Governor's Task Force on Mental Health

COMMENTS RECEIVED SEPTEMBER 6 - 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 except in cases where the authors asked that their identifying information be removed. For circulation outside the Task Force, 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 or unless we receive permission from the individual. For this reason, some identifying information has been removed from some letters for this public version of the comments sent to the Task Force.

9/8/16

Jode Freyholtz-London spoke during the public comment period at the September 12 meeting, and sent the following written information be sent to the Task Force. She also sent three attachments, which will be circulated to the Task Force and posted on the Task Force website.

Wellness in the Woods
TRANSFORMING WELLNESS INTO REALITY

Dear Mental Health Taskforce Members,

Wellness in the Woods (WITW) was founded in March, 2013, in response to the need for a consumer-run, consumer-led statewide organization. All board members and staff identify as living with a mental health experience. In June of 2016, WITW was awarded a federal grant through the Substance Abuse Mental Health Services Administration (SAMHSA) to form and establish a Statewide Consumer Network for MN. This grant creates opportunity to connect mental health consumers across MN and provides a united voice to offer feedback to groups like the Mental Health Taskforce. With that concept in mind we are requesting your support for consumer run Peer Respite Programs.

We believe it is imperative that the success of any mental health service must have input from consumers from inception, during service implementation, and through evaluation of outcomes. In response to the identified governing principles of: Prevention and early intervention, resilience and recovery driven, person centeredness, autonomy, anti-stigma, community based, accessible and evidence based practices, we offer the successful option of creating in Minnesota two peer respite programs to be funded through legislative block grants.

Included in this informational packet you will find the Peer Respite Hospital Diversion Manual created by Optum, Wisconsin's Peer Respite Request for Proposal, and the 2015 annual report from (AFIYA) Peer Respite. The Minnesota Peer Respite Program gathered information from consumers, family members and providers in Todd & Wadena counties. We learned there is a desperate need for intermediate support for people with serious mental illnesses who seek help through local hospital emergency rooms, experience interventions via local law enforcement, or learned there are no services that meet their needs until they experience a higher level of crisis resulting in the need for acute or subacute treatment in hospitals or intensive community and/or residential treatment services. This results in an increase in trauma for the person and often their loved ones, as well as losses of housing, jobs, community integration, and engagement in supportive relationships, and the costs to the State of Minnesota associated with higher levels of interventive services.

Peer respite services offers an alternative, non-medical approach that activates peer support. Individuals can stay from 1-5 days in a supportive environment that has proven to decrease emergency department (ED) visits and hospitalizations by 40-70%, according to Recovery Innovations in Arizona. Through our SAMHSA grant, WITW can leverage national and regional consultation. Wisconsin's *Grassroots Empowerment Program (GEP)* oversees one of three peer respite programs, and will provide three years of consultation and guidance as we develop the first of its kind in Minnesota.

I will be available at the September 12th meeting in Duluth to answer further questions. Thank you for the work you are doing to improve mental health services in Minnesota.

Respectfully,

Jode Freyholtz-London

Jode Freyholtz-London, Executive Director

Wellness in the Woods, Incorporated

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9/9/16

Kathy Czech sent materials about co-responder models in which mental health professionals accompany law enforcement personnel on calls that may involve a mental health crisis. Because all three attachments are lengthy, they will be sent electronically to the Task Force and posted on the Task Force website, but are not reproduced in this document.

9/12/16

Dave Lee spoke during the public comment period of the September 12 meeting and submitted his written comments to be circulated to the Task Force members.

My name is Dave Lee and I am the Director of Public Health & Human Services in Carlton County. Thank you for this opportunity to share my thoughts and suggestions.

