Governor's Task Force on Mental Health

TASK FORCE MEETING SUMMARY

Monday, August 15th, 2016
8:30 a.m. – 4:30 p.m.
Orville Freeman Building- Room B144 & B145
625 Robert Street North, Saint Paul, MN

Governor's Task Force on Mental Health- Members Present: Commissioner Emily Piper, Dr. Paul Goering, Dr. Bruce Sutor, Shauna Reitmeier, Sara Suerth, Representative Roz Peterson, Commissioner Tom Roy, Chief Rodney Seurer, Commissioner Jim McDonough, Melissa Balitz, Representative Clark Johnson, Brantley Johnson, Hon. Jamie Anderson, Sue Abderholden, Eric Grumdahl (for Cathy ten Broek), Pahoua Yang, Senator Tony Lourey, Crystal Weckert, Roberta Opheim, Senator Julie Rosen, Jeanne Ayers (for Commissioner Ed Ehlinger), Liliana Torres Nordahl, and Daron Korte (for Commissioner Brenda Cassellius).
Governor's Task Force on Mental Health Members Absent: Kim Stokes
Governor's Task Force on Mental Health Staff Present: Susan Koch and Mariah Levison
Presenters: Dr. Michael Goh, Suzanne Koepplinger, Kathryn McGraw-Schuchman, Lul Noor, Bisharo Yussef, Dr. Joi Lewis, Commissioner Kevin Lindsay, Angie Hirsch, Virgil Sohm and Jessica Gourneau

Commissioner Emily Piper called the Governor's Task Force on Mental Health meeting to order at 8:33 a.m.

8:30 a.m.   Welcome - Commissioner Piper
- Commissioner Piper welcomed the Task Force members and guests, and reviewed handouts, including prior meeting summary.
- Commissioner Piper reminded members and presenters to minimize the use of acronyms that may hinder understanding, since the group represents many different backgrounds.

8:35 a.m.   Follow up from Second meeting- Commissioner Piper
- Sue Koch reviewed the Principles document and changes made to the items regarding stewardship, employment, and capacity.
- Commissioner McDonough asked that on behalf of counties, that the intersection of chemical dependency and mental illness be called out more specifically.
- Members approved the Principles document by consensus.

8:45 a.m.   Panel of Providers of Culturally- Specific Mental Health Services
- **Michael Goh, Ph.D., University of Minnesota**
  Dr. Goh discussed the immigrant experience and cultures that do not incorporate the western medical conceptions of mental health and instead focus on resources for self-help and mental wellbeing. He pointed out that the

therapeutic alliance is very culturally dependent. Barriers and estrangements in society are reflected in therapy, and hinder the use of any other therapeutic approach.

- **Suzanne Koepplinger, George Family Foundation**
  Suzanne discussed the how mental health begins with belief that individuals have a broad spectrum of abilities to heal and restore themselves, which focuses on the individuals rather than society. Suzanne recommended that addressing historical and systemic trauma by creating upstream preventive measures can sustain and spread cultural practices of self-care and well-being.

- **Kathryn McGraw-Schuchman, MA, LP**
  Kathryn discussed that individuals in the mental health system have the challenges of learning the limits and boundaries of the system as they are in the process of seeking care. Kathryn recommended that mental health professionals and others in the mental health care field need to be ready to fully explain the mental health system to people who do not share the mainstream background, education, language, culture, etc.

- **Lul Noor, Watercourse Counseling Center**
  Lul described how the refugee experience can involve significant cultural adjustments, fracture of identity and trauma. Lul indicated that Somali culture has a strong emphasis on resolving challenges such as mental health and other health diagnoses within the family structure. Immigrant children find themselves unable to fully identify with their culture origins (i.e. what is upheld in their homes) or the predominant culture they currently reside in. Lul recommended that the mental health system and mental health professionals focus on building trust with families, parents, communities and faith based leaders when they are working with individuals with mental illnesses and co-occurring disorders. Her work requires creating relationships and engaging families before focusing on behavior problems or clinical issues.

