STATE ADVISORY COUNCIL ON MENTAL HEALTH

and Subcommittee on Children's Mental Health

State Advisory Council on Mental Health Subcommittee on Children's Mental Health

2024 Report to the Governor and Legislature

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Land Acknowledgement and Declaration of Commitment

We, the members of the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health, acknowledge that the wealth of this country was built on stolen land and with enslaved and underpaid labor of African American, Native American and immigrant people.

We acknowledge that the recent global uprising, which was sparked by the murder of George Floyd here in Minnesota, paired with the COVID-19 pandemic, makes for a time of profound uncertainty, shame, fear and distrust. We also recognize that despite those feelings, we all must actively challenge the impact of our own implicit biases and how they may influence our decisions as individuals and leaders.

Furthermore, we recognize that racism also expresses itself in policies and practices that either target or erase Black, Indigenous and People of Color (BIPOC) communities and erects barriers to their prosperity.

Therefore, we pledge to be vigilant in monitoring the formulation of policies and practices that produce harm to vulnerable populations. We also commit to being open to other people's truths as we acknowledge the resilience, creativity and generosity of the human spirit, and we hold firmly to a persistence of hope.

With these issues in mind, we commit to dismantling systemic and structural racism by initiating and supporting policies, practices and the allocation of resources that promote diversity, equity, inclusion and shared power.

Executive Summary

The State Advisory Council on Mental Health was established in 1987 under Minnesota Statute 245.697 1 and the Subcommittee on Children's Mental Health was established in 1989. Members for both the Council and Subcommittee include individuals with lived experience of mental illness, parents and family members of those with mental illness, county commissioners, social service directors, advocacy organizations, educators, psychiatrists, psychologists, social workers, community corrections, legislators and representatives of state agencies. The Governor appoints members to the State Advisory Council on Mental Health. Members of the Subcommittee on Children's Mental Health are appointed by the chair of the State Advisory Council on Mental Health.

Per statute, the Council and Subcommittee are charged with:

- Advising the Governor and heads of state departments and agencies about policy, programs and services affecting people with mental illness
- Advising the Commissioner of Human Services on all phases of the development of mental health aspects of the biennial budget
- Advising the Governor about the development of innovative mechanisms for providing and financing services to people with mental illness
- Encouraging state departments and other agencies to conduct needed research in the field of mental health

- Educating the public about mental illness and the needs and potential of people with mental illness
- Reviewing and commenting on all grants dealing with mental health and on the development and implementation of state and local mental health plans
- Coordinating the work of local children's and adult mental health advisory councils and subcommittees

The 2024 Report to the Governor and Legislature provides recommendations from the members of the State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health. The Council and Subcommittee are dedicated to improving mental health services for all Minnesotans. Members considered current social, cultural, whole family and person-centered needs when developing these important recommendations.

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health's 2024 recommendations to the Governor and the Legislature include the prioritization of the following areas related to mental health in the state of Minnesota:

- Develop a comprehensive understanding of the State of Mental Health in Minnesota through the development of a comprehensive mental health needs assessment databank for the population of Minnesota
- Increase the viability of the provision of mental health services through a reimbursement rate adjustment for providers
- Remove barriers to accessing needed services by removing the need for prior authorization for critical psychiatric & substance use medications and treatments
- Support and fund the collaborative care management model of addressing mental health concerns
- Address mental health needs in schools by fully funding a permanent per pupil allocation for specialized instructional support personnel, fund training to manage mental health and behavioral concerns and address workforce challenges in filling these positions
- Increase mental health educational requirement for licensure/re-licensure of school staff, including training on the impact of digital media on the mental health of youth
- Support students with 504 plans by increasing eligibility for reimbursement at par with those with an individualized education program (IEP)
- Target mental health and juvenile justice by developing a centralized data collection system for the demographics of youth interacting with the juvenile justice system
- Increase the scope of mental health services and supportive services to at risk youth and youth within correctional facilities
- Address the currently unaddressed topic of juvenile competency attainment in Minnesota
- Expand access to wraparound mental health care through increasing funding for Minnesota's System of Care initiative
- Expand family peer support opportunities
- Grow family support opportunities within schools
- Build Community Initiated Care to support young people and families
- Address housing barriers for those living with mental health and substance use disorders
- Continue to support Community of Practice and community-based wellness resources

- Increase financial support for peer recovery support specialist providers
- Address the workforce shortage of licensed mental health professionals from diverse backgrounds
- Collect and provide community access to data to enhance accountability
- Provide affordable and supportive housing for BIPOC & formerly incarcerated populations
- Increase Funding for the Cultural and Ethnic Minority Infrastructure Grant (CEMIG)
- Expand the required community participation in Local Advisory Councils (LAC)
- Statute revision to use inclusive person-first language
- Statute revision to increase equity between adult and children's Local Advisory Councils

Recommendations from Work Groups

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health have organized their recommendations in the following Work Groups:

- Integrated Care and Access
- Mental Health and Schools
- Mental Health and Juvenile Justice
- Family Systems, Prevention, Intervention and Supports
- Recovery Supports
- Outreach to Diverse Communities
- Local Advisory Council

Integrated Care and Access

Development of a comprehensive mental health needs assessment databank for Minnesota

Problem statement: Within Minnesota are many governmental programs operating to address mental health needs. Additionally, there are local, private, public, non-profit, tribal etc. entities and institutions also serving components of Minnesotans' mental health needs. Despite a multitude of programs and services, the consensus is that the current supply and infrastructure is inadequate to meet the needs of all state residents. Furthermore, the individual programs and entities are operating without any coordination or communication with each other. Without an overall knowledge base of the population of Minnesota, it is difficult to understand the inadequacies in mental health, as there is no comprehensive view of all resources and needs.

Background information: Background information: Markers of mental health inadequacies include 13.9/10K homelessness rate in the state[1]. Between 16-24% of inmates suffer mental health issues[2]. Suicide and substance abuse rates are increasing. Particularly at risk are populations of color and rural populations[3]. Kaiser Foundations estimate that Minnesota has only 27% of its Mental Health needs met[4].

Recommendation: DHS will create a comprehensive state Mental Health Needs Assessment data bank to use as a template for measuring and monitoring the mental health needs of the state and which can be used to proactively plan appropriate programming and infrastructure to meet the mental health needs of the population.

Expected outcomes & who will benefit if this recommendation is implemented: With a comprehensive data bank of state mental health needs, proactive actions/legislation can be taken to develop programming and infrastructure in the locations that will best reach the needs of our population.

What is the impact on diversity of this recommendation? A comprehensive needs assessment data bank will provide DHS with information on which segments of the population are at risk, which are inadequately served and where targeted programs need to be developed. All segments of the state population will be reflected in a comprehensive data bank, and diverse populations can be tracked, monitored and assessed for adequacy of resources.

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[1]Homeless Population by State 2024 (worldpopulationreview.com)

[2]Fact Sheet: Incarceration and Mental Health | Weill Cornell Medicine Psychiatry

[3]Mental Health by the Numbers | NAMI: National Alliance on Mental Illness

[4]Mental Health and Substance Use State Fact Sheets: Minnesota | KFF

Reimbursement rate adjustment to support mental health services

Problem statement: The current rates at which mental health services are reimbursed are below standards given the reimbursement rates for other medical services. Low reimbursement rates are having a negative ripple effect in areas of employment retention, equitable access to care and the ability of agencies to remain viable.

Background information: Mental health services have been underfunded for years despite the ongoing need for services in the community being on the rise. Since 2018, Children's Minnesota has experienced almost a 100% increase in emergency room visits related to mental health needs. The number of available residential treatment beds for children in Minnesota decreased from 2,474 to 1,586 between 2005 and 2023. The pandemic did not help an already difficult situation and resulted in increased requests for mental health services, while the field of mental health experienced (along with other sectors) a workforce crisis. Nationally, salaries for mental health providers have risen, but the reimbursement rates for the mental health services (a portion of which is passed onto providers) remains stagnant. Mental health providers and organizations are having more difficulty keeping their doors open with inadequate funding to support operating costs. In July 2023, Options Family and Behavior services, an organization operating for 27 years and serving adolescents with severe mental health issues and substance use disorders closed their doors. North Memorial shuttered their mental health outpatient services in August 2024. This is happening during a time when requests for mental health support services are rising versus declining. The growing numbers of Minnesota residents whose care is paid by Medical Assistance (MA) have trouble accessing care. Current rates are unsustainable for providers and agencies. There were bills introduced in the 2022-23 legislative session that suggested increases in the 30% range. The legislature did acknowledge identified concerns and provided a 3% increase. During the 2024 legislative session, the legislature had an opportunity and declined to correct the sunsetting of a critical care access law that will start to reduce funding used to support a variety of mental health services in the community starting on January 1, 2025, and are estimated to be a loss to the community of approximately $25M over the next three years. There was a modest allocation of $1.6M towards rates in 2025, and $8.4M during the next biennium to bring rates up to 83% of the Medicare Physician Fee Schedule (RBRVS). Although it is recognized and appreciated that movement forward has been made, it does not resolve the inadequacies.[5]

[5] Mental Health Rates Factsheet. (2024). AspireMN.
Dead Phone Lines and Empty Offices: Mental Health Providers are Closing and Minnesota Doesn't Know. (Nov 15, 2023). Kirsten Swanson and Ricky Campbell. KSTP News.
Legislative Update. (May 20, 2024). NAMI Minnesota.
Mental Health Legislative Network (MHLN) Priorities and Legislative Agenda. (Jan 24, 2023). Mental Health Legislative Network.
MHLN Members Across the State Urge Legislators: Raise Medicaid Rates to End Children's Mental Health Crisis. (2024). NAMI Minnesota.