Today I am wearing many hats. As a member of the MN State Advisory Council on Mental Health - which I am honored to serve on with Melissa - I represent the 87 County Social Service Directors. As county directors, we encourage the task force to be looking at expanding the services that are proven to work, including Assertive Community Treatment Teams, Mobile Crisis Teams, Adult Rehabilitative Mental Health Services, Intensive Residential Treatment Services and Crisis Stabilization Centers. One of the largest issues for Minnesota counties is the inability to move patients from either Anoka or St. Peter facilities, when deemed to no longer meet "medical necessity", yet no other facilities in Minnesota will accept many of those being discharged. We have had one person who was turned down by 35 facilities in this situation. This puts an unrealistic burden – both programmatic and financial, on the counties. We hope the regional innovation will be encouraged and incentivized, including such efforts such as the possibility of competency restoration services in areas such as NE Minnesota. We also want to highlight the need for expanded housing opportunities for people in recovery with mental health issues, including the increasing number in the criminal justice system. Through experience, it is clear that we can move many people from our correctional system to stable community housing when given the chance. Facilities such as the San Marco in Duluth play a key role in stabilizing an individual's life in order to set a successful path to recovery. The term "recovery capital" best describes what we need to foster, to allow for people to acquire these vital resources (capital) in order to have what is needed for the next steps of mental health recovery.

Second, I represent the Region 3 Public Health & Human Services Directors, the Arrowhead counties, on the Adult Mental Health Initiative. With the help of DHS and MN IT, we are breaking new ground in the world of tele-mental health. We have 23% of the State's geography in our seven counties and 6% of the population. With this span of geography, we've needed to innovate, and partnering with the State of Minnesota with tele-mental health has opened new doors. We need to develop a state wide, common tele-mental health platform that can allow all providers to interconnect and be able to quickly distribute the scarce resource of mental health services anywhere, at any time. Services that are currently being connected in NE Minnesota include mental health centers, jails, emergency departments, mobile crisis teams, tribal & county workers and schools.

Third, as a mental health professional and practicing clinician, I ask that you look at helping to have the mental health system in Minnesota evolve more quickly. Our current reimbursement system pays for volume services, not for the value of what we provide, even if people are not benefitting from our services. We know that integrated behavioral health - having behavioral health consultants embedded in primary care practices - allows for exponentially more people to be assessed and treated for mental health concerns. Research clearly demonstrates that

integrated behavioral health care saves money, produces significantly better outcomes, and has higher satisfaction ratings from patients. Minnesota is very well positioned to lead in the area of IBH with champions such as CJ Peek, Mac Baird and other national leaders in our state. We have to change the paradigm of traditionally trained mental health professionals and primary care physicians in order to leverage this advanced model of care. Integrated care can also benefit Minnesota's inmates, by providing integrated care in county jails with local care systems, allowing for better continuity of care when inmates are released back into the community.

Fourth, as a person whose family has been impacted by suicide, I strongly encourage the further expansion of innovative programs such as TXT4Life which has shown that we can reach people in a timely and effective way. Currently, 1000 people/month use TXT4Life and it appears to be one of the reasons why we are bending the curve in the area of suicides in young people, as demonstrated by the latest release of Minnesota's statistics related to suicide. TXT4Life's educational outreach covers 39 of our MN counties and we need the other 48 counties to also benefit from these efforts.

Last, we need to look at mental health as an area that needs expedited research and development. We need to do more of what works and less of what doesn't while being creative to find new solutions. I have been very fortunate to work with individuals within Minnesota state government such as Roger Root at MN IT and people such as Sue Koch, who over the years have shown strong leadership and the ability to support rapid innovation. *Carving out a more autonomous office of mental health innovation may bring us to our needed solutions more quickly.* As we work to rapidly innovate to increase the speed of mental health R&D, we need people in state government who can say "yes" or "we can do that" vs. "we don't do it that way", thus impeding needed progress.

As a songwriter from our area once wrote, "the times they are changing" and the field of mental health needs to do the same. Thank you.

Dave Lee, MA, LP, LMFT, LICSW
Director
Carlton County Public Health & Human Services
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Other comments from local county social workers:

