Person and Family-Centered Approaches in Mental Health and Co-Occurring Disorders Training Project: Final Report

Background to the Project

In 2015, Minnesota's Olmstead Plan was approved for implementation. The Minnesota Olmstead Plan requires that people receiving services for disabilities be provided with person-centered planning and positive behavior support. Older adults, children, and people with mental health conditions are included in these requirements, when their needs aligned with definitions of disabilities in various systems. (For example, receiving waiver services, or meeting criteria for 504 plans or Individual Education ("Special Education") Plans in school systems).

This requirement mirrors an ongoing advocacy and public policy push. Increasingly key components of person and family-centered approaches are expected in public services and medical care. This includes going beyond diagnosis as a way of matching treatments, services, and support to an individual. There is an expectation that professionals will gain an understanding each person's strengths, preferences, resources, and relationships and embed this into a customized approach as part of the path to recovery and/or supported community living. Adopting these approaches also fundamentally changes the dynamic between professionals and persons supported to one of shared decision-making rather than professional in charge. Finally, it asks professionals to take a more active role in pushing the systems and communities to be responsive to including their members who live with these conditions in community life.

In 2016, the Minnesota Department of Human Services (DHS) introduced the Person-Centered Informed Choice and Transition Protocols (PCICTP). These were meant to help case managers and others who supported people in developing individualized plans related to treatment, services, and supports to understand how to comply with expectations of the Minnesota Olmstead Plan. The PCICTP contains checklists of components that should appear in plans to ensure they are compliant. However, these were framed in five valued effects that should be the result of this compliance. (See inset on the Five Effects).

The Five Effects of Person-Centered Services as outlined in the Person-Centered Informed Choice and Transition Protocols (PCICTP) as part of the Minnesota Olmstead Plan

People receiving person-centered services will experience five effects:

- Grow in relationships.
- Contribute to their community.
- Make choices.
- Are treated with dignity and respect and have valued social roles.
- Share ordinary places and activities.

Adapted from John O'Brien and Connie Lyle O'Brien (1987)

We need more community awareness and support from our rural community.

-Alexandria

Response to Training and Support for Olmstead in the Mental Health Community

Originally the Mental Health Division (since then this division has combined with Chemical Health into the Behavioral Health Division) required Mental Health Targeted Case Managers to use these Olmstead protocols in their work. Eventually, this became a recommended but not required practice. However, case managers for waiver funded services for mental illnesses or related conditions were still required to meet the expectations of the protocol. It was also recommended that all community services align with Minnesota Olmstead Plan expectations.

To support lead agencies, counties, and providers in complying with the Minnesota Olmstead Plan, training in Person-Centered Thinking (TLCPCP, 2016) was deployed across the state (funded by DHS). As with other communities of practice, the mental health community

I want the bosses-supervisors, money people @ the table at training and working together.

-Bemidji

did not uniformly agree with or adopt these approaches. Some of the common themes of concern expressed by those in the mental health community included the following:

• There is no shared understanding of what these terms mean.

• They are a step back from participant driven, self-directed services.

• They distract from recovery and resiliency-based approaches.

• There is no way to be person and family-centered at the same time.

• They are not possible in the context of civil commitments, guardianship, or similar court ordered supports.

• They do not align with or include various cultural contexts and backgrounds.

• They are not substantially different from what is already happening. Therefore, they are a burdensome addition.

• They are not evidence-based.

• Expectations are not clear and therefore are impossible to implement with fidelity and accountability.

• They require efforts that are not reimbursed. There are too many gaps in billable or available services to achieve this.