- **Bisharo Yussef, Watercourse Counseling Center**
  Bisharo discussed that fitting clients into the western medical mental health model pushes people from Somali culture away and discourages them from utilizing mental health services. Bisharo explained that even her Somali background does not create automatic trust with clients who mistrust the medical model. Labeling is a major barrier for the Somali community and ends the conversation and any opportunity to provide psychoeducation to the family. Therefore, reducing labeling would be beneficial to increase collaboration with family and to destigmatize mental health in traditionally underserved communities. Bisharo said that addressing the person in their family context is key to providing culturally appropriate and responsive mental health services.

Using family psychoeducation as the entry point takes time but leads to successful outcomes in the mental wellbeing for the individual.

- **Joi Lewis, Ph. D., Joi Unlimited**
  Dr. Lewis discussed the work she does with healing trauma and holding space in communities of color and marginalized communities. She said that healing trauma requires a holistic approach that addresses the person and their community as a whole, while simultaneously attempting to increase their mental and emotional wellbeing. Dr. Lewis said that the current mental health treatment model tends to locate the problem in the individual, not in the systems and institutions that harm the individual. She pointed out that emotional support work and healing work is already happening in marginalized communities without compensation or clinical framework. The approach does not prioritize the will or direction of the healer, but holds space for the person and community that are in pain. She recommended that this informal healing work be recognized as an important dimension of individual and community mental health and that formal mental health services learn from the approaches that community healers employ.

- **Questions and Comments from Task Force members**
  - **Commissioner Tom Roy:** Not all aspects of culture are positive. What about some of these cultures' roles in violence against women or cultures that are male dominated?
    - Dr. Goh: Cultural responsiveness includes truly understanding the location of the individual, shaped by their culture. Some people come to the field primarily informed by stereotypes, which is counter to that.
  - **Sue Abderholden:** How do we protect the workforce from being re-traumatized?
    - Suzanne: We need self-care as a foundational value in our systems and as a topic included in professional training.
    - Kathryn McGraw-Schuchman: Cultural competency is best practice, but we don't regulate or pay as if that is the case.
  - **Dr. Paul Goering:** How does this work look when you can start with relationship vs. when your first contact is in a crisis situation?
    - Dr. Joi Lewis: Healing work happens in all settings. The current system does focus on crisis, so the resources tend to be thinnest around the follow-up and the ongoing relationship work.

10:05 a.m.   **Break**

10:20 a.m.   **Presentation: Human Rights Commissioner Kevin Lindsay**
Human Rights Commissioner Kevin Lindsay presented on the work of the Minnesota Department of Human Rights. Commissioner Lindsay said that people with, or identified as having, a disability face discrimination around housing, employment, and other services. There is a need for state agencies to do more

intentional civic engagement across cultures and underrepresented communities. Commissioner Lindsay discussed the successful strategies the Department of Human Rights uses, in collaboration with other state agencies, to increase and diversify the state's workforce. The mental health system should strengthen supports for individuals and families so that they can consider employment within the field and other related fields. In order to accomplish this, state agencies need to address the demographic changes in the state and collaborate with each other to make their services and strategies more person-centered and relevant to the communities in MN. Commissioner Lindsay recommended that state agencies foster relationships with community organizations, both private and nonprofit, in order to adequately meet the needs of communities.

Questions and Comments from Task Force members
- ○ **Roberta Ophiem:** Who has responsibility to address discrimination within mental health services provided?
  - • Kevin Lindsay: We take complaints broadly, and complaints from persons with disabilities have always been a significant portion of our work.