- Need for more mental health beds statewide

- Private hospitals (Fairview, Essentia, Mayo, etc.) are now very selective of patients they accept due to risks to staff and other patients. This leaves most individuals with any criminal history or violent acts in the ER's for days sometimes weeks, where they are then a risk to others without appropriate mental health treatment. In order to access a state mental health bed the patient must be under commitment (a new commitment takes 2 weeks to get), and at that point the state then has 7 more days to find placement. How can hospitals keep these patients, other consumers of the hospital, and staff safe with the unrealistic timelines?
- When patients are in a hospital based mental health setting it takes months to move them into a CBHH (Community Behavioral Health Hospital) bed. Due to the timelines hospitals are unwilling to take people under commitment due to the fear of being "stuck with them."
- Transportation: There needs to be some consideration in how much law enforcement time is used making these transports that is then leaving our communities under staffed with safety personnel.
- It appears person centered planning is moving towards the mental health programs. Will this improve the communication between the state and counties for better planning? Do they have timelines when this will be implemented?
- Staff shortage: Mental health consumers are becoming more challenging, and with fewer services within the state system this has passed the responsibility to the counties. Many adult foster care homes, board & lodge facilities, IRTS (Intensive Residential Treatment Services), ARMHS (Adult Rehabilitative Mental Health Services), and ILS (Independent Living Skills) providers are unable to maintain staffing due to shortages in the workforce. Some of the concerns have been the increased difficulty in clients and the pay ratio. These professionals find other employment where they are not at risk in the workplace from physical or verbal attacks.
- Clients in the Anoka Metro Regional Treatment Center being deemed "not hospitalization criteria" and sitting there for months on the counties' dime.
- Lack of funding and placement options when trying to transition people out of Anoka RTC.
- Community Alternatives for Disabled Individuals (CADI) funding limitations

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9/14/16

Letter received from provider of Targeted Case Management in northern Minnesota:

I attended the Monday mental health task force meeting this past Monday in Duluth and found it very interesting and exciting that the Governor is taking a closer look at mental health service delivery, services offered, issues, and current concerns.

[Mental health provider] contracts for Targeted Case Management (TCM) services with [northern MN county]. On Monday, there was discussion about whose cost responsibility is it. I would like to ask the Task Force to look at the current TCM rate structure across the State of Minnesota, as it varies greatly. We are one of the lowest paid TCM providers, at $330.00, according to the MH- TCM rate grid, updated, 8/3/16; Family Service Rochester has a TCM rate of $915.00 per target. If the same service is provided, how can the different rate be justified? If we have a client who is placed out of the county, perhaps in Fargo, our current TCM rate barely pays for the staff time to transport the client home. Typically when an individual is in crisis and going into or out of a hospital placement, more time is spent with that individual. Approximately 6 years ago, with [northern MN county] support and approval, we attempted to pursue an Assertive Community Treatment (ACT) team, but we were declined by DHS. I understand that we may not have enough clients for an ACT team in our county. I would like to suggest that a tiered rate structure based on the time spent with each client doing TCM activities could be considered.

Our current starting pay for TCM is $38,000; seasoned and trained staff are in the $45,000 pay range. The expectation is a 4 year degree as well as a Mental Health Professional license. I recently saw that [another MN county] was hiring for an Income Maintenance staff and their starting pay was $41,000 with no degree needed. At current time our staff is under the age of 45, with a median age of about 27. Another factor we will need to take into consideration is the new federal rule regarding overtime and staff wages. As a contracted provider, we constantly have an ebb and flow with referrals, clients who are “opening and closing” to TCM services, maintaining staff caseloads, as well as balancing agency budgets.

I am hopeful the Task Force can look at a more uniform option for a TCM rate across the State.

Thank you for your time.

Provider of Target Case Management services in northern Minnesota

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9/18/16

Hello,

I applaud all the team members’ efforts to help solve the crisis we have in Minnesota in how the mentally ill are handled.

My story would fit in the "crisis response" category. I have a brother who in 1980 suffered a severe brain injury due to a motorcycle accident. After a long and intense rehabilitation he was able to live independently in the city of Robbinsdale. He owned his own home. He was able to work, and for the most part got along o.k. That all changed with a new neighbor and a barking dog. They took an instant dislike to my brother and made his life hell. The barking dog and taunting drove my brother to a reaction. Police were involved and somehow a restraining order was put in place. The neighbors would call the police if my brother placed one foot on their property while mowing his lawn. They placed a security sign on the property line and my brother touched it. The neighbors called the police and here’s where my brothers story started. He was placed under arrest, spent three days in Hennepin county jail

and released with no money, no transportation and unable to remember his brother's phone number who lived in Coon Rapids. He spent four hours walking home. Luckily he recognized a bike path that he had used in the past. The family intervened and demanded that any issues at my brother's residence be handled by calling a family member. The Robbinsdale police told us that was not their policy but eventually agreed. The neighbor still tried to "stir the pot" but this time the family was there to assist our brother.