Recommendation: The Minnesota legislature instructed the Department of Human Services to produce a rate analysis to assess this area and to provide recommendations. DHS has completed this task and published a comprehensive rate analysis in January 2024. It is recommended that our legislature use this resource as a tool to establish reimbursement rates.

Expected outcomes & who will benefit if this recommendation is implemented: The expected outcome will be growth and support for Minnesotans in need of mental health/substance use services. Addressing this topic will work to alleviate the current mental health crisis being experienced by our communities. This adjustment should be seen as building a base of stability to our mental health system. The benefits will create a ripple effect in a way that is restorative.

Those involved in the business of mental health will be able to pay competitive wages to their employees. Young people will see the mental health field as a viable occupational choice for themselves to seek education. Our workforce will be increased. Families will be able to obtain needed services. Restored mental health can benefit other larger societal areas where there are known intersections with mental health such as abuse, violence, school functioning, homelessness, substance use disorders, crime, incarceration, etc.

What is the impact on diversity of this recommendation? As described above, marginalized populations have been inordinately impacted by a lack of resources. Addressing the topic of rate reimbursement will have an uplifting impact to those who are most in need.

Prior authorization reform: Forbid prior authorization for critical psychiatric & substance use disorder medications and treatments

Problem statement: The prior authorization (PA) process denies or delays a patient from starting a medication or critical service or staying on a treatment that previously worked for them. PA is a requirement from insurers that requires the clinician to go through a burdensome process of obtaining approval or denial from the health plan before a treatment prescribed by the clinician is covered.

Overuse of a PA barrier causes catastrophic restrictions and delays in treatment, distracts physician's time away from patient care, adds to cost of care and risks destabilization and disability of vulnerable patient populations.

Background information: The PA process seems to have evolved among health plans without formal regulatory oversight. This has led to unequal and random requirements by different health plans that have the authority to override health care decisions made by expert psychiatric clinicians and autonomous patients. Although there may have been a desire to reduce costs by preferring less expensive medications over newer treatments, at a practical level, there are significant problems.

There is no clear scientific evidence that the PA process improves patient care or is cost effective. However, there is evidence that any outpatient medication cost savings are offset or negated significantly by adverse outcomes or hospitalization for destabilized patients. In a 2016 survey of practicing psychiatrists, a considerable number reported refraining from prescribing a preferred medication because of PA requirements or anticipation of one.

One study showed that 46% of Medicaid patients had medication access problems during the past year because of drug coverage issues. Emergency room visits were 73.8% higher among psychiatric patients with medication access problems and expected number of hospital days was 71% higher.

Administrative cost and time required for obtaining PAs can be a significant burden. A 2017 American Medical Association survey showed that the average physician and office staff spends 14 hours per week processing PAs. The cost of interacting with third party payers is approximately $83000 per physician annually, the majority of which are related to PA requests.

Review of these PA requests is often not handled by specialist psychiatrists with in-depth knowledge of psychiatric treatments. PA requirements can result in circumventing mental health parity laws by denying optimal treatments to be replaced by less effective medications. Studies have shown that new PA requirements cause 70-80% of affected patients to not start treatment or discontinue currently existing treatment without appropriate substitution.

Often, a new prior authorization can be required by insurers annually or when changing health plans even if the patient is currently on the specified treatment.

Recommendation: Legislation should prohibit prior authorization for treatments for mental health and substance use disorders in Minnesota. Annual requirements or repeat prior authorization for established treatments should be abolished.

Expected outcomes & who will benefit if this recommendation is implemented: Removal of the burden of PA requirements for psychiatric and substance use disorder treatments will allow clinicians to prescribe the most appropriate treatments for their patients, facilitate faster care for complex cases and avoid adverse outcomes for mental health patients. Implementation will significantly benefit populations with severe and persistent mental illness and substance use disorders, while also reducing cost of care and avoiding healthcare workforce burnout.

What is the impact on diversity of this recommendation? Psychiatric patients from lower socioeconomic classes and racial and ethnic minority communities are most affected by restrictions to care and the burden imposed by the current PA process. Members of minority groups may already have barriers to access and could be unable to seek care elsewhere or pay out of pocket for critically needed treatments.

Collaborative care management

Problem statement: There is a need to improve access to mental health and substance use disorder services as rates of depression, anxiety and opioid deaths are rising**.**

Background information: Collaborative care is the most effective model to treat mental health and substance use disorders.

More than 90 well-designed, controlled studies show that it:

- Obtains better outcomes than other models of care
- Improves access and allows far more patients to be seen
- For depression, shortens time to remission
- Saves money (for every $1 spent $6.50 is saved in decreased overall health costs and improved productivity)
- Saves employers a combined cost savings of $1,815 per employee per year in health care spend and improved productivity
- Results in knowledge transfer from psychiatrists to primary care clinicians who become more comfortable and adept at treating patients with behavioral health problems
- Reduces stigma for patients[6]

Recommendation:

- Expand utilization by mandating that Minnesota Medical Assistance (MMA) reimburse the full suite of Collaborative Care Management Codes (CoCM) everywhere at sustainable rates
- Mandate that all future health plans managing DHS Prepaid Medical Assistance Plan (PMAP) contracts:
  - Reimburse the full suite of CoCM codes everywhere at sustainable rates
  - Measure utilization of CoCM codes and work to improve utilization by at least 15% each year of the contract

Expected outcomes & who will benefit if this recommendation is implemented: Since this is based in primary care and for each hour of psychiatric consultation 80-120 cases are discussed, it leverages psychiatric expertise to far more patients than is currently available. Results are better, faster and both patients and primary care givers are much more satisfied than in the current care model.

What is the impact on diversity of this recommendation? BIPOC populations tend to have poorer access to care, and this significantly improves their access and outcome.

Mental Health in Schools

Fully fund a permanent per pupil allocation for specialized instructional support personnel, fund training to manage mental health and behavioral concerns and address workforce challenges

Problem statement: The state of Minnesota provides inadequate funding for specialized instructional support personnel such as licensed school social workers, school psychologists, school counselors and school nurses. We

[6] https://aims.uw.edu/collaborative-care/

need a permanent per pupil allocation dedicated to these positions to support student mental health and in turn support their academic progress. We also require funding to train personnel on how to de-escalate and respond to a student experiencing a mental health crisis. In addition, we have a workforce challenge in filling these positions and we need to identify and implement solutions so that we have specialized instructional support personnel positions filled.

Background information: Schools are often the first line of defense in addressing the mental health needs of students, but a lack of funding undermines and prevents schools from providing these crucial mental health services. Expanding our investment in mental health services in schools will help ensure greater student success. Approximately 80% of children and adolescents with mental health diagnoses have unmet mental health needs. Minnesota students increasingly report experiencing mental health problems that affect their lives.

In the 2022 Minnesota Student Survey, students reported greater struggles with mental health, such as depression and anxiety, than at any other time in the history of the survey, which began in 1989 and occurs every three years. The 2022 survey saw the continuation of an upward trend, with 29% of students reporting long-term mental health problems compared to 23% in 2019 and 18% in 2016. Long-term means problems lasting six months or more.

Another alarming trend was reports of serious suicidal thoughts. Reports of 11th graders having seriously considered suicide at some point in their life jumped to 28% in 2022, compared to 24% in 2019 and 23% in 2013. The numbers are even more troubling for lesbian, gay, bisexual, queer (LGBTQ+) and transgender students. LGBTQ+ students were about three times more likely than other students to report seriously considering suicide and four times more likely to attempt suicide than other students. Transgender students in the 11th grade are most likely to attempt suicide and are more than four times more likely to attempt suicide than their cis-gender 11th-grade peers.

Rates of depression and anxiety among American adolescents jumped by more than 50% in multiple studies between 2010 and 2019, writes Jonathan Haidt, a leading expert on the spike in teen mental illness and its correlation to the rise in the smartphone, social media apps and gaming. Those numbers were relatively stable in the 2000s.

The suicide rate for kids between 10 and 14 tripled between 2007 and 2021, according to the CDC. The share of high school girls who seriously considered attempting suicide jumped from 19% in 2011 to 30% in 2021.

Additional information just came out in the 2023 Minnesota Principal's Survey data. Minnesota principals perceive student mental health as their single greatest challenge. Almost all (94%) principals agreed or somewhat agreed that student mental health challenges represent a major barrier to student learning at their schools. Principals believed that the student mental health challenges they witnessed at school were primarily caused by student trauma, social media engagement and the mental health challenges of caregivers.

There is a tremendous need for additional specialized instructional support personnel to support students with mental health concerns. Ratios of specialized instructional support personnel (i.e., licensed school social

workers, school psychologists, school counselors and school nurses) to students in Minnesota do not meet the national recommendations by their respective professional associations, except for school nurses[7].

