasons. Over six hundred miles in a day for one of our deputies to find a mental health solution. In reading the minutes of the Task Force that was assembled, I'm not seeing much when it comes to addressing this issue. A thirteen hour day for one of my people to get this person a bed they need, that is 220 miles from the area they live in?? More beds, more staff and more outstate regional sites needed. Still watching to see what comes from this task force.

County Sheriff
[Minnesota County]



August 8, 2016

Susan Koch
Project Manager

Governor's Task Force on Mental Health Susan.E.Koch@state.mn.us

Dear Ms. Koch:

We represent many of the doctors and advanced practiced nurses providing care on the State of Minnesota's Assertive Community Treatment (ACT) Teams. We are writing to express concerns regarding the impact of the State system's shortage of hospital beds over the last two years. Our ability to provide effective services, to fulfill our mission, has been greatly impacted. It is our understanding that the Governor's Task Force is reviewing these issues and we hope our input will be helpful.

We work with individuals with severe and persistent mental illness in an effort to have them remain in the community as much as possible and to have meaningful and fulfilling lives. While our goal is to limit use of hospitalization, because we treat many of the sickest individuals in the State, this is not always possible. Over the last two years we have seen a dramatic decrease in our ability to obtain admission for our most seriously ill patients when medically necessary in Regional Treatment Centers and CBHH facilities. We support the principle that all mentally ill individuals should receive medically appropriate treatment. However, it is our understanding that somewhere in the range of 40-50% of State hospital beds are now occupied by inmates from the correctional system who are given priority over other referrals. While most of the mentally ill patients that we treat may only require short stays in community hospitals when they develop acute symptoms, a significant number require longer term treatment beyond what community hospitals typically offer.

There have been a number of adverse consequences that have resulted from this. Patients who in the past may have been referred to the State system are now discharged from community hospitals when they are unstable. We are seeing more and more of the "revolving door" problem of frequent hospital re-admissions. Community hospital emergency departments that are overburdened have at times been unwilling to admit our patients even when we feel this is absolutely necessary. This creates a cascade of negative effects on our outpatient services and for the patients we care for. Patients who are not receiving the level of care they warrant require a disproportionate amount of time from staff who divert resources from the many to care for the few. Staff are overburdened with attempting to treat people who are not stable in the community and tend to become frustrated and "burn out". This is a difficult job for our case managers even in the best of times. We are now having trouble retaining good staff. When we do not have access to structured behavioral environments for longer term treatment we may be forced to over utilize other interventions such as medication and ECT beyond what would have otherwise been necessary. Finally, our patients typically are referred to us because they have been a danger to self or others. We have increasing concerns about the safety of these unstable patients and that of the community.

We continue to see our mission as treating and maintaining our patients in the community as much as possible. However, if we are to be successful with this goal we would strongly recommend there be an increase in State hospital bed capacity to compensate for the higher utilization by corrections patients. We are concerned that the actual number of patients who are not getting the services they need is not recognized because frustrated community providers are no longer even placing patients on the waiting lists for longer term services. As providers we do not have access to statistical data about utilization. However, we have numerous anecdotal examples of patients who we feel are not getting the services they need. We would be interested in providing more specific information of examples to the Task Force if this would be helpful.

Sincerely,



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SIGNING FOR:

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