

# Governor's Task Force on Mental Health

COMMENTS RECEIVED AUGUST 8, 2016 – SEPTEMBER 6, 2016

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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 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.

8/10/16

## Comments from a Peer Recovery Specialist

**What are the challenges for the Peer role?** The biggest challenge for me as a Peer Recovery Specialist is working in a system that has been in place for a long time. Sometimes, I feel like a square peg trying to fit into a round hole. It feels as though I am expected to adapt and conform to rules and standards of practice that an agency or hospital has adopted that I see as a direct contradiction to the recovery values I have. Old ways keep consumers AND providers stuck. It is difficult work to champion the idea that people with a mental illness can get better, have meaningful work, education and relationships when the established mental health system along with its stigma is just barely entertaining the concept.

It reminds me of that old story about the new bride making a rump roast. Her husband noticed that she cut off the roast on both ends before putting it in the pan. He asked why she did that and she said that it was the way her mom always did it. Then the bride asked her mom about it and her mom said that her own mother cut off the ends, but she didn't know why. Together they called the grandmother and asked her, "Why did you cut off the ends of the roast before cooking it?" The grandmother replied that she did that "because otherwise the roast didn't fit in the pan" she had. It had nothing to do with making a better roast. It was just making it fit into the existing pan. I think the message here is to quit wasting our rump roast with old ideas and ill-fitting equipment.

From my experience, it is easier to work with someone who is just entering the mental health system than those that have been working with it for some time. The newer person has not had years of hearing from their providers how they will never work or go to school, how they have to live alone, how they will never get better or how hopeless their life is.

LEAVING the old mental health system can be scary. You may be on a program where you can get your medication regularly. It is scary to leave that system to be in a society where only the fortunate are guaranteed health coverage. It is scary to leave affordable housing to be in our current market price and availability for housing. It is scary to leave a steady income when your abilities, experiences, or opportunities to work have been compromised.

In ANY system, what do we do with people who become desperate because of no resources, such as transportation, food, and shelter? How do we differentiate between real need and entitlement? What should a person be entitled to have, food, shelter, medicine, dignity? How do we fight the stigma that make so many give up before they try? How do we create a system that helps, but does not get in the way when someone is trying to get off the system? In addition, those people who ARE using the programs (programs in general to help us heal, as well as those to help us get off assistance) should not be in the minority. For Crisis Stabilization, only 40% of our referrals manage to actually be seen.

When you work with crisis and post crisis, you can have some hard cases where the answers meet up against institutions, such as prison, legislation, and poverty. Our society CREATES mental illness through these institutions, our military environment, and our abuses, such as crime. When we really learn to deal with mental illness, we will

have addressed many of our societal problems in a more humane compassionate manner. It is something worth working on.

The mental health system has to adjust to big needs, shifting and dwindling resources in addition to the challenges of mental illness and its stigma. Peers can help the changing system move into the future when our experience, expertise, ideas, and hope are allowed to infuse every level of the mental health delivery system and not just a few stages.

First, whenever possible, Peers could be involved or offered during the first point of contact. Perhaps we could make it so that Peers are available as walk-ins or by appointment. We could encourage people to use "Crisis and Stabilization" at the stage of "When things are Breaking Down" rather than "Crisis and Post Crisis" stages only.

We could have employment assistance programs that teach or direct us to resources that explain how to participate in economics from Gross National Product to self-employment to business to working with non-profits. Address us at all levels of capabilities.

Remembering that we as consumers NEED to influence the system, we, as consumers, could work with organizations like National Alliance for the Mentally Ill or NAMI and their legislative activism or Wellness in the Woods and their work to bring education to everyday consumers. We can champion the idea that recovery is possible by being living proof of recovery.

To give you some personal examples of my own personal struggles, when I was going to school, I had finals in the month of May. Also due during the month of May, was my Medical Assistance renewal application. The stress of having to do both at the same time for me was overwhelming, so I called Human Services to ask if they could move my application process up or back one month. I bet you can guess the answer. My school wouldn't move my finals either.