MN Ratio	Position Title	Recommended Ratio
1:852	Social Worker	1:250
1:1,273	School Psychologist	1:500
1:654	School Counselor	1:250
1:695	School Nurse	1:750

In 2022, the Minnesota legislature secured $64.4 million for the next biennium and $117.7 million in Fiscal Year 26-27 for student support personnel. By creating a new revenue stream, this funding provided stability for mental health experts who serve in our schools and help to mitigate cuts to mental health services for students. These investments provide a minimum per-student investment for many districts, and for smaller schools, a minimum of $40,000 to each district and $20,000 to charter schools. This funding is inadequate to address the needs of all Minnesota students.

Recommendation: Designate a permanent per pupil allocation to hire specialized instructional support personnel including, but not limited to, licensed school social workers, school psychologists, school counselors and school nurses in schools. Provide training to all school personnel so they may provide de-escalation and crisis response support to students. Identify and develop a plan to implement solutions to the workforce challenges in filling these crucial positions.

Expected outcomes & who will benefit if this recommendation is implemented: All Minnesota students would have adequate access to specialized instructional support personnel to support their mental health. All school personnel would have adequate training to provide de-escalation and crisis response support. Minnesota workforce challenges would be identified and addressed so that positions can be filled.

What is the impact on diversity of this recommendation? Data gathered across Minnesota and the nation indicate an overall rise in the mental health crisis of our state's young people, with a disproportionate effect on marginalized youth. By providing all schools with specialized support personnel there will be a positive impact on all youth, especially those reporting greater mental health impacts.

Increase the mental health training requirement for school staff including digital wellbeing training

Problem statement: Students' mental health challenges continue to increase across a broad spectrum. Current educator mental health licensure training is limited to early warning signs of suicide and suicide prevention.

[7] Hopeful Futures Campaign- America's School Mental Health Report Card Feb 22.

While essential and critical, a broader, more comprehensive approach to building capacity for educators to have the skills, knowledge and background to address a range of mental health deterrents is now essential, especially in a highly experimental and uncharted digital age.

Background information: The Minnesota Student Survey results from 2016, 2019 and 2022 continue to show decreases in student mental health with increases in anxiety, depression and suicide ideation. This demands community action.

Correlational and causational evidence shows device use can create a profound risk to student learning and wellbeing. According to US Surgeon General Dr. Vivek Murthy, the increase in youth mental health needs is "the defining public health crisis of our time" and "there is growing evidence that social media is harming our kids." Device use can create lifestyles for developing bodies and minds that are sedentary, solitary and virtual - all counter to the needs for healthy development.

Rates of depression and anxiety among American adolescents jumped by more than 50% in multiple studies between 2010 and 2019, writes Jonathan Haidt, a leading expert on the spike in teen mental illness and its correlation to the rise in the smartphone, social media apps and gaming.

Educators in a school environment may be the first to notice changes in a student's attendance, behavior and achievement - all possible signs of diminished mental health. Expanding mental health training will help build capacity for a broader, community-based mental health approach.

The U.S Surgeon General writes in his advisory "Protecting Youth Mental Health" that the negative impact of the pandemic "most heavily affects marginalized youth, such as disabled children, kids of color, LGBTQ+ youth, children who are either homeless of in low-income households, kids in rural areas, youth in immigrant households and children in the juvenile justice system." This group of students reported greater struggles with mental health, such as depression and anxiety, than at any other time in the history of the survey, which began in 1989 and occurs every three years. The 2022 survey saw the continuation of an upward trend, with 29% of students reporting long-term mental health problems compared to 23% in 2019 and 18% in 2016. Long-term means problems lasting six months or more.

Another alarming trend was reports of serious suicidal thoughts. Reports of 11th graders having seriously considered suicide at some point in their life jumped to 28% in 2022, compared to 24% in 2019 and 23% in 2013. The numbers are even more troubling for LGBTQ+ students. LGBTQ+ students were about three times more likely than heterosexual students to report seriously considering suicide and four times more likely to attempt suicide than heterosexual students. Transgender students in the 11th grade are most likely to attempt suicide and are more than four times more likely to attempt suicide than their cis-gender 11th grade peers.

The above description of data gathered across Minnesota and the nation indicate an overall rise in the mental health crisis of our state's young people, with a disproportionate effect on marginalized youth.

Recommendation: Broaden the current scope of teacher relicensure requirements for mental health to include a comprehensive school-based mental health framework that includes digital wellbeing training.

Expected outcomes & who will benefit if this recommendation is implemented:

Students will see:

- Improved mental health support
- Increased capacity to understand that mental health is health
- Increased ability to share the impact of digital devices on learning and wellbeing

Educators will see:

- Increased capacity to observe changes in student mental health
- Increased early intervention strategies that support positive mental health growth
- Increased ability to self-regulate and model those approaches
- Increased capacity to hold conversations with students about the impact of digital devices on wellbeing and learning
- Increased community-based, comprehensive approach to supporting the whole child

Communities will have:

- Increased positive student-teacher relationships
- Increased positive school-to home communications that support mental health outcomes
- Increased knowledge about the impact of device use on learning and wellbeing
- Increased supportive conversations and communication strategies about factors that promote positive health outcomes

What is the impact on diversity of this recommendation? Students of color experience mental health distress at higher rates relative to their peers and students who identify as LGBTQ+ are nearly twice as likely to report mental health concerns as students who do not identify as LGBTQ+. The comprehensive school-based mental health approach will positively impact all youth, especially those reporting greater mental health impacts.

Include students with 504 Plans in the IEP Medicaid Third Party Reimbursement program

Problem statement: We have many students with 504 plans in the state that could benefit from being included in the IEP Medicaid Third Party Reimbursement program. The statute already exists, and we can expand its use and effectiveness by including students with 504 plans.

Background information: Support for the inclusion of students with 504 plans with disabilities under the provisions outlined in the 256b.0625 subd. 26 of the Minnesota Statute pertaining to IEPs and Medicaid reimbursement through the Third-Party Reimbursement program. For inclusive education, it is imperative to ensure that all students, regardless of their disability status, have access to the resources and support necessary to thrive academically and socially within the school environment.

Students with disabilities in the United States are protected under two federal laws: The Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act. Both laws ensure that students with disabilities have access to a free and appropriate public education (FAPE).

Recommendation: We are recommending the inclusion of students with 504 plans within the scope of the 256b.0625 subd. 26 of the Minnesota Statute governing IEP Third Party Reimbursement program. By doing so, we can provide additional school resources to support inclusivity, equity and access to education for all students, regardless of their disability status.

Expected outcomes & who will benefit if this recommendation is implemented: The students with 504 plans, covered under Section 504 of the Rehabilitation Act of 1973, represent a diverse group with varying needs and challenges. While they may not meet the eligibility criteria for special education services under the Individuals with Disabilities Education Act (IDEA), they still require accommodations and support to fully participate in educational programs and activities. By including students with 504 plans within the scope of the Minnesota statute 256b.0625 subd. 26 governing IEPs Third-Party programs, we can ensure that their health-related needs are reimbursable MA in the same way as IEP services.

What is the impact on diversity of this recommendation? Incorporating students with 504 plans into the IEP Medicaid Third Party Reimbursement framework aligns with the principles of inclusivity and equity, which are fundamental to the mission of our educational system. It acknowledges the fact that students with disabilities, regardless of the specific classification, are entitled to a free and appropriate public education that meets their individual needs.

By extending the Medicaid reimbursement support mechanisms of the IEP process to students with 504 plans, we can foster a more inclusive and supportive educational environment where all students can reach their full potential.

Mental Health and Juvenile Justice

Centralized data collection system for juvenile justice system

Problem statement: Meaningful system change must be led by measurable, reliable and current data. Minnesota has no statewide juvenile justice data system that gathers data consistently, using the same definitions, data points and measurers.

Background information: The juvenile justice system needs significant reforms, and the legislature must address the impacts of incarceration on children and families. Recently released data from The Sentencing Project shows that BIPOC youth are detained or committed in a juvenile facility at a rate 4.7 times higher than their white peers according to the nationwide data collected in 2021. (This same data shows Minnesota in 2021 to have a 7.5% disparity). Minnesota needs to implement strategies aimed at reducing the number of youths of color in

correctional facilities as disparity reduction efforts and reforms happening statewide are not sufficient. More support for youth in our communities is needed. Recent research from the University of Minnesota showed that over half of all adults incarcerated in Minnesota jails and prisons are caretakers of minor children. Further research has shown that children with incarcerated parents are more likely to be involved in the juvenile justice system and face negative outcomes in health, education and social life down the road. Children and families need resources to connect with their loved ones and prevent generational cycles of incarceration.

Currently youth with mental health diagnosis contributing to at risk behaviors are being boarded in correctional facilities due to the lack of mental health residential treatment placements. There is no tracking of the time they spend waiting for placement or what mental health services are being provided during the time in the correctional facilities.

Without proper data collection and analysis across jurisdictions we cannot understand the scope of disparities in the juvenile justice system or find adequate solutions. The National Alliance on Mental Illness (NAMI) supports the creation of a statewide data hub that requires stakeholders to report regularly and for accurate real time tracking of the number and demographics of kids in the system, so that meaningful changes and improvements can be made.