10:45 a.m.   Presentation from American Indian Advisory Council on Mental Health

- • **Angie Hirsch, Mental Health Division, Department of Human Services**
  Angie Hirch gave an overview of the American Indian Advisory Council on Mental Health. Angie explained the governance structure between state government and American Indian tribes and reservations. She explained that the relationship is a government to government relationship and that tribes have sovereignty. Additionally, federal trust responsibilities drive much of the work. Land and natural resources were surrendered to U.S. government, which then took responsibility to provide health, education, and other resources back to American Indian tribes.

- • **Virgil Sohm, Chair of the American Indian Advisory Council on Mental Health and enrolled member of the Boise Forte Band of Chippewa**
  Virgil Sohm introduced himself and gave an overview of his experience working in the mental health and chemical dependency system with American Indian communities. He discussed how he has been integrating advocacy around his work in the chemical dependency and mental health field.

- • **Jessica Gourneau, Ph. D., LP, Clinical Director at the American Indian Family Center and St. Paul Urban Community Representative, and enrolled member of the Turtle Mountain Band of Chippewa**
  Jessica Gourneau introduced herself and gave a brief overview of her background working in the mental health system. She pointed out that there are vast differences between the medical model and what Native communities need. Services will be inadequate if they do not reflect the cultural context of American

Indian life. In the current mental health and chemical dependency systems there are needs a provider cannot meet for American Indians due to the lack of knowledge about American Indian history, ways of life and beliefs.

- Questions and Comments from Task Force members
  - **Robert Ophiem:** Are there lessons that American Indian providers and healers can teach our system about recognizing trauma?
    - Jessica Gourneau: Trauma informed Cognitive Behavioral Therapy is a modality that exists at the intersection of culture and medical practice.

  - **Commissioner Tom Roy:** In hiring a culturally responsive workforce, we have seen that the most talented individuals go into business, not social services.
    - Angie Hirch: We have workforce gaps across the system. But a big driver for a more culturally-specific social service workforce is addressing the high dropout rate among American Indian students. American Indians who go into business are also creating positive impacts for our communities, however.
    - Virgil Sohm and Jessica Gourneau: Mentorship is needed, and support for people to attend school and pursue licensing.

  - **Sue Abderholden:** How do we address high suicide rate for individuals on reservations?
    - Virgil Sohm: Substance abuse creates constant occasion for self-harm, which is sometimes lethal.
    - Angie Hirch: We don't have a specific cultural way to address this, because it is something that became common after European contact. Sense of invisibility and sense of hopelessness go hand in hand.

  - **Commissioner Piper:** What are the needs for American Indian communities based on geography and other factors (tribal affiliation, urban population, enrolled/not enrolled).
    - Angie Hirch: Half of Minnesota's American Indian population does not live on a reservation. Urban communities are less likely to have formal connections to tribal leadership, but there is still a strong factor of identity.
    - Jessica Gourneau: Urban populations are less visible, but face similar needs to people on the reservations. Sense of cultural disconnection from community and land can drive mental health issues.

  - **Commissioner Tom Roy:** Is there a good inventory of services available on reservations and for urban Indian groups? Funding sources?
    - Angie Hirch: Billing happens through Medicaid, but primarily as a pass through. When tribes provide mental health services, we get 100%

federal reimbursement (compared to 50% federal reimbursement otherwise).

- o **Roberta Opheim:** Can urban Indians access Indian Child Welfare Act (ICWA) protections when child protection becomes involved?
  - Angie Hirch: Yes, ICWA is applicable, but other tribal court proceedings are not.

- o **Senator Tony Lourey:** How can we increase participation in Medicaid? Red Lake area still sees high uninsured/uncompensated care. What outreach is effective?
  - Angie Hirch: This is a very complicated system, but a big challenge is when services aren't coming from the community.
  - Virgil Sohm: Bois Forte has specific outreach workers to give people the sense of safety and navigating the enrollment process.
  - Jessica Gourneau: We need to be able to seize the moment when an American Indian is seeking help, with a Native person as a liaison to the system.

- o **Eric Grumdah:** What data is given to tribes about insurance?
  - Angie Hirch: Regular reporting, not just on mental health.

