

Governor's Task Force on Mental Health

TASK FORCE MEETING SUMMARY

Monday, September 12, 2016

8:30 a.m. – 5:00 p.m.

**St. Mary's Auditorium, 2nd Floor, St. Mary's Medical Center
407 East 3rd Street, Duluth, MN**

Governor's Task Force on Mental Health- Members Present: Commissioner Emily Piper, Melissa Balitz, Brantley Johnson, Kim Stokes, Crystal Weckert, Sue Abderholden, Shauna Reitmeir, Pahoua Yang, Dr. Paul Goering, Dr. Bruce Sutor, Sara Suerth, Deputy Commissioner Daniel L. Pollock (for Commissioner Ed Ehlinger) Commissioner Tom Roy, Cathy ten Broek, Roberta Opheim, Representative Roz Peterson, Representative Clark Johnson and Senator Tony Lourey, Commissioner Jim McDonough

Governor's Task Force on Mental Health Members Absent: Chief Rodney Seurer, Hon. Jamie Anderson, Liliana Torres Nordahl, Senator Julie Rosen

Governor's Task Force on Mental Health Staff Present: Susan Koch and Mariah Levison

8:35 a.m. Welcome

- Commissioner Piper welcomed the Task Force members and guests to the Governor's Task Force on Mental Health meeting.
- Commissioner Piper called the Governor's Task Force on Mental Health meeting to order at 8:37 a.m.
- Commissioner Piper asked Task Force members to introduce themselves.

8:45 a.m. Overview of Today's Meeting

- Commissioner Piper informed the Task Force members that the meeting summary for August 15th, 2016 is posted on the Task Force website at: <https://mn.gov/dhs/mental-health-tf/>. For questions about the meeting summaries, contact Sue Koch at Sue.Koch@state.mn.us
- Mariah Levison summarized the work structure. There are 5 topics that the Task Force members have agreed to focus on:
 - Immediate Improvements in Two Challenges
 - Crisis Response
 - Inpatient bed capacity and level of care transitions
 - Three Transformational Challenges
 - Redefining and transforming the continuum of care
 - Address the governance structure
 - Using a cultural lens to reduce mental health disparities

8:55 a.m. Continuum of Care Transformation: Formulation Team presentation and discussion

- Presenters: Kim Stokes, Melissa Balitz, Cathy ten Broke, Anna Lynn, Sue Koch, Paul Goering, Sue Abderholden, Mariah Levison
- Sue Koch gave an introduction of the formulation team and reviewed the draft document that the formulation team has prepared on the continuum of care transformation.
- Anna Lynn, Mental Health Coordinator at the Minnesota Department of Health, gave an introduction to mental health promotion and primary prevention work in Minnesota. She reviewed the list of prevention and health promotion activities in the Draft Existing Activities and Services in the Mental Health Continuum of Care document that was provided by the Formulation Team and that is posted on the Task Force website. She suggested that the goal should be changing the ratio of risk and protective factors when doing prevention and health promotion work (reducing risk factors while strengthening protective factors).
- Sue Abderholden reviewed the Early Intervention and Basic Clinical Services section of the draft document which focused on secondary and tertiary prevention activities and clinical services available in the mental health system. She discussed the First Episode Psychosis program which focuses on youth and adolescents experiencing their first episode of psychosis. This services is in the process of being implemented in the state. She also discussed the current focus on Adverse Childhood Experiences (ACE) as a means of building resiliency in individuals. Mental Health First Aid is a training that is available which one day program individuals can go through is. Sue reviewed the basic clinical services list and discussed the need to expand specialized services for mental health, similar to specialized services in health care.
- Paul Goering reviewed the hospitalization and residential treatment sections in the draft document. He discussed that there are access issues with inpatient treatment options in the state. Psychiatric Residential treatment for children is currently being developed, which will add to the continuum of care. There is some data sharing with some systems with quality services and pockets of excellence for hospitalization and residential treatment services in Minnesota. There are some issues with access and specialty services in the mental health system.
- Melissa Balitz reviewed the community services and supports services listed in the draft document, including case management, targeted case management, community supports program such as club houses, children's therapeutic services and supports, adult rehab mental health services, assertive community

treatment, youth assertive community treatment, respite care, personal care assistance and community first services and supports.