Recommendation: Create a centralized database for the juvenile justice system to include reports to allow real time tracking of numbers and demographics of youth in detention facilities and correctional out-of-home placements. Support data transparency by mandating stakeholders to report data on a regular basis.

Expected outcomes & who will benefit if this recommendation is implemented: Acknowledge and address the racial disparities of youth in the juvenile justice system by updating the juvenile justice process to be more person-centered including more opportunities for diversion, mental health services and engagement in voluntary treatment.

Expected outcomes would include more support and assistance for at-risk and BIPOC youth by having more referrals sent into the community for mental health evaluations and services. Increased assistance to families unaware of alternative services to address delinquent and criminal behavior. Protection of youth while promoting the justice system to be more just, fair and balanced.

What is the impact on diversity of this recommendation? Youth benefit holistically from culturally relevant strategies that are based in rehabilitation and restorative practices. These approaches support and strengthen the BIPOC populations when services can be provided in the community of the justice involved youth. This community engagement provides more support and opportunity to the youth and family allowing for a more just and equitable way of life that can significantly disrupt and end the school to prison pipeline, and intergenerational incarceration for the BIPOC population.

Mental health services desperately needed in correctional facilities

Problem statement: Correctional facilities are currently being used to house kids with mental health issues due to the loss of residential treatment beds over the last five years, loss of community mental health services and the current workforce shortage in mental health.

Background Information: Data reviewed by AspireMN of data provided by the Minnesota Department of Human Services Licensing Division to analyze capacity found a loss of residential treatment beds from 2005 to 2023. In 2005 there were 2,474 licensed children's residential beds in Minnesota. In 2023 there were only 1,586 licensed beds in Minnesota. This represents an overall loss of 888 beds, a reduction in capacity of 36%. Due to the impact of COVID, between 2020 and 2023 601 beds closed, meaning 30% of total capacity has been lost in the last three years.

There has been an increase in the prevalence of diagnosable mental health conditions for our youth during and after COVID.

- The Journal of Pediatrics reports "behavioral and mental health conditions are the most prevalent and costly impacting children today. One in six has a diagnosable mental health condition. One in thirteen high school students attempted suicide in the past year. Fifty to seventy percent of kids with serious mental health issues do not receive treatment."
- American College of Emergency Physicians, observes worsening trends through the pandemic, including a 51% increase in suicide attempts by teenage girls from 2019 to 2020.

With the current lack of mental health beds and community services, youth with mental health issues are being boarded at correctional facilities while waiting for mental health placements, sometimes for months. These youth with mental health issues often have related high-risk behavioral needs that cannot be safely managed by families and outpatient services.

There are insufficient onsite services to meet youth's mental health needs in correctional facilities. Decriminalizing mental illnesses not only saves resources in the long term, but it saves lives and promotes safety and justice for all Minnesotans.

Recommendation:

- Maintain and develop the critical capacity of mental health services in residential treatment beds and community-based service including:
    - Increasing respite care
    - Sustaining existing residential treatment capacity including making investments in residential treatment staffing
    - Fixing the Medicaid outpatient community-based rate structure so early intervention and transition care is available to children and families
- Increase resources to meet the mental health needs of the youth in Minnesota Juvenile Detention Association Facilities (MNJDA)
- Allocate $3-4 million per year for MNJDA facilities to contract for services or hire staff

- Minnesota Department of Corrections will request the funding and oversee the use of funding
- MNJDA facilities will approve a funding formula based off the size of the facility
- Funding can be used for direct mental health treatment services, safety stabilization staff to support children in being safe and staying out of their rooms or transition services to and from facilities to maintain continuity in treatment plans
    - $4 million provides approximately:
        - Two to five contracted or facility positions for each 11 MNJDA members based on number of youth served
    - $3 million provides approximately:
        - One to four contracted or facility positions for each 11 MNJDA members based on number of youth served.

Expected outcomes & who will benefit if this recommendation is implemented: Youth that are in correctional facilities will receive needed mental health services that will support their recovery, prevent their mental health from worsening and potentially reduce the time needed in residential treatment once a placement is secured.

In preparation for the January changes in room-time in correctional facilities, these services would reduce the use of room time, improve mental health outcomes for youth and increase staffing with skills to meet the needs of youth before room time is necessary.

What is the impact on diversity of this recommendation? Youth benefit holistically from culturally relevant strategies that are based in rehabilitation and restorative practices. Providing needed mental health services in a timely manner will enable BIPOC youth to progress and be released sooner rather than later and significantly disrupt and end the school to prison pipeline and intergenerational incarceration for the BIPOC population.

Juvenile competency attainment in Minnesota

Problem statement: Rule 20.01 on juvenile competence currently needs clarity and has gaps which leave youth and their families with no service or support and at times in limbo.

Background information: In 2022, the legislature enacted consensus legislation updating the process for adults and competency attainment. This was the result of a legislatively created task force and ongoing efforts from advocates and partners. Shortly after the law passed in 2022, a group formed consisting of attorneys, the bench, counties, providers and advocates to review and put together revision recommendations for the juvenile system. The group is seeking to bring recommendations to the 2025 legislative session.

Gaps identified are:

- When a child is found incompetent, there is no direction given to any entity to provide the child or family with services for competency attainment or any support at all

- Children can wait years to be found competent, all the while the state spends resources reexamining them every six months; a recent supreme court decision also allows prosecutors to renew intent to prosecute until the child is 18
- Competency is a legal standard only; the goal of competency attainment is to proceed in court, not to address the root causes of delinquency in a holistic way

Other issues:

- The lower age of delinquency in Minnesota is 10 years-old which doesn't fit with developmental maturity levels
- When a child is found incompetent, they can either be civilly committed, which is very rare, or referred to the child protection system, which does not address the delinquency court procedures, and it has been shown to harm children and families; children's mental health services and support for families are not ordered or required
- There are very little training requirements for forensic examiners. Evaluating for competency should include foundational knowledge about the court system, due process and case law. Best practices also suggest that examiners for children should be specialists in children's psychology or psychiatry. There are no minimum requirements for examiners in Minnesota
- The current juvenile competency process is not aligned with the stated rehabilitative goals of Minnesota's juvenile court system

Recommendation:

- The new process should include:
    - Engaging children and families as soon as possible in the court process
    - Timely access to wraparound services
    - Clarity on the responsibilities of all stakeholders when a child is found incompetent
    - Aligning the process with the needs of all parties (child, family, community)
    - Prioritizing a restorative justice approach
    - Increasing the lower age of delinquency from 10 to 13 years of age

Expected outcomes & who will benefit if this recommendation is implemented: Expected outcomes would include more support and assistance for at-risk and BIPOC youth by diverting children and providing access to community mental health services and increased assistance to families unaware of alternative services to address delinquent and criminal behavior. Children and families will benefit by receiving needed mental health and wraparound services to decrease the recidivism rate. The judicial process will have clear guidelines and rules concerning juvenile competency, and therefore the process will promote the justice system to be more just, fair and balanced to all who encounter it.

What is the impact on diversity of this recommendation? Youth benefit holistically from culturally relevant strategies that are based in rehabilitation and restorative practices. These approaches support and strengthen the BIPOC populations when services can be provided in the community of the justice involved youth. This community engagement provides more support and opportunity to the youth and family allowing for a more just and equitable way of life that can significantly disrupt and end the school to prison pipeline and intergenerational incarceration for the BIPOC population.

Family systems, prevention, intervention and supports

Expand access to wraparound through the System of Care initiative

Problem Statement: Families need help navigating the many different systems that are essential to provide their children needed support. This is especially true for families with:

- Children who may have social needs and risk factors but not necessarily a specific mental health diagnosis
- Children with atypical or lower priority needs from a particular system perspective (E.g., a high performing student with anxiety)
- Children who are not officially in the mental health system currently but are beginning to exhibit symptoms.

Background information: Wraparound is an evidence-based practice. If structured to support the identified families above, wraparound can provide early intervention and access to supports when they are needed and it may help prevent the need for clinical care or prevent further decline and utilization of higher levels of care.

The Minnesota System of Care grant has included wraparound supports for many children and families at different points in their journey in the mental health system, including those who are not connected to resources. For example, the SOC grant has enabled Intermediate District 916 to provide connections to families for children who had no pre-existing condition but who experienced risk factors such as high number of school absences. Local Minnesota counties have been involved in the system of care and support this effort.

Recommendation:

- Develop grant funding for county and school partnerships to expand wraparound services, building on the system of care model and initiative. Per wraparound models, local partnerships should include school, local public health, mental health providers and especially organizations that provide natural supports (youth centers, faith communities, etc.)
- Local partnerships will coordinate with others doing the same work through the system of care grant initiative
- State resources should support a learning community to continue to have opportunities for local partners to share best practices with each other after the System of Care grant expires

Expected outcomes & who will benefit if this recommendation is implemented:

- Improved mental health and well-being outcomes for young people
- Reduced stress among participating families

- Increased family and young people's connection to their school and community (e.g., an increase in the number and percentage of students who report in the Minnesota student survey that their community cares about them)

What is the impact on diversity of this recommendation? The system of care grant prioritized children and families from BIPOC communities; this priority population could continue with additional resources. BIPOC families have often cited distrust of systems because of historical trauma and personal experiences. A wraparound approach with the family at the center could help identify people and organizations that are most trustworthy and valuable to the family.

