

Governor’s Task Force on Mental Health

DRAFT RECOMMENDATIONS

draft as of 10/13/16

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The Task Force offers recommendations in nine topics. In general, the Task Force has kept recommendations at a high level, acknowledging the complexity of the issues and calling for continued collaborative work to follow the road maps provided by the Task Force. For Recommendations #8 and #9 (crisis response services and inpatient psychiatric bed capacity), the Task Force recommends more short-term solutions that could be implemented within the next year or so. These can help ameliorate the problems while more systemic solutions are devised and pursued.

A. A Comprehensive Mental Health Continuum of Care

The Task Force embraced the Governor's charge to recommend changes that would transform Minnesota's array of mental health services into a true continuum of care. This section describes a conceptual framework and recommendations for achieving that transformation. To begin, it is useful to recognize that "continuum" suggests at least these four types of continuity and completeness:

- Complete range of services and activities: The system would have services and activities that respond to the entire range of mental health needs of Minnesotans.
- Universal access: The services and activities would be accessible by all Minnesotans, which includes awareness of services available; geographic availability (with realistic expectations for travel or transportation); capacity of providers to serve everyone in their service area; accessibility to people with disabilities; responsive to clients' cultural and demographic backgrounds, etc.
- Smooth transitions: A person's experience of services would have continuity across levels of care (for example, from an inpatient hospital stay to outpatient services in their community).
- Integrated care: The various services that a person receives (for example, health care, income supports, housing, child welfare, and parole) would be integrated or coordinated so that the person isn't faced with conflicting expectations and doesn't have to struggle to put all of the pieces together as he or she pursues recovery.

Recommendation #1: Comprehensive Continuum of Care

The Governor and Legislature should adopt a wide definition of the Mental Health Continuum of Care (as illustrated on page 4). The Governor and Legislature should consider improving availability and access to mental health services and activities in the continuum to be Minnesota's highest mental health priority. To fulfill this priority, responsibility for the following process should be assigned, along with the funding and staffing to complete it.

1. Defining and Further Developing a Comprehensive Mental Health Continuum of Care

A continuum of care that would meet the principles listed on Page **Error! Bookmark not defined.** would need to comprise six categories of activities and services:¹

- Health promotion and illness prevention
- Early intervention
- Basic clinical services
- Inpatient and residential services
- Community supports
- Crisis services

In addition, the continuum should support three categories of collaboration and integration mechanisms:

- Collaboration among providers, payers, consumers, and others to support operations and improve service delivery: case management, care coordination, discharge planning, care management, shared record-keeping, transition protocols, etc.
- System-wide collaboration and oversight functions: Governance and funding structures; centralized assessment, forecasting, and planning; quality assurance and metrics; workforce development; etc.
- Collaboration with other sectors: Mechanisms to collaborate or integrate with substance use disorder treatment, public health, primary care, housing, employment, education, transportation, criminal justice, and social services.

These components of a comprehensive continuum of care are illustrated in Figure 1. The individual, family, and community are at the center, surrounded by the sectors of social services and support systems available to them. In addition to the mental health system, these include substance use disorder treatment, public health, primary care, housing, employment, education, transportation, criminal justice, and other social services. The mental health continuum of care includes services and activities in the six functional categories (tan rectangles), with the lines connecting them representing the operational collaboration that enables smooth access and integrated service delivery. System-wide collaboration and oversight functions (gray oval) help ensure that the system as a whole meets the needs of all Minnesotans, has adequate resources (funding, workforce, technology infrastructure, etc.), is sustainable, and engages in ongoing data-driven assessment, planning, innovation, and service and activity development. Lines connect the mental health continuum of care with all of the other sectors

¹ These six functions are not intended to prescribe an individual's treatment and recovery path; people will access the services and activities in whatever functional category or categories meet their current needs. This document refers to "services and activities" in the continuum to acknowledge that the continuum includes not just direct services to individuals, but also population-based health promotion and prevention activities as well as all the collaborative activities that ensure a robust and responsive service system.

to emphasize the importance of collaboration among sectors to meet the needs of individuals and families.