- Sue Abderholden reviewed the list of crisis services section in the draft document, including crisis, crisis teams, crisis stabilization, crisis homes for adults, psychiatric emergency departments and psychiatric urgent care.
- Sue Koch asked for questions from the Task Force members and input on the Formulation Team's presentation so far.
 - Commissioner Tom Roy: Can we do a dashboard? Can we assess these services shown in geographic areas?
 - Roberta Opheim: These array of services are not available in all of MN. People cannot access this in their neighborhoods. Some of these services are delegated to counties to develop and each county has the authority to develop the services they way they want to.
 - Dr. Sutor: This is a comment about some long term work for governance team- How do we make sure that these services are more coordinated and seamless?
 - Commissioner Jim McDonough: It would be good to identify what private insurance is paying for out of this list.
 - Senator Tony Lourey and Commissioner Jim McDonough: More sustainable and stable funding is needed in order to have all these services available in all communities in the state.
 - Dr. Paul Goering: How do we partner with other industries, private and nonprofit, in order to have more sustainable funding of mental health services?
 - Commissioner Tom Roy: Is there a competition between physical and mental health funds?
 - Dr. Goering: There may be some unintentional cost shifting that occurs between the physical health care funds and mental health care funds.
 - Roberta Opheim: Rate setting the state did for Chemical Dependency and Mental Health were adopted by the private insurance. We don't pay services providers enough in the mental health system to provide incentives?

Second part of the continuum of care presentation: collaborative functions

- Dr. Paul Goering reviewed the Continuum of Care Issue Overview document and the diagram that the Continuum of Care Formulation Team prepared (posted on Task Force website). The collaborative functions to be included in the Continuum of Care are:
 - Collaboration among particular services and providers
 - System-Wide Coordination Functions
 - Coordination with other sectors (to be discussed by Cathy ten Broeke)

- Dr. Goering discussed that we are missing important infrastructure in our data: quality, sustainability, community services. We don't have this currently and if we did we can plan and forecast appropriate. We can also look into health care disparities by utilizing the data we have and look at where the gaps are and when the disparities are occurring.
- Cathy ten Broke, introduced herself and reviewed the critical sectors that the mental health system interacts with. Additionally, she reviewed the effectiveness of supportive and permanent housing.
 - Primary Care
 - Housing- especially supportive and permanent housing
 - Substance Use Disorder Services
 - Education
 - Employment
 - Transportation
 - Criminal Justice
 - Natural Supports
- Sue Koch asked each Task Force member to comment on what was heard in the Continuum of Care Formulation Team presentation
 - Funding and policy decisions are so dispersed. For example, housing funds go through the Minnesota Housing Finance Authority, but a person with mental illness who needs housing is considered by staff in the Department of Human Services. Different staff are listening to the needs of the same person with different paradigms. This is problematic, and there needs to be collaboration and coordination across our state agencies.
 - Continuum of care needs to be looked at from macro and micro level (look at the individual experience and then look at the systems and policies).
 - Governance needs to be coordinated.
 - Having agencies collaborate and bring policies in a coordinated manner needs to happen.
 - Funding discussions needs to be more inclusive.
 - The challenge seems to be integration but there are opportunities to mitigate this.
 - Funding is piecemealed with mental health. A lot of smaller local groups are working on pilot projects but we don't have larger systems-level work taking place.
 - There are inexpensive ways to utilize data and information sharing (ex. tracking of individual's progress once they have been discharged) that should be pursued.
 - There are a lot of siloed systems and services.
 - Rules that are in conflict with each other in mental health and chemical dependency make it very complicated to integrate systems and services.