Expand family peer support opportunities

***Problem statement*:** Families need support to help manage their stressors and create a more nurturing environment for their children. This is especially true for families who are just beginning to navigate the mental health system and those with increased risk factors (E.g., families with an incarcerated parent, children in foster care or children with a special health care need).

Background Information: The CTSS Family Peer Support has a certificate training program. This service is only available to families with a child who is in CTSS. Families who are just beginning to navigate the mental health system or other related systems, such as foster care and special education, need this type of support. The peer support training program that has been developed is valuable based on reports from parents who have participated.

The need outweighs the labor market and county social workers and other mental health providers may not have the capacity to provide the family support (because of caseloads, etc.). Building upon these resources and offering peer support to families as early as possible, serves to help reduce family stress, avoid common system pitfalls and potentially avoid more intensive services; it may also help build sustainability for existing family peer support specialists.

Evidence shows that the pile up of toxic stress for children and families impacts the mental health and well-being of children and that of their caregivers. When parents are unable to manage their emotions and behaviors, they are unable to effectively nurture and support their children. Having an opportunity to connect with peers and share common experiences can help reduce that stress and provide valuable skills and information from those who have navigated the same systems.

Recommendation:

- Develop family peer support program for families earlier in their journey through the mental health system and for families with other risk factors, such as those with a child in foster care or with an incarcerated parent
- Through this program, offer families 1:1 and/or group support, opportunities to share different experiences and information about relevant systems

- Develop outreach mechanisms through which families can engage with a family peer support specialist or family peer support groups. Schools, foster care, local public health and other county systems (E.g. county jails) could refer families to peer support specialists
- Expand the capacity of the CTSS training program or coordinate with the program to train additional family peer support specialists who will offer support to newly eligible families
- Ensure that foster care parents are included and recruited in the training, as well as a focus on BIPOC families, LGBTQ+ families and those who have children who are transgender
- Create opportunities for family peer support specialists to learn from each other and continue to develop skills through regional and topic specific groups to sustain the resource

Expected outcomes & who will benefit if this recommendation is implemented:

- Improved mental health and well-being outcomes for young people
- Reduced stress among participating families
- Improved parent-child relationships
- Reduced social isolation among participating families

What is the impact on diversity of this recommendation? With a focus on recruiting parents from marginalized communities more families will have an opportunity to connect with someone who has similar background and experiences.

Grow family support opportunities within schools

Problem statement: Families need support to help manage their stressors and create a more nurturing environment for their children. This is especially true for families who are just beginning to navigate the mental health system and those with increased risk factors (E.g., families with an incarcerated parent, children in foster care or children with a special health care need).

Background information: Schools are natural supports for children and families, but schools do not have sufficient resources to provide significant outreach to families to build community and connect them to additional supports if needed. Models such as FAST- Families and Schools Together, an evidence-based program, have demonstrated feasibility and impact. For example, District 622 implemented FAST through grant funding. Family outreach included a variety of strategies, such as providing meals for families where families cooked together. This offered opportunities to develop skills for children and families. The program helped to get families connected to school, practice skills together and build communities. The school was able to provide referrals to other agencies based on needs of the family.

Family connection to schools improves educational outcomes. Many families from marginalized communities do not have a deep trust and connection to schools because of past experiences of trauma, discrimination and/or inequities in schools.

Recommendation:

- Provide grant funding to schools to develop family outreach programs to engage families with specific risk factors
- Develop partnerships between schools and local public health and school health clinics if a school clinic is available
- Engage families through social activities, self-care practices, opportunities to develop relevant skills and information and connect family to supports based on specific family needs. The outreach will include culturally specific practices and opportunities as defined by the community population.

***Expected outcomes & who will benefit if this recommendation is implemented*:** Utilizing evidence-based practices derived from social, behavioral and physiological science, FAST builds protective factors focusing on:

- The child's interpersonal bonds
- The family system
- Parent-to-parent support
- Parent peer social network
- Parent empowerment training
- School/community affiliation

Other expected outcomes include:

- Increased social connection among participating families
- Reduced stress among participating families
- Improved mental health and well-being outcomes for young people
- Increased family and youth connection to the school and community (E.g., an increase in the number and percentage of students who report in the Minnesota student survey that their community cares about them)
- Increased early access to care among participating families

What is the impact on diversity of this recommendation? FAST is implemented by trained four to 10-person teams comprised of local parents, teachers (or other school representatives) and community-based professionals. At the middle school and high school levels, youth are also provided with leadership opportunities within the team. Each FAST Team is representative of the population served. that is, consistent with the race, ethnicity, culture and language of the participating families.

Many BIPOC families have had negative experiences with school systems. Intentionally building a community of support with schools could help to mitigate some of the trauma and stress that remains for many BIPOC families, especially if the outreach and engagement is inclusive of cultural traditions and openly acknowledges past harms.

Build community initiated care to support young people and families

Problem Statement: The pandemic and resulting layers of stress have highlighted and exacerbated poor mental well-being throughout the community, especially among those who experience the greatest social inequities. The current system of supports does not adequately promote mental well-being across the population and cannot meet the depth of need and current interest in promoting well-being. Children and families need a range of opportunities to build skills, mental health awareness and social supports. Minnesota does not have adequate community-based infrastructure for mental health promotion and prevention to offer evidence-based programs that can augment the current system of care.

Background information: Community initiated care is a model that provides community support by non-specialized health care workers or 'lay' community members and can include community services that are not clinical. This model has been successfully used internationally to offer support through trained non-specialized health care providers and lay community members. This could include a support or skills group, programs to develop mental well-being awareness and skills among community members (e.g. barbers, hairdressers, baristas) and culturally specific healing practices offered in community.

There are current Minnesota examples. For example, Wellshare International is using COVID resources to train community health workers from the Somali, LatinX and Oromo communities in Living Life to the Full, an evidence-based program that has been broadly implemented in Scotland, Wales, Ireland, Australia and Canada. Kente Circle, a community mental health clinic in Minneapolis, launched a program to equip barbers with knowledge and awareness of mental health and well-being so they can offer general support and accurate information to customers. Many different organizations have offered culturally specific healing circles throughout COVID and the civil unrest after the George Floyd murder and related incidents.

There is growing national interest in this scope and direction for promoting mental well-being. See Community Initiated Care: Building Skills to Improve Mental Health - Well Being Trust for more information. This was also a focus area of recommendations included in the Children's Summit Prevention/Promotion workgroup.

Recommendation:

- Grant funds to community-based organizations to train community members in evidence-based and culturally informed programs
- Conduct an evaluation of the impact of community initiated care on mental well-being
- Establish a network or community of practice to build sustainability and quality improvement
- Develop an advisory council to outline best practices and build the infrastructure needed to sustain this work. Infrastructure includes things such as an inventory of current informal support models, a utilization assessment, established guidelines for implementation (e.g., how to connect to higher levels of care), formal linkages to existing programs (e.g., FHV, ECFE) and an assessment of sustainable funding sources (e.g., MA billing)

Expected outcomes & who will benefit if this recommendation is implemented:

- Improved mental well-being among participants
- Improved mental well-being among families of participants

- Reduced social isolation among participating families
- Improved awareness and understanding about mental health and well-being
- Reduced barriers to higher clinical levels of care for those who need it

What is the impact on diversity of this recommendation**?** Building the infrastructure and expanding access to community-initiated care will allow BIPOC communities greater opportunity to get mental well-being support directly from BIPOC people. It can help center culturally specific practices and it can facilitate access to clinical care when needed among populations with historical distrust of health care systems. Community care can help BIPOC individuals address collective trauma and continuous trauma from ongoing social and health inequities in the community.

Recovery supports

Address housing barriers for those living with mental health and substance use disorders

Problem statement: Service providers and advocates emphasize that getting patients into treatment isn't enough and having limited affordable housing and shelter options means many people end up without a safe, healthy and affordable home. Those most vulnerable and with the fewest temporary housing, permanent housing or residential options are persons with severe mental health and chronic substance abuse issues.

Background Information: Our community is struggling with a significant need for affordable housing and vulnerable populations are disproportionately impacted. There is a great need for single-room housing, support services and on-site mental health and dual diagnosis treatment for severely mentally ill persons. The relationship between co-occurring mental health and substance use disorders combined with housing instability is intricate and deeply interconnected. Approximately 50% of homeless adults in the United States with a serious mental illness also experience a co-occurring substance use disorders, making them particularly susceptible to the adverse effects of housing instability. This instability exacerbates stress, heightening symptoms of anxiety and depression and increasing the likelihood of substance use disorder relapse. Conversely, supportive housing provides a stable environment that fosters recovery by allowing individuals to concentrate on their treatment. Research has demonstrated that supportive housing not only reduces re-hospitalization rates but also enhances overall life satisfaction for adults with co-occurring disorders. In Minnesota, the rate of drug overdose deaths surged by approximately 160% between 2011 and 2021, highlighting the urgent need for effective interventions. Additionally, nearly 30% of adults in Minnesota reported experiencing symptoms of anxiety or depression in 2023.[iv] These statistics underscore the critical role of stable housing in supporting mental health and substance use disorder recovery.

