

# Governor's Task Force on Mental Health

## SUMMARY OF COMMENTS RECEIVED SEPTEMBER 22, 2016 – OCTOBER 10, 2016

---

The Governor's Task Force on Mental Health received comments from several stakeholders between August 9, 2016 and September 6, 2016. Those can be summarized as follows:

- Trained mental health practitioners (who are always under supervision by a mental health professional) are allowed by statute to provide face-to-face crisis care. They should also be allowed to provide that care by tele-mental health. The current statute requires a higher level of training (mental health professionals) to provide care by tele-mental health, and this should be changed.
- Voluntary home visiting programs are a proven strategy for supporting maternal health, child health and development, and the promotion of safe and nurturing parenting. Further investment in programs like the Nurse-Family Partnership is a key cost-effective step in health promotion and prevention of mental illness.
- The Police-Based (Embedded) Mental Health Co-Responder model is an efficient innovation that can work well with existing mobile crisis teams, help improve integration between law enforcement and community mental health provision, build police officers' skills in responding to mental health crises, and improve the experience of the person in crisis.
- The medical system in Northern Minnesota is not capable of properly caring for people with mental illnesses, and Michael's story shows the terrible consequences of this. Rather than trying to improve the medical system's ability to treat mental illness, we should build more mental health provider capacity at various levels of care throughout the state. When people in crisis seek treatment and are put on a hold, they should receive care for the entire 72 hours of the hold. Moreover, treatment providers should include families and care-givers in decisions about treatment and discharge, especially in critical situations where the providers haven't had time to learn the detailed history of the people they are treating.
- Nursing facilities, senior housing, and assisted living providers are not currently capable of meeting the needs of seniors with challenging mental and chemical health needs. There are a variety of solutions to increase capacity and capability, including increased funding under the critical access nursing facility program (for providers specializing in mental and chemical health services) and the Elderly Waiver.
- The impact of the 48-Hour Law must be considered in the Task Force's recommendations about inpatient bed capacity. Given some patients' symptoms that include violence, we should add mental health services in jails, rather than moving some people into the mental health delivery system.
- Northern Minnesota lacks adequate inpatient psychiatric bed capacity, which force people to travel long distances to receive care and also burdens law enforcement with significant transportation costs (Koochiching sheriff transports totaled 53K miles and 1,115 hours in 2015).
- People experiencing a mental health crisis should have fast access to a psychiatric prescriber.
- Data should be collected to determine the number of beds/programs needed in each region.
- Crisis stabilization programs decreases healthcare utilization and is cost-effective.
- We should project the future needs for inpatient psychiatric beds and plan to meet those needs.

- DHS should reduce DCT's role to serving people who are committed as MI&D and sex offenders, transferring all other services to community providers.
- We should implement multiple solutions and expansions to improve crisis response
- The Task Force should consult with the many existing bodies that are working on integrating cultural traditions into treatment models.
- Minnesota needs to expand its psychiatric residency programs.
- There are not enough inpatient psychiatric beds in Minnesota.
- Minnesota should establish a "4.5" setting for students with severe mental illnesses and substance use disorders.