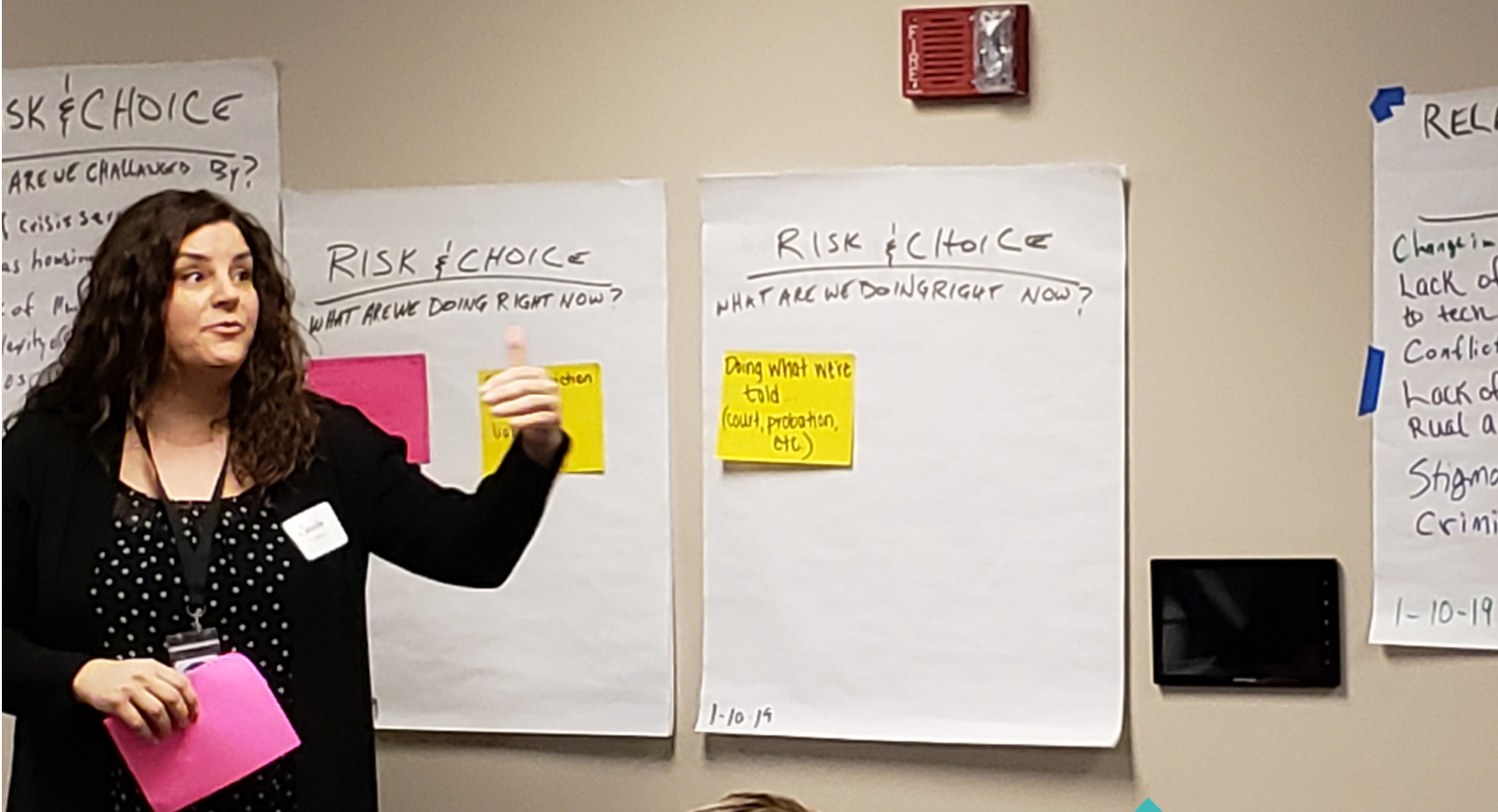• Deeply rooted community stigma keeps this from being a reality.

Purpose of the Project

Many of the issues and concerns of mental health community about whether person-centered practices could or should work for people with mental health conditions are common concerns professionals have when these practices are introduced. Others were due to some people delivering the training not being well-versed in mental health systems or mental health practices and approaches. This made it difficult for some learners to translate the skills from the training to daily practice. Despite concerns of professionals and sometimes advocates, it is clear that person and family-centered approaches

are going to be part of the landscape in mental health services. Many forms of regulations and guidance regarding the most innovative of funded services (including Certified Community Behavioral Health Clinics and Systems of Care), have expectations of person and family-centered approaches in their service models.

In order to help ensure the needs of the Minnesota Mental Health community were met, the Mental Health (Behavioral Health) Division of DHS, put out a Request for Proposal (RFP) for a qualified entity to develop training on person and family-centered approaches, specifically for Minnesota's mental health community. The goal of the RFP was to develop training that would help providers and professionals better meet the vision and

expectations of the Minnesota Olmstead Plan as well as ongoing expectations in broader mental health initiatives. The Research and Training Center (RTC) at the Institute on Community Integration (ICI) at the University of Minnesota was contracted to fulfill the duties of the RFP. The contract ran from April 1, 2017 to March 31st, 2019.