The other problems I had was the Human Services not knowing their own rules for their own programs designed to help people get off assistance. There was insufficient help to understand such processes, such as Pass Plans, Vocational Rehabilitation, and other employment assistance. The consequences of mistakes, clerical or otherwise that are the norm more than the occasional, of ours or the systems, end up as OUR consequences and can be costly, such as homelessness, the inability to get medications, and, in my case, some schooling.

When I began to work, I had to use the help of a Pass Plan because I was initially hired part time, which was enough to get me off my programs, but not enough for me to afford to manage my illness. There were certain rules that each program that I was on had to follow when an individual was on a pass plan and of course, they made errors. At one appeal that I had to file, the representative for the system said she had been working there for 23 years and had never heard of a Pass Plan. How could someone work for the system for 23 years and not be aware of the programs that help people get off assistance? My first year of employment, I spent every sick and vacation day I had coming, traveling into Hennepin County, Social Security, and Section 8 offices trying to fix their mistakes.

How do we move into the future? Continue to make and influence the system using our tools of hope, personal responsibility, self-advocacy, support, empowerment, choice, recovery environment, and spirituality to make a system that fits us and not us it. Continue to live recovery, to be the hope; and support each other.

YOUR work is very important.

© [the author of the message]

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8/10/16

Hello Susan - I was at a portion of the Governor's MH Task Force meeting a few weeks ago, and wondered whether the Centers for Medicare/Medicaid Services' IMD (Institutions for Mental Disease) Exclusion has been discussed as a barrier to treatment, for both Mental Health and Chemical Health treatment services? The IMD Exclusion affects funding for residential treatment in facilities (either MH or CD treatment) with more than 16 beds, and threatens to shut down long-term providers or anyone who wants to treat clients with more than 15 days of service. Attached is a letter to CMS signed by 20+ US Senators in response to the IMD Exclusion. I am happy to add more about how this is a barrier, especially for MI/CD treatment facilities, if this has not already been discussed at the Task Force meetings.

Thank you!

[Vice President of a CD treatment provider]

Attachment:

United States Senate  
WASHINGTON, DC 20510

August 2, 2016

The Honorable Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, MD 21244

Dear Administrator Slavitt:

In December 2014, 18 bipartisan Senators wrote to the Centers for Medicare and Medicaid Services (CMS) regarding the Institutions for Mental Disease (IMD) Exclusion, which prohibits federal financial participation (FFP) for services furnished in an IMD setting to adults age 22-64 years. This existing policy limits treatment for those who need it most, is clinically inappropriate for proper care, and is rooted in an outdated definition of mental health. In light of the ongoing heroin and prescription opioid epidemic that is impacting communities across the nation, we urge CMS to take additional steps, utilizing existing authorities, to provide greater flexibility in ensuring patient access to medically necessary evidence-based substance abuse treatment.

Over the past two decades, CMS has taken important strides to expand eligibility, protect benefits, and improve provider capacity for the coverage of substance use disorder (SUD) services in Medicaid. The emergence of coordinated and integrated service delivery models that include behavioral health care services in Medicaid have improved outcomes and reduced costs. We also applaud CMS for its leadership in identifying innovative approaches to expand access to SUD treatment, through recent measures including the July 2015 1115 waiver guidance letter, the focus of the Innovation Accelerator Program on SUD treatment, the March 2016 mental health and SUD parity final rule, and the April 2016 Medicaid managed care final rule. Specifically, we commend CMS on the acknowledgement that the IMD Exclusion poses a barrier to beneficiary access to SUD treatment, and for incorporating new tools to mitigate the effect of this policy.

However, we remain concerned that these measures may be insufficient to respond to the opioid epidemic and will not afford enough states the opportunity to enact meaningful changes for beneficiaries. For example, only one state has received approval from CMS for an 1115 waiver for SUD treatment overhauls, whereas many states have indicated an inability to marshal the resources to undertake such a broad, budget-neutral proposal.