- What kind of data is available? What kind of “yard sticks” are we measuring? What is present and missing in the data?
- There are issue with communication between patients and providers. We need data sharing between systems so patients are not falling through the cracks. Open communication with providers is an issue, especially in urban communities.
- The mental health continuum of care is complicated, big and hard to navigate if you don’t know the system. How do we expect people that are from different cultures or new to the system to navigate it to get their needs met?
- The Legislature is looking at data practice and information sharing in health care.
- There are currently 44 crisis numbers; this should be a simple fix that can improve access to crisis services significantly.
- I am curious about research with chemical dependency and mental health. Is there data on chemical dependency causing mental illness?
- Return on investment should be the focus- program administrators need to make their case when utilizing funding, creating programs, etc.
- The mental health workforce is only trained to look at treatment and provide crisis response services. When we are looking at expanding the continuum, will we have the workforce for the rest of the continuum (i.e. prevention, health promotion, etc.)?
- Silos and lack of communication between and within systems continues to be a theme in the Task Force’s conversations
- How do we pay for services and create sustainable funding for effective and quality services?
- Private insurance needs to be addressed in this conversation. What is their role?
- We are stuck in a model where we tell individuals what services they will go into next. We don’t explain the available services to individuals and then let them pick. The system should person centered so that individuals have a choice about what level of care and services they can chose from.
- We don’t want the Legislature to make the continuum. This should be developed on the community and local level.
- What do citizens deserve and what do they trust, we need to keep this in consideration.
- There is a quality issue in the mental health system and that is there is very little engagement with communities. This needs to improve.
- Mental health care has been looked at from a health care perspective. We need to look at this from a civil and human rights perspective and issue as there has been and still is a lot of discrimination in mental health system.

10:30 a.m. Break

10:58 a.m. Inpatient Psychiatric Bed Capacity and Levels of Care Transitions: Formulation Team Presentation and Discussion

- Jen McNertney introduced the formulation team and gave a brief description of the task and focus of this team. Dr. Bruce Sutor gave a presentation on the guiding themes, long term plans and vision.
- Guiding themes
 - This is a very complex issue
 - It is important for the Task Force to coalesce around actionable items that can be implemented within 1-2 years
 - Build towards longer-term solutions
 - We can't build our way out of the problem
- Some proposed solutions from this formulation team:
 - Increase bed capacity
 - Patient flow
 - Increase community resources
 - Role and responsibilities
- Possible options for Task Force members to consider
 - Establish an ongoing body to coordinate and oversee work on inpatient bed capacity
 - Increase Intensive Residential Treatment Service capacity
 - Consider housing and supports: Short term supportive structured housing
 - Community and based competency restoration
 - Civil commitment, small changes: Specifically, call out that there are other community mental health services options other than inpatient hospitalization for commitment. Clarify this in the statute.
 - Improve local coordination around crisis response
- Previous Recommendations for Inpatient Psychiatric Bed Capacity and Levels of Care Transitions have focused on the following
 - Person-centered planning
 - Strengthen community services
 - Reducing readmissions
 - Improving care coordination/management
 - Improving mental health, substance use disorder, and primary care integration
 - Building workforce capacity
 - Streamline and expand competency restoration services
 - Discharge planning/transitions to community

- Improve crisis response
- Questions for the Task Force Members from the Inpatient Psychiatric Bed Capacity and Levels of Care Transitions Formulation Team
 - Does this overview present an understanding of the issue?
 - What are Task Force members' thoughts on the possible options?
 - What options should be added?
 - What options should the Formulation Team continue pursuing with additional research and work?
- Mariah Levison facilitated the go around for this section and asked for thoughts on the Inpatient Psychiatric Bed Capacity and Levels of Care Transitions Formulation Team presentation. Responses included:
 - Linking the funding to the referral network and strengthening responsibility
 - Do we sacrifice peoples' autonomy?
 - Community paramedics are needed to enhance crisis services in the state
 - Are there incentives associated with mental health assessments and beds?
 - Bed tracker is not available to the public. This needs to change.
 - No other illness requires you to harm yourself or harm others to get admitted to an inpatient service. This relates to a capacity issues that is not measured or tracked right now.
 - Management, coordination, accountability, local and community are the words I heard during this presentation.
 - Let's look at this from the community level perspective and encourage the communities.
 - Let's think about the impact that hospitalization of an individual (parent or child) has on the family system.
 - People are getting stuck at Emergency Departments, jails, and Regional Treatment Centers (Anoka, St. Peter). On the community level people are getting stuck in the adult foster care system. Let's look at this in depth.
 - If people are utilizing the Emergency Department as an entry point, let's make this the best Emergency Department possible and create a model for that if that's the entry point of mental health services.
 - Reverse Return on investment: let's look at investing in human capital instead of systems
 - Community based competency restoration--what does that look like? What does the hand off look like from the Regional Treatment Centers to the next level of care? What is the expertise necessary to make community based competency restoration effective?
 - County shared cost: Should this be the accountability measure for county human services? If this group looks at this and cannot agree on a policy

recommendation, what are the alternatives instead of the money going back to the general fund?