Recommendations:

Provide additional rental assistance and other housing resources.

In many areas of Minnesota, especially in areas with the greatest concentration of Medicaid members, there is an inadequate supply of affordable housing units or rental assistance. Following CMS Guidance, this committee recommends exploration of the use of Medicaid Authority to cover certain housing related services and supports. Policymakers should seek Medicaid coverage for various state-funded services, including housing stabilization, one-time client assistance and supportive staff time to administer rental assistance. By securing Medicaid funding for these services, state dollars can be redirected to provide additional rental assistance. This approach not only addresses the immediate need for affordable housing but also supports long-term stability and recovery for vulnerable populations, offering more incentives to developers and landlords to house eligible persons.

Offer more incentives to developers and landlords to house eligible persons

Many supportive housing providers rely on existing private market housing, which tenants can lease with the help of rental assistance. But some supportive housing providers develop and operate their own properties, which requires funding to acquire, build or rehabilitate the housing. Developing supportive housing enables providers to configure the space to accommodate on-site services and their tenants' needs and development is important in markets where there is little available rental housing, such as high-cost urban areas and some rural areas.

Grants and other development subsidies should be explored to reduce the amount that a developer must borrow to finance the development, which allows the owner to offer lower rents, since less rental income is needed to cover the owner's loan costs. Rental assistance is usually necessary to cover owners' regular maintenance and administrative costs.

State and local program administrators can target vouchers and subsidized units that become available for specific populations to provide supportive housing, but they are not required to, and few currently do so.

Reinvest savings to increase rental assistance

California and New York are pioneering efforts to reinvest savings from reduced use of health services and corrections into supportive housing through section 1115 Medicaid Waivers. In California, counties now can create pilot programs that allow various entities, including healthcare plans, public hospitals and charitable organizations, to contribute to county-based housing funding pools. These contributions stem from savings achieved by reducing jail, emergency room and homeless shelter utilization through supportive housing programs. The funds in these pools can be reinvested to expand affordable housing, particularly targeting high-cost groups and combining housing with necessary services. This reinvestment not only helps in creating more supportive housing but also further reduces costs associated with healthcare and corrections by providing stable housing and support for those in need. It is recommended that our governmental bodies in Minnesota explore similar options to enhance our supportive housing infrastructure, thereby creating a sustainable cycle of savings and reinvestment that benefits both the individuals served and the broader community.

Make greater use of Medicaid services for supportive housing

Most health services available through Medicaid to help people stay in their homes are optional for states, and many state Medicaid programs do not cover them. The federal CMS recently outlined how Medicaid can support services for supportive housing. Medicaid can provide various necessary services, such as personal care services, behavioral health care, intensive case management and housing-specific supports like assistance in searching for housing and working with landlords. These services are crucial for maintaining health and avoiding costly institutional care. Policymakers should take full advantage of the flexibility within Medicaid to offer these supportive services. Traditionally, many supportive housing providers have not billed Medicaid for services eligible for reimbursement. Therefore, managed care organizations should provide training and outreach to encourage supportive housing providers to bill Medicaid when appropriate. By maximizing the use of Medicaid for supportive housing services, states can better support individuals in maintaining stable housing and improving overall health outcomes.

Review and simplify zoning and licensing processes

Legislative efforts should be made to streamline the approval processes for housing development. Currently, existing zoning laws imposed by cities, combined with complex licensing processes by the Department of Human Services and the Minnesota Department of Health (MDH), are time-consuming and complex. They do not

incentivize organizations to build supportive housing for individuals with co-occurring disorders. Additionally, funding mechanisms are unclear, and current rates are low. In Minnesota, the zoning and development process presents significant challenges. For example, restrictive zoning laws have contributed to higher housing prices and limited the availability of affordable housing. Moreover, the approval process for developing supportive housing is often bogged down by bureaucratic hurdles, making it difficult for developers to proceed efficiently. These regulatory barriers discourage the creation of supportive housing units, particularly in high-cost urban areas and certain rural regions where the need is critical. Simplifying these processes is crucial to encourage the development of supportive housing. By reducing bureaucratic hurdles and clarifying funding mechanisms, we can make it easier for developers to build and maintain supportive housing units. Streamlined approval processes can significantly reduce the time and cost associated with developing supportive housing, making it a more attractive investment for organizations. Additionally, reinvesting savings from reduced use of health services and corrections into supportive housing, as seen in California and New York, can further enhance funding availability and incentivize development. Legislative action is essential to implement these changes and ensure that supportive housing development can proceed efficiently and effectively, ultimately addressing the critical shortage of supportive housing and providing stable environments for individuals with co-occurring mental health and substance use disorders.

Expected outcomes & who will benefit if this recommendation is implemented:

Addressing housing needs for those with mental health and substance use disorders will enhance individuals and family's ability to focus upon, address and even alleviate their mental health/substance use disorder issues without the additional stress of having a lack of shelter. Supporting these recommendations will benefit all who are at risk for homelessness.

What is the impact on diversity of this recommendation? Individuals from marginalized groups are disproportionately represented in experiencing hardships associated with housing and homelessness. Supporting these recommendations will serve to uplift underserved communities.

Outreach to Diverse Communities

Continue to support community of practice and community-based wellness resources

Problem Statement: Mental Health providers often practice in silos and systems are not equipped to financially support consortia or alliances.

Background Information: Many BIPOC, culturally specific organizations do not have the infrastructure or means to access funding that will support their growth, development and participation in the mental health marketplace. Thus, there is very little support in meeting new guidelines to be licensed or certified as service providing agencies for designations/programs such as Certified Community Behavioral Health Clinics (CCBHC), substance use disorder, Adult Rehabilitative Mental Health Services (ARMHS), Mental Health centers, Children's Therapeutic Services and Supports (CTSS), etc. While these groups may be actively engaged in their communities, there are very few mentors or organizational road maps to follow. Consequently, they often work in silos. Additional funds for supporting community of practice alliances will not only promote the sharing of technical assistance, but such coalitions will also increase access to financial support, increase the presence, viability and sustainability of a more diverse workforce and mental health marketplace.

Most BIPOC communities hold communal value systems that require collaboration (vs. competition) as cultural strengths. Traditional ways of sharing knowledge and resources create systemic problems that detract from optimal success among multiple organizations. These practices lead to fractured community alliances, communication problems and the limited sharing of resources.

According to research, the communities of practice idea has been around for 25 years. It "refers to groups of people who genuinely care about the same real-life problems or hot topics, and who on that basis interact regularly to learn together and from each other[89].

Recommendations: We recommend the creation of innovative paths that facilitate alliances that empower culturally diverse providers to name and legitimize cultural ways of engaging within their groups and with allied organizations.

Expected outcomes & who will benefit if this recommendation is implemented:

- Increased availability of culturally consistent support of traditional healing practices and ongoing research and establishment of shared knowledge and better practice-based evidence models.

[8] (Wenger et al., 2002)". Thinking together: What makes Communities of Practice work? - Igor Pyrko, Viktor Dörfler, Colin Eden, 2017 (sagepub.com) (Research Article First Published online August 25, 2016.

[9] MN Dept of Health – Mental Well-being and Resilience Learning Community https://www.health.state.mn.us Minnesota Thrives.

- More resilient and formalized alliances among diverse groups of mental health professionals.

What is the impact on diversity of this recommendation? Culturally diverse providers will create innovative strategies of healing and supporting their communities.

Increase financial support for peer recovery support specialist providers

Problem statement: A lack of cultural competency in the healthcare workforce is an issue that has been documented in the literature. We need to do more to address the unmet need for culturally, racially and ethnically appropriate care for individuals dealing with substance use disorders and mental health issues. Peer recovery support specialist providers, especially BIPOC providers, is an essential component in meeting this need.

Background information: Research shows that the use of peer recovery specialists is effective in supporting recovery and reducing recidivism among those whose lives are impacted by substance use disorders, mental health disorders and incarceration. Among that group, there is an overrepresentation of members of the BIPOC population although there is an underrepresentation of BIPOC specialists who are trained. Additionally, the rate of pay for peer recovery specialists services is too low for providers to support specialists at a living wage.[10]

According to the Substance Abuse & Mental Health Services Administration (SAMHSA), among individuals who need treatment for illicit substance use disorders, whites receive treatment 23.5% of the time while Black and Hispanic individuals receive treatment 18.6% and 17.6% of the time respectively. SAMHSA further reports that adults who identify as two or more races have the highest estimated need of mental health services followed by white adults and American Indian or Alaskan native adults, however people from racial and ethnic minority groups are less likely to receive mental health care than the overall population.[11]

Recommendation:

- Increase the current rate of reimbursement that providers receive for peer recovery specialist services
- Provide funding for the recruitment and training specifically of BIPOC peer recovery specialists

Expected outcomes & who will benefit if this recommendation is implemented:

[10] [Center for Behavioral Health Statistics and Quality Peer Recovery Services for Substance Use Disorder/ Minnesota Management and Budget (MMB) (mn.gov)]

[11] (2021). Racial/ethnic differences in substance use, substance use disorders, and substance use treatment utilization among people aged 12 or older (2015-2019) (Publication No. PEP21-07-01-001). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https:// www.samhsa.gov/data/] [2022-nsduh-race-eth-highlights.pdf (samhsa.gov)] [Racial Disparities in Accessing Treatment for Substance Use Highlights Work to Be Done – USC Schaeffer]

- Increased availability of providers in rural and urban settings
- An increased of providers of color to address the disproportionate level of need
- A reduction in the recidivism rate of incarceration and successful treatment outcomes for substance use and mental health issues
- Improved mental health and well-being outcomes
- Reduced social isolation for participants receiving services

What is the impact on diversity of this recommendation?