Furthermore, the recent managed care rule only allows for 15 days of care furnished in an IMD setting over a 30-day period to be eligible for FFP, and it is our understanding that only American Society of Addiction Medicine (ASAM) Level 4 facilities are eligible. We have serious concerns about limiting eligibility to medically managed intensive inpatient care settings, while precluding all types of Level 3 residential treatment facilities when such settings may be more clinically appropriate. Further, we question whether a 15-day length of stay is evidence-

based for SUD treatment, considering numerous studies suggesting the cost-savings, readmissions reductions, overdose preventions, and recovery efficacy from longer lengths of stay in residential settings as a patient progresses down the clinical continuum of care.

CMS' recent mental health and SUD parity final rule extends certain protections from the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations. CMS noted in its fact sheet that this final rule "helps to prevent inequity between beneficiaries who have mental health or substance use disorder conditions in the commercial market and Medicaid." We seek clarification from CMS on whether the IMD Exclusion can be justified given these parity laws and regulations, especially considering the fact that Medicaid beneficiaries are not covered for medically necessary treatment within settings that play an important role within the continuum of care. Such an exclusion appears to be discriminatory to the estimated 12 percent of adult Medicaid beneficiaries ages 18-64 who have SUDs.

Our nation is in the midst of a heroin and prescription opioid epidemic that has shined a spotlight on barriers to patient access to life-saving care. Improved understanding of addiction pathologies have also informed novel therapies, and patients with SUDs can now manage addiction and reach recovery using medication-assisted treatments. There are numerous Congressional efforts underway seeking to address this issue, but we strongly urge CMS to use existing authorities to broaden treatment opportunities, such as by removing SUD treatment and facilities from the IMD Exclusion.

We look forward to your timely response.

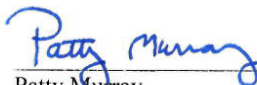
Sincerely,



Richard J. Durbin  
United States Senator



Susan Collins  
United States Senator



Patty Murray  
United States Senator



Lisa Murkowski  
United States Senator



Barbara A. Mikulski  
United States Senator



Shelley Moore Capito  
United States Senator



Sherrod Brown  
United States Senator



Kelly A. Ayotte  
United States Senator

8/15/16

**Presentation to Governor's Task Force on Mental Health, August 15, 2016**  
**MN American Indian Mental Health Advisory Council (AIMHAC) representatives:**  
**Virgil Sohm- Bois Forte Human Services**  
**Jessica Gourneau, PhD, LP- American Indian Family Center, St. Paul**

**Introduction (Angie Hirsch, LICSW- AI MH Coordinator, DHS MH Division, DHS staff to Council)**

Key concepts: Tribal Sovereignty (Government to Government relationship), Federal Trust Responsibility (health, education, housing, etc. in exchange for land and natural resources), Self-Determination (natives serving natives), Governor's Executive Order

**Virgil Sohm, Chair of AIMHAC, Bois Forte rep to Council**

Who is the AIMHAC? The American Indian Mental Health Advisory Council (AIMHAC) is composed of representatives who are authorized by tribal resolution from each of the 11 Minnesota reservations; and one representative each appointed by the commissioner from the Duluth, Minneapolis and St. Paul urban Indian communities. The Council provides guidance to the Department of Human Services Mental Health Division regarding mental health policy and the mental health services continuum.

Cultural teachings have mental health prevention, intervention and after care throughout. These ways are not legitimized by our system, due to cultural leaders not being allowed to bill for their healthcare services. We propose a demonstration grant where cultural services are used as the primary mental health intervention and researching how to bill for cultural services through MA. We assume American Indian cultural communities are not the only cultural communities that this might benefit.

Most of the AIMHAC recommendations align with the priorities of the Task Force (see handout "AIMHAC Recommendations," from 2012 AIMHAC brochure, available in its entirety at <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-6652-ENG>. The Council updates this brochure periodically).