- I have heard nothing but complaints about Adult Foster Cares. Employees are not being trained adequately and do not have the right qualifications to provide person centered and culturally responsive mental health services.
- Kids are not being served well in schools. There is a significant lack of services in schools.
- Children most likely will be on private insurance and the more intensive services are not covered under private insurance. This is a problem.
- No one from the metro area has applied to provide Psychiatric Residential Treatment Facilities; this is an issue. We need to get specialized care in these facilities in the metro area and all areas of the state.
- Are the solutions linked with data metrics?
- There are issues with the Adult Foster Cares. We could look into improving this service and a having mental health workforce that is proficient in this level of service
- What's the outcome we collectively want for the individual and how can we do this in collaborative manner?
- What county or city intervention can we do right now to make these services available?

12:15 p.m. Lunch: Presentation and Discussion with Duluth Mental Health Task Force members

- Commissioner Piper asked the Task Force members to get lunch and come back to the meeting by 12:30pm. Then Dr. Steve Sutherland and the Duluth Mental Health Task Force members spoke with the Governor's Task Force.
 - Dr. Steve Sutherland gave an introduction to the Duluth Mental Health Task Force and the work that they are doing in their local community.
 - Duluth Task Force members went around and gave a brief overview of the history of their Task Force. The Duluth Task Force members discussed the bed shortage and other shortages in mental health services in the Duluth area.
 - The Duluth Police chief, Mike Tusken, discussed some of the capacity issues in serving individuals who are experiencing homelessness, chemical dependency, mental illness and co-occurring disorders. Additionally, 50% of people in Duluth jails have mental illness and there are mental health services issues in jails.
 - Other Duluth Task Force members discussed issues with bed capacity and stated that there are not enough inpatient beds available to serve all individuals that need that level of care.

- The Duluth Task Force members discussed their hopes to decriminalize mental health.
- The Task Force discussed issues with transitions of care limitations; there are pockets of good services but accessibility and care coordination is an issue in the Duluth area. There are permanent and supportive housing needs in the area and the need for appropriate funding for these services so that they can be provided to all individuals that need this level of service.
- The Duluth Task Force asked the Governor's Task Force on Mental Health for support of the Duluth Task Force's work.
- Questions from the Governor's Task Force on Mental Health members
 - Is there an emphasis on youth for the Duluth task force?
 - Can you describe the triage center?
 - What's working well in the Duluth area?
 - What are the barriers to sending individuals back to their areas/place of permanent residence once they get to Duluth?

1:00 p.m. Crisis Services: Formulation Team presentation and discussion

- Ben Ashely- Wurtmann presented on crisis services that are available in the state. He gave an overview of the 2015 legislative charge, crisis response models and crisis standards work that is currently taking place for the 2017 legislative session. Ben announced that the Crisis Response Formulation Team met this past Friday and the Formulation Team would like input from the Task Force members on the direction the Crisis Formulation Team should be heading and what the Task Force members would like to see from the Crisis Formulation Team.
- Questions from Crisis formulation Team to Task Force members
 - Crisis services need to be able to....
 - What does a successful crisis intervention achieve?
 - What competencies do teams need to bring the table?
 - What values and priorities need to come to the forefront?
 - I think the biggest obstacle to providing better crisis response is.....
 - What are the barriers we face?
 - What collaborations haven't happened in the ways we need?
 - Where could the taskforce move policies to resources to improve crisis?
- Questions and comments from Task Force members to Crisis Formulation Team
 - Crisis teams work. They don't rely on the Emergency Department unless it's absolutely necessary.