Process of the Project

The team at the RTC/ICI took a co-creation approach to developing this training. Initial work included an environmental scan. The scan looked at multiple reports, training materials, etc. to understand and clarify how the expectations of the Minnesota Olmstead Plan (Via the PCICTP) translated into expectations and practices of the mental health community. From there, a review of what training was currently available was completed.

What we heard

What valued social roles have been lost? How is this contributing?
-Duluth

What we heard

Be okay with being uncomfortable.
-Rochester

Challenge the perception that children are better off w/out parents incarcerated or on probation.

-West St. Paul

Finally, gaps between what was currently available and expectations were identified. New training focused on filling those gaps. It was meant to be an evolution of what was available and focus on where practitioners needed more support, rather than a repeat or repackaging of what people could already access in the state.

A central part of the development of the content included feedback and connection with a variety of Minnesota's community members. This co-creation process included a variety of ways of connecting and engaging the influence of community members on the final products. The attribution section of this report includes who, where, and how various members of the community were engaged.

What we heard

Discuss with company HR Dept what type of training, if any, are being provided to the front desk personnel.

-Virginia

Outcomes of the Project

The contract product outcomes include:

- Creation of a review tool for evaluating the potential usefulness of training or resources specifically for the purpose of meeting requirements of the PCICTP in mental health services.
- A resource list of training and resources available in Minnesota that may be useful to people in the mental health community.
- Creation of eight online modules (available through Trainlink and DirectCourse)
- Training of over 300 people in twelve in-person day-long seminars around the state
- Over 100 people attended two follow-up webinars focused on practical strategies in equity issues and supporting people with choice limits.

The co-creation processes included an evolution of definitions and concepts regarding person and family-centered practices. They also refined how training gaps should be filled and what should be emphasized. Facilitated discussions and co-creation events started with the definition of person-centered practices as defined in the Minnesota Olmstead Plan. Specific processes were used with participants to support their ability to reflect on that definition and contribute to a more enriched understanding. The co-creation processes lead to a deeper set of defining characteristics of "person and family-centered practices", "culture, cultural identity, and worldview", and "cultural humility" than is found in the Minnesota Olmstead Plan. These descriptions are included here exactly as they were at the end of the co-creation process and not edited to "plain language." This was done deliberately to honor the work by not editing it outside of the co-creation process before sharing it with training participants. (See final definitions in insets.)

What we heard

Keep bringing cultural humility back to the table.

-Carver

FINAL DEFINITIONS

**Project Vision Statement
of Person and Family-Centered Practices:**

Person and family-centered practices honor and support people's abilities, strengths, and personal power. Each individual, family, and community has the ability to co-create a path that includes health, wellness, recovery, and resilience. Person and family-centered practices are rooted in cultural humility. Professional supporters engage in these practices to co-create unique paths with each person in the context of their current circumstances, preferred life choices, family/family of choice and/or other natural supporters. Professional supporters also engage in these practices in their organizations and communities in order to create and sustain positive changes toward these practices.

Culture, Cultural Identity, and Worldview - Are multidimensional. They are influenced by aspects such as the following: (not a complete list)

- language, ethnicity, and heritage;
- spiritual practices and beliefs,
- family and community norms;
- personal attributes such as gender, age, race, abilities, sexual orientation, and gender identity; and
- personal experiences such as others' responses to personal attributes, economic status, military service, education, trauma-experiences, and geography.

Cultural Humility

- Cultural humility acknowledges that culture influences all things and exerts a powerful force on behaviors and beliefs. It acknowledges that all people, communities, organizations, and systems are cultural carriers whether they are conscious of this or not.

- Cultural humility acknowledges that the current human service systems unintentionally but powerfully perpetuates a historical and limited set of cultural norms and patterns of inequity. These norms and patterns include a perspective of people and families in these systems as being separate, broken, and needing to be fixed.

- Cultural humility makes a commitment to lifelong learning about self and others. It includes a commitment to equalize power imbalances in our work, systems, and communities. It commits to co-creation of communities where all are included, valued, and represented in power.

Through the environmental scan and co-creation processes it was identified that the following areas were the ones where professionals needed more skill and that systems needed to most change. They were also the areas where there was the least readily accessible training available in Minnesota. Both online and in-person training focused on enhanced skill and understanding of the following:

- Cultural responsiveness and equity issues in mental health services.
- Bringing forward the authentic voices of people supported and their families in mental health services through on-going and proactive co-creation processes.
- Integrating support networks (family, friend, other important relationships) into plans effectively.
- Supporting people to maintain and develop valued social roles.
- Managing risk and choice limits (such as mandated services) in a person and family-centered way.
- Shifting roles and responsibilities of professionals to promote and sustain these approaches.