An example of that is the Robbinsdale police called a family member stating that there is an arrest warrant out for my brother for failure to show. Our older brother paid a bond to keep my brother out of jail. We investigated and found that the city of Robbinsdale sent the court date notice to the wrong address, they also kindly told us no refund for the bail. Had the family not been notified, my brother would have ended up in jail again. The neighbor tried a couple more times to get my brother in trouble but the Robbinsdale PD's phone calls to a family member prevented any escalation.

By the grace of God this neighbor finally moved away but it was too late for my brother. He died of a massive heart attack on May 8th of this year. I truly believe the stress he endured was a contributing factor.

A lot could be learned from this story:

- Training for the police on how to deal with a situation like this. Early family involvement could have saved the police a lot of work.
- Mental health experts respond to situations like this. They would have recognized that my brother did not understand a lot of what was happening to him.
- Easier access to mental health courts. We did not know anything about the mental health court system until my brother hired a lawyer who got my brother on the right path.
- Help after the fact. My brother was on Medicare and did not qualify for a lot of programs because they would not accept Medicare.
- Explain to the responding officers that there are two sides to every story and in my brothers case they only listened to one side.

Thank you
Kirk Bergeron

9/20/16

Hi Susan, my name is Steve Swensen and my son Pavel "Pasha" Swensen almost died in my arms last year the night before school was to start. I've attached "At What Cost" that briefly outlines the circumstances surrounding Pasha's near-death and our continued battle with South Washington County Schools for him to get the support, resources, and assistance he needs. After a year of advocating for his rights, filing complaints with the MN Dept. of Education, and now in due process proceedings we've decided to bring "Pasha's Story" to all those who can assist us and hopefully prevent others from having to experience what we have gone through.

In consideration of the above I am requesting an opportunity to meet with you and/or the task force to discuss this in further detail. Thank you.

Steve Swensen
1708 Colby Lake Drive
Woodbury, MN 55125

The following information was conveyed in a second email:

In addition, I believe the task force should look into Special Education Advisory Councils (SEAC) that by MN law every school district is supposed to convene. There is a major difference in how each district develops, implements, and uses SEAC. I served on the SWCS-833 SEAC for several years but resigned when the district made it clear that they considered SEAC as nothing more than a satisfying state statute venture. MN state law concerning SEAC needs to be revised to establish consistency and continuity throughout every district in the state and to ensure the meaning and intent of our legislators is being upheld. From our experiences in SWCS-833 it is not. I have materials and correspondence that explains this in much more detail and would be happy to share it.

The students that are falling through the strategic gaps in Special Education are becoming the adults with mental health issues and having enhanced suicide risk. Personally I consider our students (and adults) with developmental disabilities to be the "silent minority." Because of their disabilities they are often not able to advocate for themselves and/or express themselves as needed.

I am aware of task force meetings and am planning on attending (likely with Pasha) next Monday's (9/26) in Cambridge. Can you let us know how long we are able to speak for?

Thanks again Susan.

Steve

Attachment: "At What Cost"

9/21/16

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

September 21, 2016

Dear Susan E. Koch,

Due to the impending crisis that Douglas County is facing on the local mental health front, we are writing to convey our concerns.

Locally, we have formed and support our multi-disciplinary Community Coalition which is our local response to the mental health crisis. They are seeking new legislation and policy changes at the State level and would like to partner with the State of Minnesota to move forward in solving this mental health crisis.

To discuss ways we can mutually address these issues (please see attached information), please feel free to contact any of the Douglas County Commissioners or County Attorney.

Sincerely,

James Stratton

Douglas County Board Chair

Heather Schlangen, Douglas County Coordinator/Human Resource Director
305 8th Avenue West, Suite 246, Alexandria, MN 56308
Phone: **(320)-762-3858**

Attachment: Douglas County