- Crisis services are not culturally competent to be able to respond to communities they may not be familiar with or are not from. This can be an issue in many ways.
- Data access and sharing for crisis teams are limited or nonexistent.
- Accountability in the court system and criminal justice systems are needed.
- Crisis services need to be holistic and person centered.
- We need an accessible and easy way to remember the phone number for one crisis line in the state (currently one number for crisis services does not exist).
- Building relationships and partnerships with other organizations and other services in the area is needed to improve crisis services.
- Culture training is needed for crisis teams.
- Funding and dollars are through grants for crisis services in the state. There is no true base funding system for crisis service funding.
- A high level of trust is needed from the person receiving the service and the individual providing the services. How do we keep the individuals being serviced in the center?
- Crisis services need to be implemented with 911 just like other basic need emergency services.
- Currently, 911 services are not provided in the same way in the different neighborhoods especially in urban and inner city neighborhoods. Additionally, communities of color and disenfranchised communities don't trust law enforcement due to history of law enforcement not responding to them in a timely manner or other discrimination that has occurred in these communities. Integrating 911 and crisis services is not a good idea as this will cause further disparities and access issues of mental health services in inner city communities.
- 911 responders need to be properly trained to respond to every community appropriately. Culturally responsive and appropriate services need to be provided by law enforcement.
- Crisis services have to be 24/7 and have to come to the individual who needs them, when they need them. There shouldn't be a wait or a hold to get services.
- State wide accountability is needed for the overall mental health system and especially crisis services.
- A warm handoff after the crisis services have been given is needed.
- Basic response standards need to be implemented equally in all communities through the state. Consider this as the crisis standards are being formalized.

1: 45 p.m.

Governance Transformation: Formulation Team presentation and discussion
Presenters: Shawna Reitmeier, Melissa Balitz, Representative Clark Johnson

- Shawna gave an overview on the work of the Governance Formulation Team. She discussed the focus of the team is - Let's figure out "what" first then "who" later. This team had their first meeting over a conference call and have planned future meetings.
- Some areas in Governance Structure Issues that have been discussed in during the last team meeting are:
 - Sustainable and equitable funding is necessary for quality assurance.
 - Parity is needed in order to sustain services long term.
 - Roles and responsibilities need to be clearly defined especially when service is being provided and when individuals are between levels of care on the continuum.

1:55 p.m. Cultural Lens Transformation: Formulation Team presentation and discussion

Presenters: Paoha Yang, Carol LaBine, Angie Hirsch

- Angie Hirsch gave an overview of the task and focus of the formulation team and discussed 4 themes the team is focusing on.
- Pahoua Yang reviewed how culture impacts mental health in our work. The team also discussed that engagement matters but this is not funded in the mental health system. Creating a much more seamless system starts with what people need.
- Using a Cultural Lens to Improve Services and Supports and Reduce Mental Health Disparities Formulation Team 4 Themes
 - Medical vs. culturally based healing
 - Our mental health system needs to be more trauma-informed
 - Evidence Based Practices vs. Practice Based Evidence
 - Identifying and growing culturally specific providers
- Carol LaBine presented on what the state is currently doing to address disparities in the mental health system.
 - Cultural and Ethnic Minority Grants have been available through the Department of Human Services and have been funded for the last 5 years both through Children's Mental Health and Adult Mental Health.
 - Rule 47 and outpatient rules which ensure providers are mindful of cultural influence when conducting diagnostic assessments and clinical supervision have been added.
 - The Department of Human Services funds tribal providers to attend culturally adapted evidence based practices trainings in Trauma-Focused Cognitive Behavioral Therapy and Parent Child Interactive Therapy.
 - Department of Human Services is currently in the middle of a rate assessment for mental health services.

- There are other things happening within the state, nonprofit and private sector on using the cultural lens and the team is currently pulling together a list of these.
- Questions from the Cultural Lens Formulation Team to Task Force members
 - What do you think of these opportunities?
 - Do you think it is appropriate for the Task Force to make recommendations along these lines?
 - Is the system ready to embrace these ideas? Where are the best places to start building awareness and collaboration?
 - We know that insurance reimbursement and programmatic funding will be central to implementing these ideas. Where might be the best places to focus our attention on first?
- Question and Comments from Task Force members
 - There are misperceptions about historical trauma. Can the team give a brief explanation of historical trauma?
 - The role of government being the leader on using a cultural lens needs to be discussed further and well thought out.
 - How do we normalize the cultural lens approach into clinical work?
 - We talked about equity, culturally competent services but it's hard to measure these things within in large initiatives. How are we going to measure that mental health services are truly equitable?