The training developed through this contract expects professionals to reflect on and take responsibility for changing systems and communities, as well as their own practices. Through-out the in-person sessions, professionals processed aspects of each core area together. They engaged in activities that helped them define and describe what challenges they were having. They processed what needed to happen at an organizational, system, or community level to change this. They were then encouraged

to define and share small changes or next steps they could or would take to move toward these changes ("nudges"). A sample of the nudges from these sessions, appear in the "What We Heard" discussion bubbles through-out this report. As with the co-creation definitions, these appear as people wrote them, without editing.

The majority of participants of in-person participants felt they gained skills in these key areas and/or had increased their confidence in communicating the value of person and family-centered practices. Themes of ongoing areas of emphasis included:

- Involving a variety of community members in understanding the value of person and family-centered practices and to fight prejudice. This included ministers, waitresses, guardians, judges, first responders and others.
- Ensuring that decision-makers and everyone who had contact with people in organizations were expected to understand and support these approaches. (Front desk, finance workers, child protection, etc.)

What we heard

Modeling with staff how to talk/ask about culture in creative, organic ways.
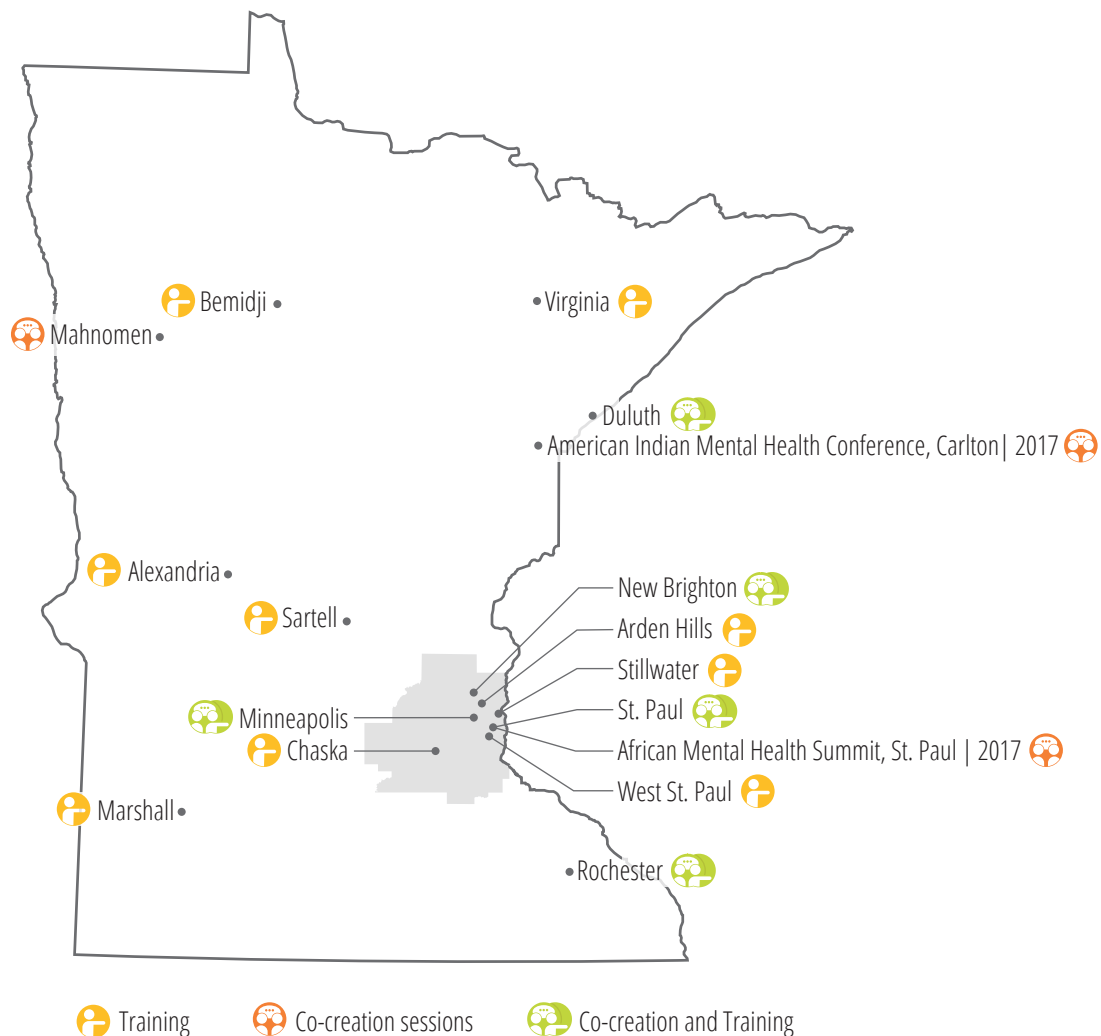
-Arden Hills

- Becoming more sophisticated in understanding and approaching equity issues in Minnesota. Engaging underserved communities proactively and in an ongoing way to define what will work.