11:30 a.m. Lunch

12:05 p.m. Prioritization: Review the list of challenges and the ratings that members assigned to the them. Through open discussion, choose the priority challenges that the Task Force wants to focus on

- Mariah Levison reviewed the process for identifying challenges for the Task Force to focus on. Mariah explained that the ranking process is not supposed to be definitive, but a starting point for discussion amongst the Task Force members. Mariah announced that members will probably need to volunteer for working groups to keep us on schedule. Only three working meetings remain for the work of formulating the recommendations.
- The list of priorities as ranked by the Task Force members were provided to the group.
- Mariah asked each Task Force member to discuss their initial thoughts on the list of priorities and how they have been ranked by the Task Force.

  - o Some of these areas have cascading effects on others, so we need to choose wisely. Each member needs to be accountable for continuing this conversation beyond the Task Force.
  - o Without cultural knowledge and relationship, services are too brief and too impersonal to make a difference.

- The list seems overwhelming. The Task Force needs to step back from our assumptions about how the system works, and look for a new way of doing things.
- The priority list is overwhelming, but if we take small pieces we can start doing it well.
- I am pleased with the ranking of the priorities; it seems reflective of priorities that are needed to improve the state's mental health system.
- All these goals are intertwined. Adding in one area alone can't work. What is needed for a person to succeed? We need to look at the outcomes we want and work backwards to get there.
- How can our work drive systems change, not just response to specific gaps? More attention is needed to all forms of prevention, especially prevention of mental illness and promoting health and well-being.
- The exercise was helpful in forcing members to choose the priorities. Some of the community outreach we discussed was helpful.
- The list is still daunting. Each area has implied detail far beyond what's written. We are still going to have to consider where our work may have unintended consequences.
- Public comments from last meeting were about bed capacity. The Minnesota Hospital Association report points that way too.
- We need to seek the areas where we can build consensus and support, so that this can be a building block. Our timeframe is short, and the work will need to continue.
- The top three priorities are really the issues. The rest fold into those issues. If we do the high level stuff well, the rest will follow.
- The community I represent doesn't have the basics of life, so these goals are hard to comprehend in that context.
- Individual and family centered focus needs to be a priority. This includes outreach to faith-based communities.
- There are still recommendations about ways to improve the mental health system that are pending from other groups. When adding capacity, we need to be careful to add where people are moving to, not necessarily where they are now. Governance and responsibility is the key question, and we have not yet had a full discussion of this and other groups have not made recommendations on this yet.
- What can we do now to save lives right now? Suicide prevention, crisis, chemical dependency? We need to focus on these issues as priorities.
- We need to narrow this field to be effective. Each issue has complexity when we get to looking for practical solutions.
- The panels have taught us that deep change is relationship driven, and is slow. Fast, easy solutions don't lead to major transformations in systems and institutions. We need to look at state supervised/county administered mental health services/system.

- These items reflect the reality that people are not reaching out when they are more able to change. They get pulled in involuntarily at the worst moment. Two tracks of attention: short term and long term vision.
- We have found that we have gaps in our knowledge, and we needed to bring in outside specialists (NAMI, social services) to fill us in. Maintaining capacity is easier in the metro. Bed shortage and revolving door issues are the most immediate crisis in the law enforcement community.
- Our recommendations need to be hopeful. The work will be ongoing, but the feeling of being overwhelmed keeps us from doing our best work.
- Our work needs to stay grounded in our charge from the Governor's Executive Order. Our work will look different on systems issues (criminal justice, civil commitment) vs. the work that specific services might need.