3:00 p.m. Public Comment Period

- Jode Freyholtz- London, Wellness in the Woods, Executive Director and Co-Founder
 Jode introduced herself and stated she is present to talk to the Task Force about Peer Respite. Jode gave an overview about Certified Peer Specialist services in MN. In 2007 MN passed Certified Peer Specialists statute but only 30% of the Certified Peer Specialists that have been trained since then have been hired to do the work. Jode stated that she supports that Task Force's focus on accountability. Peer Run Respite is a service that is available in Wisconsin and other states around the nation. There are 3 organizations in Wisconsin that provide peer respites services and 20 total organizations that provide that service in the nation. Peer Run Respite services are for people with mental health and substance use concerns who may be experiencing increased symptoms or stress and can benefit from being in a peer-supported environment. Jode stated her organization currently has bi-partisan support starting Peer Run Respite services in MN and stated that a couple of representatives are willing to author a Peer Respite Bill. Jode asked for the Task Force member's support on this service. For more information, Jode can be

contacted and is willing for answer questions and discuss this with Task Force members.

- Dave Lee, Carlton County, Director of Social Services
 Dave introduced himself and stated that there is a need to work together to improve the Regional Treatment Centers (Anoka Medical Regional Treatment Center and Minnesota Security Hospital in St. Peter) operated by the Department of Human Services. The concept of housing first and housing stability needs to be discussed in depth and these services need to be readily available in state. Additionally, Vidyo Tele Presence, which is also known as Tele- Mental Health Services, has been utilized more effectively and the state can encourage one form of Tele-Mental Health Services and create a standard for statewide use of this tool. In Minnesota, integrated care has some of the best researchers and services, especially in the University of Minnesota system. Integrated services have higher patient satisfaction, better outcomes for recipients and they save money. We need to think about partnering and collaborating to create an effective and accessible integrated system in the state; we need to look at public and private partnerships. Txt4Life has been a successful service that has been effective in suicide prevention. We need to invest more in this services so that all parts of the state have access to the Txt4life regional coordinators. Dave recommended that a Center for Mental Health or Behavioral Health Innovation should be created in the state as there is a need for this as reform in the mental health system continues to occur.
- Pastor Jerome _____. [Name not available; did not sign up on public comment sign in sheet]
 Jerome said that no one has mentioned resources from churches and faith based communities in the conversation from today. We should look at how primary care has been able to partner with other sectors (i.e. churches) to improve access and availability of services. For example, there are parish nurses who are available in hospitals and hospitals. Recommendation to the Task Force: make it possible for churches and faith based community, faith based leaders to be involved in and partner with the mental health system.
- Rebeca Paulson, Public Health Nurse
 Rebeca introduced herself. She discussed her work in a perinatal mental health program. Perinatal Mental Health is an evidence based program that exists in the state. The goal of the home visiting program/service is to improve the health for mother and child. Postpartum depression affects women of low socioeconomic status more often than women who are in higher socioeconomic status. Interventions that address post-partum depression are needed. Rebecca

recommended that the Task Force support home visiting programs and funding for these programs.

3:30 p.m. Next Steps

- Sue Koch review of comments received from August 8th – September 6th, 2016. This document is available on the Task Force Website and handouts were provided.
- Commissioner Piper announced that the next meeting will be in Cambridge, MN on September 26th, 2016. Further meeting details will be available on the Task Force website.
- Mariah Levison reminded Task Force members to turn in their reimbursement forms with receipts attached to Heron Abegaze.
- Commissioner Piper announced the Formulation Team Work Timeline. Formulation teams will have time to work within their teams from 3:45pm until 5:00pm.

3:35 p.m. Break

3:45 p.m. Formulation Team Work Time

- Formulation Teams worked with their team members to prepare for the next meeting.
 - Immediate Improvements in Crisis Response
 - Immediate Improvements in Inpatient Bed Capacity and Levels of Care Transitions
 - Redefining and Transforming the Continuum of Care
 - Addressing the Governance Structure
 - Using a Cultural Lens to Reduce Mental Health Disparities

5:00 p.m. Adjourn