- Working more collaboratively and proactively across systems in community to develop necessary relationships and develop capacity to be responsive for individuals. (This includes education, corrections, transportation, human services, vocational rehabilitation services, housing, faith communities).

- Continuing to build the mental health services system so that people can access services in their own communities and in ways that make sense to them.

What we heard

The importance of holding hope first and foremost.

-St. Cloud/Sartell

Attributions

The content of materials developed through this contract were co-created with members of Minnesota's communities. Co-creation included structured and open-ended conversations as well as listening sessions. It also included seven structure co-creation processes conducted in different parts of the state. These sessions included professionals, community members, and people with lived experience and their families. Community members were also invited to review and edit the content of online materials (Community Reviewers).

Map of Minnesota showing locations:
- Bemidji
- Mahnomen
- Virginia
- Duluth
- American Indian Mental Health Conference, Carlton | 2017
- Alexandria
- Sartell
- New Brighton
- Arden Hills
- Stillwater
- St. Paul
- African Mental Health Summit, St. Paul | 2017
- West St. Paul
- Minneapolis
- Chaska
- Marshall
- Rochester

Legend:
- Training
- Co-creation sessions
- Co-creation and Training

Challenge each other, are you considering the risk to individual or your own liability

-New Brighton

Community members were invited to co-facilitate in-person sessions and engage in development and delivery of final in- person materials. Participants were kept informed about ongoing progress through a website.

The following sessions helped to shape refined definitions and areas of focus after the initial environmental scan was complete.

- African Mental Health Summit (2017)- Open-ended conversation with a large group regarding goals, definitions, and gaps.
- American Indian Mental Health Conference (2017)-Structured conversation with a smaller group around goals, definitions, and priorities.
- DHS Mental Health Division –Structured conversation with a larger group around definitions and priorities.
- Parent Catalyst Leaders Group (Hennepin County) – Listening session with parents who were newer to the system and guided by more experienced parents around gaps and challenges.

There were seven (7) Co-Creation Groups (in 6 communities) Rochester, Duluth, Mahnomen, Minneapolis, St Paul (2), and New Brighton.

A total of 89 people participated in these groups. Participants included a spectrum of people with a variety life experiences and backgrounds. These processes were developed to support the maximum engagement of each participant. The following people attending a co-creation session:

Thomas Anderson, Minneapolis
Laura Armstrong, Minneapolis
Mina Blyly-Strauss, Minneapolis
Carol Brogan, Chatfield
Brenda Caya, Duluth
Mary Chazen, St. Paul
Rose Chos, Duluth
Cristina Combs, St. Paul
Jennifer Conger, Savage
Heidi Crees, Minneapolis
Debbie Crittenden, Bloomington
Tom Crittenden, Bloomington
Nicole Duchelle, Lake City
Polina Duchelle, Lake City
Amber Dukowitz, Duluth
Josephine Eades, Duluth
Karen Ellian, Duluth
Feisal Elmi, Minneapolis
Angela Elwell, Eagan
Amelia Fink, St. Paul
Kassandra Flake, Minneapolis
Mike Francis, Eagan
Carl Gardner, Minneapolis
Colleen Garman, Minneapolis
Gerald Geist Jr., Moorhead
Cathy Gillman, Cottage Grove
Triasia Givens, Minneapolis
Susan Govern, Minneapolis
Amy Granquist, Duluth
Jane Haas, Stillwater
Kristin Hale, Duluth
Ricky Hamm, Rochester
Keven Hardy, Rochester
Tom Haselman, Minneapolis
Vivian Henry, St. Paul
Jenny Isaacson, Duluth
Melissa Johansson, Maplewood