- Further discussion of Task Force members on how to organize the priority list:
  - Look at governance. Counties can buffer come of the changes that come from political winds at the state level.
  - We lack health plan representation, and parity is a big driver in our conversation. Private system resources don't catch people, and they come into our public programs.
  - Budget and feasibility always play into what immediate next steps we take, but we need a broader plan to refer back to.
  - Community strength: addressing economic and racial equity gives our community the ability to take on other challenges.
  - There is a quality of services problem, too. Bad experiences push people out of the system. Then they get labelled as missing appointments or having late cancellations. We hold the people receiving services to a higher standard than we do providers, regulators, etc. This quality issue needs to be addressed.

- Commissioner Piper suggested that the Task Force members focus based on the subsets of the Executive Order rather than the priority list.
- Mariah Levison identified the following 5 areas/themes that were addressed in the Governor's Executive Order, and the top priorities the Task Force expressed:

  - Continuum
  - Roles
  - Levels
  - Diversity
  - Prevention

- Mariah Levison asked the Task Force members to discuss their thoughts on the 5 areas and if members had concerns with the areas that have been identified as focus/priority areas.

- ○ Levels and continuum seem the same
- ○ Levels, continuum, prevention can all be linked in the same area
- ○ Part of our work is to take the spirit of what has been asked of us, and do something with it.
- ○ Continuum is what starts the discussion. Then frame it in terms of the charge back to the specifics asked for.
- ○ The workload is going to be an issue for this group if the priority list is more than these 5.
- ○ We have a list of the recommendations from the last 12 years of history and past reports. We can look at those and use those as resource so that the recommendations are not redundant.
- ○ Can we define a proper continuum of care? This group has not gotten that yet.
- ○ Our services (continuum) is predicated on getting worse before you can get services
- ○ Geography should be represented in diversity work
- ○ Continuum can't be limited to what we have now. I affirm Commissioner McDonough's point that we can't divide up the broad representation of the Task Force to do our work.
- ○ Broad level recommendations would be a good outcome.
- ○ If a properly imagined continuum represents our positive vision, then the roles, levels, diversity, and prevention can be addressed in understanding the gaps and barriers in the mental health system
- ○ The 5 keywords/areas are helpful in breaking this down into manageable areas.
- ○ Prevention has to be integrated into continuum. Once prevention is separated, we miss out on opportunities. Private side doesn't offer prevention, then public system has to come in with the heavier services.

- Mariah Levison asked the Task Force to discuss their thought on the process for formulating recommendations within these 5 areas/theme, including the possibility of work groups.

  - ○ Other workgroups and efforts have addressed all the other areas to some extent, and have recommendations that have not yet been implemented. The exception is roles; we have not discussed this topic much. This area needs a workgroup more than the other areas.
  - ○ Governance is the keyword, beyond roles. Accountability may be another way to rephrase the area "roles" so we all have a common understanding.
  - ○ There is a potential in losing perspectives if we break out to discuss important issues like governance. Workgroups may hinder all Task Force members from participating in the conversation and formulating the recommendations.

- ○ We need to shift to meeting/discussing. Presentations have been good, but now it is time for the group to respond to our charge.
- ○ There is a concern with doing this type of work with a large group. It may be harder if we don't break out into workgroups.

2:30 p.m. Break

2:45 p.m. Go- Around: Comments Task Force members' thoughts on workgroups continues

- ○ I am uncomfortable with pulling recommendations that have not been implemented from other reports but time commitment will be hard for most Task Force members to do workgroups with the 5 proposed areas/themes.
- ○ The work still needs to get done, regardless of format.
- ○ The original ask for our time on this Task force didn't include workgroups.
- ○ When people divide up, we tend to choose the areas and topics what we already know and are well versed in.
- ○ We get more challenged and out of the box when we operate in the diverse setting of larger group like being in the full Task Force meeting.
- ○ I have an interest in all those topics, but would not be able to cover all the workgroups and will not be able to participate in all of them.
- ○ If we break out in workgroups, each workgroup can come and report back to the whole Task Force so that it can be inclusive.
- ○ Department of Human Services staff should provide an overview to the taskforce, and report what they hear in other workgroups so that the Task Force members can get a summary.
- ○ This experience today shows us the challenge of having discussions and doing work in larger group format.