**Jessica Gourneau, PhD, LP, Clinical Director, American Indian Family Center, St. Paul rep to Council**

The way mental health professionals are trained often conflicts with native worldview. Mental health professionals must use a "cultural lens" when applying mainstream training to treatment of American Indians.

When it comes to cultural teachings and healing ceremonies, the cultural leader is the mental health professional.

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8/29/16

**Recommendations to the Task Force from Katy Armendariz, Director of Minnesota CarePartner**

We are a mental health agency that serves the needs of families involved in the child welfare system. Our goal is to keep families together and remain healthy without stripping them of their culture, as well as reduce the disparities of low income families of color in the child protection system and improve equal access of care. We employ largely people of color and people who are bilingual. Our goal is to improve outcomes by providing services in the language of the family by people who are from the same culture. We only accept MA and PMAP plans and do not accept commercial insurance, as clients with commercial insurance have plenty of options, whereas those who don't do not. We are a place where people with MA/PMAPs know they will get served in a timely manner.

**Problems:**

- People without a diagnosis cannot receive services
- Agencies turn away people with Medicaid plans
- Long waiting lists
- Authorization limitations
- Insurance denials
- Not enough Practitioners or Professionals of color
- People with commercial insurance can't receive in-home services

**Suggestions**

- Require all mental health providers to accept clients with MA or PMAP insurance plans and penalize those that do not somehow. Or create incentives for those who do accept MA/PMAP.
- Insurance companies should have to pay even if there isn't a diagnosis. Some people are under stress and require mental health support, but yet insurance won't pay for services unless a person meets full criteria.
- Authorizations limit the number of sessions allowed. MA allows 26 therapy sessions per year, which is not sufficient for many marginalized and oppressed communities that are unequally targeted in the child protection system (and all other systems)
- Blanket guidelines are applied to all people applying for benefits and/or authorizations and treats high income White clients the same as low-income clients of color. There should be varying levels of guidelines for varying circumstances.
- More Practitioners of color are needed, but the law says that a Practitioner needs 2,000 hours of experience, with a BA in the human services. How is someone supposed to get the 2,000 hours of experience if nobody will hire them without it? There is a lack of opportunity for bilingual and Practitioners of color to get the degrees and the required hours. Changing this requirement would allow for more to be employed and for agencies to better provide services by those who represent the demographics of those who are over-represented in our systems.
- Medical clinics should partner with mental health agencies
- Medical clinics should employ Clinical Social workers to integrate the medical and mental health care

- Hold insurance companies accountable. Maybe they should have to pay the same for MA/PMAP clients so that agencies aren't motivated to turn away low-income clients. Insurance companies are denying services and authorizations. They also won't pay for in-home services for commercial plans. Skills and in-home therapy should be available to all families in the state.

KATY ARMENDARIZ, MSW, LICSW

Minnesota CarePartner

Director

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8/31/16

These are comments received by Task Force member Rodney Seurer and forwarded to the Task Force:

Dear Rodney:

You requested examples of breakdowns with the Mental Health systems in MN; here are three:

- 1) Officer involved shooting on July 23, 2015 – the decedent was struggling with mental health issues and was left the night before with healthcare professionals. He was seen on numerous occasions without resolve.
- 2) Officer involved shooting on February 12, 2016 – the decedent murdered his girlfriend and then engaged police in a firefight before committing suicide. He was diagnosed with a mental illness and his condition managed well.
- 3) Officers place a transport hold on a person who was in a mental health crisis. He was released from hospital within a few hours and later jumped into traffic on a highway. Officers responded to offer aid and he assaulted the officers.

Like many departments, I could fill a page with more examples. We need a facility where those in crisis will be held up to 72-hours like with Detox facilities where they can interact with healthcare professionals, be aligned with support mechanisms and have a chance to decompress and come back into a more balanced state of mind before being released – the revolving door phenomenon must stop.

Thank you for your work and leadership on all of this,

[Chief of Police of Twin Cities suburb]