James Johnson, Duluth
Carolyn Keefner, Westminster, Co.
Jessica Kisling, Minneapolis
Bob Klade, McIntosh
Kay Knight, Duluth
Fonda Knudson, Fergus Falls
Jeanne Kolo-Johnson, Moorhead
Maggie Lemasters, Duluth
Jenny Linder, Duluth
Tulu Lope, Inver Grove Heights
Ginger Madeiros, St. Paul
Diane Marshall, St. Louis Park
John Martin, Minneapolis
Kristy Matzke, Rochester
Lamont Mayo, Minneapolis
Nick Mazzoni, Duluth
Alvin McCoy, Minneapolis
Willard McDonald, Rochester
Kurt Meyer, Minneapolis
Cari Michaels, St. Paul
David Moses, Rochester
George Nadeau, Minneapolis
Beth Nelson, Fergus Falls
Richard Oni, Birchwood
Peggy Ostman, Duluth
Jovi Parm, Minneapolis
Rose Plentyhorse, Minneapolis
Tyler Rinta, Minneapolis
Ruby Rivera, St. Paul
Michael Ruhl, Minneapolis
Ryan Sandquist, Minneapolis
Julie Scharver, Fergus Falls
David Schreyer, Two Harbors
Kelsey Shoden, Rochester

What we heard

I will use plain language vs. symptom language.

-Stillwater

Glenda Smith, Fergus Falls
Cora Spear, Burnsville
Jennifer Thomas, Maple Grove
Nelly Torori, St. Paul
Maria Tripeny, Bloomington
James Van Druten, Duluth
Sarah Vinueza, Minneapolis
Kenya Walker, St. Paul
Claudia Waples, South St. Paul
Eileen Ward, West St. Paul
Terry Wasnick, Duluth
Linda Weber, Rochester
Bryant Wheeler, Minneapolis
Tobias Wilde, Moorhead
Shannon Williams, Duluth
Tera Wiplinger, Rochester
(Wendy) Maxuan Wu, Minneapolis
Ann Zick, Osage

There were seven community reviewers recruited to review the content of online materials that were developed. These reviewers were mental health professionals and included family members of service users. The following people served in this role:

Allison Brockway – Sherburne County
Tamba Gordon – Hennepin County
Tom Haselman – Hennepin County
Jessica Kisling – University of Minnesota
Jane Lawrence – Community Reviewer
Jeff Olson – Headway Emotional Health
Dorothee Tshiela – Face to Face Health and Counseling

Additional recruitment of Community Co-Facilators was completed. These co-facilitators represented people with various backgrounds and views. They supported the development and delivery of in-person materials. The full team include 11 individuals. Two RTC staff were consistently present at all sessions. Additional Co-Facilitators attended at least 3 sessions each. This was to support participants in hearing from a variety of views during the sessions and to influence the content as it was delivered. The following people served as Co-Facilitators:

RTC/ICI//UMN Staff Co-Facilitators:
Susan O'Nell-Project Director
Laurie "Chet" Tschetter – Project Coordinator
Jody Van Ness- Project Staff
Nicole Duchelle- Project Staff

Community Co-Facilitators:
Elizabeth Bieging - Hennepin County
Laura Birnbaum- St. Louis County
Melissa Cekalla - St Louis County
Shaudelle Darris- Hersilency, Minneapolis
Albert Garcia- Peer Support Specialist, Metro
Thomas J Haselman - Hennepin County
Darrin Helt- DHS Behavioral Health Division

Webinar Presenters:
Joseph Cranney, DHS - Community Support
Shaundelle Darris, HerSiliency
Zaidee Martin, Parent
Alisha Otteson, DHS - Community Support
Maria Sarabia, Ramsey County

Other DHS and RTC/ICI/UMN Staff Support for completion of the materials and tasks of this contract:
Lynda Anderson - RTC/ICI/UMN
Claire Benway - RTC/ICI/UMN
Amanda Calmbacher - Behavioral Health Division
Kristin Dean - RTC/ICI/UMN
Nik Fernholz - RTC/ICI/UMN
Sara Gable - Behavioral Health Division
Gretchen Gallagher Weinstein - RTC/ICI/UMN
Anab Gulaid - RTC/ICI/UMN
Merrie Haskins - RTC/ICI/UMN
Sarah Hollerich - RTC/ICI/UMN
Barb Kleist - RTC/ICI/UMN
Shawn Lawler - RTC/ICI/UMN
Nancy McCulloh - RTC/ICI/UMN
Macdonald Metzger - RTC/ICI/UMN
Erin Watts - RTC/ICI/UMN
Amanda Webster - RTC/ICI/UMN
John Westerman - RTC/ICI/UMN

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