- Minnesota will have access to more peer support specialists
- Minnesota will be taking steps to meet the current National Drug Control Strategy to address the unmet need for culturally, racially and ethnically appropriate care for individuals seeking substance use treatment
- Participants will have opportunities to connect with peer support specialists who have similar backgrounds and experiences

Address workforce shortage of licensed mental health professionals from diverse backgrounds

Problem statement: There is a severe workforce shortage of licensed mental health professionals from diverse backgrounds serving the state of Minnesota.

Background Information: The pandemic has highlighted the importance of investing in our health care workforce. Investing in this high-need career area is vital for the future health of our state. Building and maintaining an adequate mental health workforce requires successful recruitment and retention of licensed mental health providers.

There is a tremendous need to invest more in scholarships, loan forgiveness and paid internships to promote a more diverse and representative workforce, particularly in underserved areas.

Underserved groups like BIPOC, non-English speakers and LGBTQ+ communities often struggle to find appropriate services. The demographics of the mental health workforce often do not reflect those of the people they serve, limiting the ability of people to get culturally and linguistically appropriate care.

The workforce shortage has been particularly problematic in rural areas, where people may wait months to access therapy. Untreated mental health conditions can have devastating consequences, such as loss of employment, chronic health issues, substance abuse and suicide.

The report, Minnesota's Health Care Workforce: Pandemic-Provoked Workforce Exits, Burnout, and Shortages (PDF), is the first report of its kind covering the effects of the pandemic on most of the licensed health care workforce in Minnesota.

Minnesota has a shortage of mental health professionals, with one in four jobs in the field vacant as of April 2024. This is the highest vacancy rate compared to other health care professions, and the situation has been especially problematic since the pandemic.

We continue to have a shortage of culturally specific providers. The Minnesota Department of Health (MDH) found that 73.4% of psychiatrists, 88.3% of mental health clinicians and 86% of LADCs were white. Data also show that providers of color serve a higher percentage of people from culturally diverse communities, people who are low income and people who need interpreters. The pandemic is resulting in increased numbers of children and adults struggling with their mental health, and the workforce shortages are causing our already fragile mental health system to collapse. NAMI Minnesota began reviewing data. One of the key issues identified by the MDH, was that about 50% of people who complete a master's degree in one of the mental health professions don't become licensed.

According to NAMI's Mental Health Crisis document, dated Feb. 22, 2022, NAMI Minnesota created a survey in December 2021 to learn more from people who are current mental health professionals and from people that were or are on the path to become one.

Barriers to licensure included finding someone to provide supervision (34%), paying for supervision (52%) and low or no pay to complete the number of hours required for supervision (69%). In the comments, people included barriers such as: cost of the exam and license; inadequate or ineffective supervision; trouble finding someone in the same field to supervise me; paperwork; number of hours to complete supervision; delays by the boards in completing applications; not allowing online applications; knowing all the requirements to become and stay licensed; test was difficult because English is not my first language; cost of test preparations; transportation; time commitment; time provided to complete required hours; supervision is too tight; trouble finding culturally informed and diverse supervisors; lack of paid internships; low pay while completing number of required hours; CEU costs and difficulty accepting licenses from other states.

Recommendations:

- Implement culturally responsive strategies for recruiting, training and retaining licensed mental health professionals with diverse backgrounds and identities that reflect the populations they serve
- Provide funding for the development of a licensed mental health workforce pipeline to address the barriers to obtaining licensure such as cost of attendance, unpaid internships, cost of supervision, exam fees and licensure fees
- BIPOC organizations should be supported through funding to provide cultural-specific training and supervision for BIPOC students working to obtain licensure as a licensed mental health professional

Expected outcomes & who will benefit if this recommendation is implemented:

- Increased number of licensed mental health professionals in Minnesota serving diverse communities
- Improved mental health access and well-being outcomes for underserved communities
- Increased number of culturally competent licensed mental health professionals

What is the impact on diversity of this recommendation? These recommendations will result in recruitment, training and retention of licensed mental health professionals with diverse backgrounds and identities that reflect the populations they serve.

Collect and provide community access to data to support accountability

Problem statement: Many Minnesota entities fail to capture or allow for community accessibility demographic data that could lead to system changes.

Background information: BIPOC community mental health students, trainees, providers and agencies frequently complain that disaggregated, easy to find data is not required by notable entities. This lack of accessible data serves to perpetuate inaction and a lack of accountability among systems. For example, data on the Minnesota Student Survey requires hours of data mining to gather comparative information across racial and ethnic groups. Licensing boards do not readily provide information that identifies the demographics related to those who have failed or passed their licensing examples. Additional problems occur in other systems such as juvenile justice, where the existence of data on mental health screenings is muddy and the outcomes based on those screening are not shared; it is unclear if youth who are detected as having mental health concerns are ever referred for treatment.

Recommendations:

- Entities receiving state or federal dollars be required to report data on services rendered by formulating comparative, disaggregated results based on ethnic/racial demographics as well as other key identifiers (i.e., urban or rural)
- Professional and government-based entities should not receive state or federal funds until they have reported key disaggregated data identifiers
- State agencies should provide disaggregated and comparative data across all systems where disparities are noted (especially areas such as criminal justice, schools, out of home placement, child protection)
- Agencies that are required to report disaggregated data should be provided appropriate compensation or support to account for the time and cost needed to collect and supply the data

`***Expected outcomes & who will benefit if this recommendation is implemented:***

- Improvement in tracking evidence-based and practice-based outcomes, especially regarding mental health access and well-being outcomes for diverse people
- Increased awareness of where funds are needed for future statewide interventions and/or investments
- Measurable success of these recommendations based on how the data is currently handled (i.e., whether it is reported or not)

What is the impact on diversity of this recommendation? Communities will have access to more positive, cost-effective mental health services and targeted knowledge of where corrections are needed.

Provide affordable and supportive housing for BIPOC populations and formerly incarcerated populations

Problem statement: BIPOC populations and formerly incarcerated populations with substance use or mental illness diagnoses experience an inordinate lack of reliable, affordable and safe housing.

Background information: A recent report[12] by the Wilder Foundation revealed that during a single night count of people experiencing homelessness across the state, one-third of people experiencing homelessness were not in a formal shelter. The results are based on a survey of nearly 4,300 people experiencing homelessness. Wilder Research reports more than 10,000 people are homeless in the state today. BIPOC individuals and youth who identify as LGBTQ+ are particularly over-represented among the homeless population. While the researchers stated that it was impossible to identify all people experiencing homelessness who were not in a formal shelter, the numbers can be affected by variations in outreach efforts and the visibility of the population. Most of the homeless population had a chronic mental or physical health condition, with some 64% of both adults and youth reported having been told by a doctor or nurse within the last two years that they have a mental illness.

The researchers also stated that within the populations sampled, participants reported that their homelessness was often preceded by adverse childhood experiences, along with violence and abuse that often continue past childhood, especially among the women experiencing homelessness. Nonetheless, the researchers noted that overall, 33% of the people experiencing homelessness in Minnesota were not in a formal shelter with a smaller proportion of people not in a formal shelter in the Twin Cities metro (18%), compared to greater Minnesota (32%) and participating reservations (95%) where there are fewer shelters available.

Additionally, the report yielded that a large portion of those individuals who were unhoused consisted of smaller sub-groups such as homeless youth, Veterans, older adults, families and long-term homeless populations. Finally, those individuals and families who did not reside in a formal shelter included people staying outside, on transit or temporarily doubled up and staying in outreach locations such as encampments and other drop-in sites.

Finally, according to a Minnesota Department of Corrections 2022 report[13] the rate of homelessness among Minnesotans who were formerly incarcerated has dropped from 25% in 2021 to 19% in 2022. The report also looked at racial disparities and indicated that 50% of those who were released and homeless were black and indigenous people.

[12] Single Night Count of People Experiencing Homelessness: 2023 Minnesota Homeless Study Count Data Tables. Minnesota Homeless Study. A Project of Wilder Foundation.

[13] 2022 Homelessness Report. Minnesota Department of Corrections.

Because of their histories of mental illness, unlawful detainers, incarceration, as well as exposure (and reactions to) violence, a diverse group of Minnesotans experience barriers to being housed and could benefit from greater investments in gaining supportive housing.