4:00 p.m. Public Comment Period

- Kathy C., Safety, Triage and Mental Health Providers
  Kathy introduced herself and discussed the prevalence of mental illness and individuals with mental illness in county jails. Kathy discussed the need for police officers to receive Crisis Intervention Team training (CIT). This would increase safety when responding to cases that involve an individual living with a mental illness. This service fits into many of the priorities identified by the Task Force. Duluth is on its way to implementing this training as a part of required training for their police force, and Minneapolis, Richfield, and St. Paul are looking into this as well. Kathy recommend that the Task Force support this training and review the outcomes. Kathy handed out informational packet to the Task Force members for their review.

- Kathy Dahlness and Dr. Mark Sander, Minneapolis Public Schools

Kathy and Dr. Sander introduced themselves and discussed school linked mental health services as a priority for children with mental health diagnoses and emotional and behavioral disorders. The dropout rate for children and adolescents with serious emotional disorders is twice as high as that for children and adolescents without serious emotional disorders. Dropping out causes risks for criminal justice involvement, public assistance, and other issues. They discussed how School Linked Mental Health services address access issues for children and adolescents. These services connect students to the services they need while they are in the school. Most students who have symptoms are not yet diagnosed with mental illness and serious emotional disorders in school settings. Kathy and Dr. Sander recommended to that Task Force that schools should be a focus area for mental health promotion, prevention and early intervention efforts.

- Tracine Asberry, Ed.D, Executive Director of St Paul Youth Services, Minneapolis Public School Board Member
  Dr. Asberry described how St. Paul Youth Services assisted staff at a St. Paul Library that was calling 911 in response to youth having behavioral issues or other minor conflicts within their library. The St. Paul Youth Services helped defuse that situation by working closely with the library and youth and training adults in the youths' lives on how to act towards youth. Dr. Asberry's main concern is that disparities in outcomes stem from social determinants of health such as racism, generational poverty, socioeconomic status and historical and current trauma. There is language in some Task Force documents that states "resilience" is needed for youth and children, but asking youth to be resilient will not solve disparities in this state because it doesn't address the causes of disparities. Dr. Asberry recommended the following to the Task Force members:
    - Reactions to disparities and inequities needs to be proportional to the challenges disenfranchised communities are facing
    - Outcomes should be focused on are more upstream (i.e. early intervention, prevention and health promotion)
    - Accountably is needed from all systems and institutions in the state
    - Unchecked systems need to be recognized and checks/balances systems need to be implemented
    - Power need to be shared with individuals and communities that have been disenfranchised
    - Stop the binary thinking of "us" vs. "them"
    - This Task Force needs a racial and social justice expert to facilitate the conversations on equity, disparities, and diversity. List of referrals available upon request.

- John Seymour, Meridian, Provider of Treatment Services
  John introduced himself and stated that he is representing patients of all ages that are struggling with chemical dependency, co- occurring disorders and

mental illness. He said that substance use disorder is prevalent but often goes undiagnosed. He gave a brief overview of chemical dependency treatment services in the state and identified lack of access as a key barrier. Increases in chemical dependency services and beds are needed to respond to the opiate epidemic. Chemical dependency should be in the final recommendations of the Task Force.

4:20 p.m. Next Steps
- Sue Koch summarized the public comments that have been submitted up until August 8th, 2016. The comments were sent out to the Task Force members previous to this meeting and were posted on the website.
- Commissioner Piper announced that that the next meeting will be in Duluth, MN and the October meeting will be rescheduled but is tentatively planned to be in Rochester, MN.
- Commissioner Piper asked the Task Force members to connect with Sue Koch if they are willing to carpool or need a ride to get to the meetings outside of the metro area.

Commissioner Emily Piper adjourned the Governor's Task Force on Mental Health meeting at 4:30 p.m.