Recommendations:

- Develop more community support and resources for housing among BIPOC populations and previously incarcerated populations with mental health or substance use disorders
- Increase both housing stock and procedural eligibility for BIPOC populations and previously incarcerated populations to access low-cost and supportive housing designed specifically for them by reducing systemic and structural barriers (i.e., landlord denials)

Expected outcomes & who will benefit if this recommendation is implemented:

- More resilient and formalized alliances promoted among diverse groups of mental health professionals who are working to support BIPOC communities and formerly incarcerated individuals
- Increased access to affordable, safe housing for marginalized populations and previously incarcerated individuals. Having safe and secure housing will support health, wellness and decrease stress; having secure housing will allow formerly incarcerated individuals an opportunity to work towards successful community reintegration and ideally decreased rates of recidivism

What is the impact on diversity of this recommendation? Alliances between culturally diverse providers and specialized housing programs will reduce barriers for those in need and will create innovative culturally congruent strategies of healing, supporting and overall wellness within their communities. Given diverse communities are often overrepresented in homeless populations, specifically supporting these populations will serve to address inequities.

Increase funding for the Cultural and Ethnic Minority Infrastructure Grant (CEMIG)

Problem statement: Minnesota has a need for increased State funding to expand the nationally recognized CEMIG program. There is a need to increase the mental health workforce within cultural and ethnic minority communities. In the Gearing Up for Action report from January 2015[14], it is clear that the current workforce is aging out and does not reflect the emerging diversity of the communities being served. Because of these factors, there is a great deal of pressure to quickly develop a responsive group of qualified mental health professionals. The shortage of mental health professionals in general, while significant, pales in the face of the even greater

[14] GearingUpForAction.pdf (healthforceminnesota.org)

shortage of mental health providers from diverse cultural backgrounds. Nonetheless, funding for initiatives to support this growing problem has been inconsistent and anemic.

Background information: In 2007, Minnesota introduced a grant program to address the dearth of underrepresented ethnic minority mental health professionals. The CEMIG Program works to increase access to mental health services provided by racially and ethnically diverse mental health professionals who are proficient in providing culturally responsive and specific services to children, youth and families from diverse communities. This grant program builds capacity by supporting professionals in obtaining clinical supervision and licensure support. It also increases access to mental health and substance use disorder services for individuals from cultural and ethnic minority communities.

During the 2023 Legislative session, $3.4 million was appropriated for CEMIG. The program is currently supplemented with federal funds due to the increased need and demand for culturally specific mental health providers. CEMIG needs additional state funds that can support the cultural needs of the communities served as opposed to the Federal funds CEMIG has been allocated which come with many funding restrictions. There is a continued need for sustainable and increased funding that is equitably distributed.

The program eligibility for the CEMIG grant began as a way to target culturally specific organizations by requiring participating organizations to attest that 75% of the population they serve came from culturally underserved groups. Instead of upholding the policy to assure that culturally underserved organizations would be the primary recipients of the funds, the legislature reduced the required percentage of vulnerable populations served from 75% to only 25%. That legislative action enabled well-resourced and larger, non-culturally specific organizations to monopolize the funds that were needed for training and service delivery among the much smaller, culturally specific organizations.

Finally, and most importantly, legislation unintentionally marginalized the access for culturally specific trainees to learn the indigenous and culturally congruent practices necessary to serve their communities and, in turn, created additional barriers for children and families looking for culturally and linguistically specific and culturally responsive services.

Recommendations:

- Expand the availability of the CEMIG Program by increasing state funding for this grant program to an amount of $10M and $15M each biennium
- Grant awards should focus on increasing access to mental health services among agencies that are culturally specific and responsive with at least 75% of the adults, children, youth and families receiving services coming from underserved cultural and ethnic communities

Expected Outcomes & Who will benefit if this recommendation is implemented:

- Improved mental health access and well-being outcomes for diverse communities
- Reduced workforce shortages among participating providers

- Increased family and young people's connection to their school and community (E.g., an increase in the number and percentage of students who report in the Minnesota student survey that their community cares about them)

What is the impact on diversity of this recommendation? Communities will have access to more positive, cost-effective mental health services.

Local Advisory Council Workgroup

Expand the required community participation in Local Advisory Councils

Problem statement: Minnesota Statute 245.466 Subd. 5 should be updated to better reflect the current status of the Local Advisory Councils (LACs) by updating language to expand the required participation which allows all interested parties to have a voice when discussing the gaps and needs in local mental health systems.

Background information: The LACs are a vital part of gathering community driven information to identify the gaps and needs of Minnesota's local mental health systems. These councils consist of community members that give their time and energy to provide feedback, recommendations and insight as to how Minnesota's local mental health systems are serving individuals with mental illnesses.

Recommendation: Update Minnesota Statute 245.466 Subd. 5(1) (Local Advisory Council) to mandate that LACs arrange mental health input from a wider variety of interested individuals, including representatives from the Adult Mental Health Initiative, as they should be helping to assess the gaps and needs in the mental health systems that they are, in part, funding.

Expected outcomes & who will benefit if this recommendation is implemented: The updated language will instruct the LACs to cast a wider net when looking for important feedback related to local mental health systems. Ideally, this should allow for more diverse perspectives and experiences to be heard.

What is the impact on diversity of this recommendation? Making changes to Minnesota Statute 245.466 Subd. 5(1) calls for input from a wider variety and more diverse group of interested individuals which allows more perspectives into important community discussions relating to the gaps and needs in the local mental system.

Statute revision to utilize inclusive, person-first language

Problem statement: Minnesota Statute 245.466 Subd. 5 uses the outdated language of "consumer." It is best practice to use person-first language when referring to a group of individuals living with mental illness.[15]

Background Information: The Minnesota Comprehensive Adult Mental Health Act was enacted in 1987 and since that time language regarding individuals with mental illness has changed in other areas of the statute, but still remains outdated in the portion relating to the LACs.

Recommendation: Update the language of Minnesota Statute 245.466 Subd. 5. (Local Advisory Council) from "consumer" to the inclusive person-first equivalent of "individual with a lived experience of mental illness."

[15] https://www.apa.org/about/apa/equity-diversity-inclusion/language-guidelines

Expected outcomes & who will benefit if this recommendation is implemented: It will show all Minnesotans that the state values individuals with a lived experience of mental illness as a person instead of being referred to by their illness.

What is the impact on diversity of this recommendation? The implementation of person-first language promotes the understanding that people living with a mental illness are people first and that may combat the continued stigma around mental illness in marginalized communities.

Equity between adult and children's LACs

Problem statement: There are differences between the statutory requirements for adult and children's LACs. The adult LAC statute includes language that requires coordination between the adult LACs and the State Advisory Council on Mental Health. The children's LAC statute does not.

Background information: The LACs are a vital part of gathering community driven information to identify the gaps and needs of Minnesota's local mental health systems. These councils consist of community members that give their time and energy to provide feedback, recommendations and insight as to how Minnesota's local mental health systems are serving individuals with mental illnesses.

Recommendation: Add language to Minnesota Statute 245.4875 Subd. 5. (Local Children's Advisory Council) to parallel the language of the adult LAC statute (245.466 Subd. 5.) to promote coordination support from the State Advisory Council on Mental Health to children's LACs.

MN Stat. 245.466

Subd. 5. Local advisory council.

The county board, individually or in conjunction with other county boards, shall establish a local adult mental health advisory council or mental health subcommittee of an existing advisory council. The council's members must reflect a broad range of community interests. They must include at least one -individual with a lived experience of mental illness, one family member of an adult with mental illness, one mental health professional and one community support services program representative. The local adult mental health advisory council or mental health subcommittee of an existing advisory council shall meet at least quarterly to review, evaluate and make recommendations regarding the local mental health system. Annually, the local adult mental health advisory council or mental health subcommittee of an existing advisory council shall:

(1) arrange for input from community members, representatives from the Adult Mental Health Initiative, and providers of mental health and substance use disorder services for adults in the county or counties;

(2) identify for the county board the individuals, providers, agencies and associations as specified in section 245.462, subdivision 10;

(3) provide to the county board a report of unmet mental health needs of adults residing in the county to be included in the county's mental health plan, and participate in developing the mental health plan; and

(4) coordinate its review, evaluation and recommendations regarding the local mental health system with the state advisory council on mental health.

The county board shall consider the advice of its local mental health advisory council or mental health subcommittee of an existing advisory council in carrying out its authorities and responsibilities.

MN Stat 245.4875 Subd. 5. Local children's advisory council.

(a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with severe emotional disturbance; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with emotional disturbance in the local area and services needed by families of these children, and shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services;

(2) identify for the county board the individuals, providers, agencies and associations as specified in section 245.4877, clause (2); and

(3) provide to the county board a report of unmet mental health needs of children residing in the county.

(4) coordinate its review, evaluation, and recommendations regarding the local mental health system with the state advisory council on mental health.

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities.

Expected outcomes & who will benefit if this recommendation is implemented: Children's LACs and their individual counties will have additional support and a partner to move local issues to a state platform.

What is the impact on diversity of this recommendation? By requiring support from the State Advisory Council on Mental Health, children's LACs will have the opportunity to bring forward their county-based needs and concerns to advocate at the state level which may allow a more diverse set of problems and solutions to be heard.

Appendix I

State Advisory Council on Mental Health		
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Open	County Commissioner #1- Metro	
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Open	County Social Services Director	
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Subcommittee on Children's Mental Health		
OPEN	Childrens MH Services- Hsopital	
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