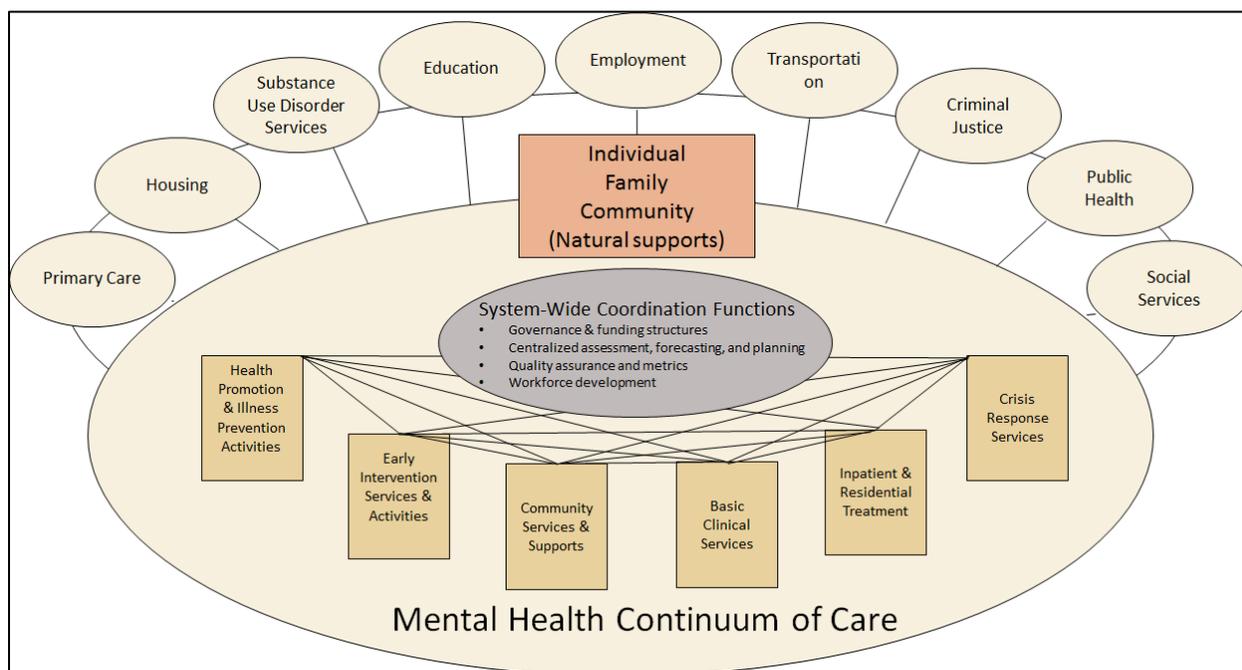


FIGURE 1: COMPREHENSIVE CONTINUUM OF CARE

2. Systematic Development of the Continuum

The Task Force provides the following “road map” for systematic development of a comprehensive mental health continuum of care:

1. Assign responsibility for the following work to an existing body or establish a workgroup or other body to coordinate the work. Designing the continuum must balance unique local and regional circumstances with the need to establish statewide expectations for a comprehensive continuum of care. It must also be driven by the needs and perspectives of the people being served, so people with lived experience of mental illness and their families should be included in the decision-making process. The work must also be designed to promote both flexibility and accountability to ensure availability and access. Responsibility for the following process should be accompanied by adequate funding, staffing, and time to complete it. The group that completes the work should include:
 - a. The services and activities needed in each function of the continuum. The Task Force recommends the services and activities listed on page _ as a starting point [this will be a revised version of the matrix presented at the September 26 meeting].
 - b. The appropriate service levels for each service or activity (e.g., every person should be within 90 minutes of a mobile crisis team, or there should be one psychiatrist for every 10,000 people in a geographic area).
2. Develop a service/need matrix that systematically identifies:

- c. The categories of population that are most relevant for population-based mental healthcare planning, including categories of age, cultural background, ability/disability, etc.
 - d. The regions of the state around which service availability and access will be planned. This could be in conjunction with the re-design of the Adult Mental Health Initiatives, or coordinated with that work.
- 3. With all of the above dimensions laid out, coordinate with regional planning bodies to prepare “Continuum Maps” that outline what activities and services are available in each region, where, and for whom, and identify what activities and services are still needed in each area for particular populations. Identify where services can be co-located (schools, colleges, clinics, etc.) to enhance access. The regional planning bodies should include people with lived experience of mental illness and their families.
- 4. Policy planning and funding decisions—including state and county agency strategic plans—should be made with consideration of the Continuum Maps. The Governor and Legislature are urged to build stable funding for the activities and services outlined in the Continuum Maps. Investments should be considered in three categories: short term priorities, investments in innovation, and sustained infrastructural investments for proven services. More details about system-wide collaborative functions are included in the Governance recommendations, below.
- 5. Implement care and funding models that promote integration and person-centered care. Care management models, including Certified Community Behavioral Health Clinics and Behavioral Health Homes, should be expanded. Substance use disorder services and mental health services should be integrated or aligned.
- 6. Throughout the mental health system, collaborate with existing data-sharing organizations and projects to develop mechanisms for better data sharing (while protecting privacy).
- 7. While the Continuum Maps are being created and implemented, the Governor and Legislature should continue to expand access to care for core services and key populations:
 - a. Expand children’s services, especially for very young children. Build capacity of children’s residential mental health services to serve specific populations and different levels of care such as crisis homes and psychiatric residential treatment facilities (PRTFs).
 - b. For adults, the Governor and Legislature should increase access to core mental health services such as crisis, community supports, residential services, and to early intervention efforts such as first-episode programs. They should also fund mother/baby programs and support child care for mothers needing to access mental health and/or substance use disorder treatment.
 - c. For all age groups, the Governor and Legislature should improve and expand services for populations who experience significant mental health disparities: people with low incomes, people of color and American Indians, LGBTQ youth and adults, new immigrants, veterans, and people with complex co-occurring conditions in addition to their mental illness. This will require addressing accessibility barriers that can keep non-English speakers, people who are deaf or deaf blind, new immigrants, and others from knowing about and accessing mental health services. See Recommendation # 3 for related recommendations.

- d. Support ongoing efforts to expand access to employment opportunities for people with mental illnesses.
- 8. The Governor and Legislature should continue to pursue promising collaborations between the mental health service system and other sectors, including public health, education, housing, corrections, etc. For example, collaboration should continue to improve students' access to mental health services; the Departments of Health and Corrections should work together to improve state prisons' visiting environments and policies to encourage and foster parent child relationships.

B. Governance in Minnesota's Mental Health System

The governance of the mental health continuum of care (which includes governmental and collaborative stakeholder planning bodies, policy making, funding decisions, service and program development and oversight, and accountability and quality assurance functions) is complex, fractured, and overlapping. Transforming Minnesota's array of mental health services into a comprehensive continuum of care will require collaboration across multiple layers government and across the entire stakeholder community: state, county, and local government agencies, tribes, providers, payers, people with lived experience of mental illness, advocates, community leaders, and others.

Recommendation #2: Collaborative Oversight Body

The Governor and Legislature should establish a high-level collaborative oversight body to set goals, develop plans, convene workgroups, assign responsibility and accountability for tasks, and report periodically to the Governor and Legislature on progress and barriers to progress. This body could take the form of a commission (like the Interagency Commission on Homelessness), a sub-cabinet (like the Olmstead subcabinet), or some other form. It needs to be an ongoing, statewide, inter-agency, non-partisan, public/private organization that can truly bring Minnesotans together to jointly pursue a comprehensive continuum of care. It must have stable and adequate funding and staffing to support its own activities, ongoing workgroups, regional collaboration, and data collection and reporting functions.

The Task Force envisions that the Collaborative Oversight Body will establish and lead the following planning/implementation workgroups:

1. **Comprehensive Continuum of Care Workgroup:** Tasked with planning the implementation of the "road map" in Recommendation #1.
2. **Governance Workgroup:** See below for the recommended focus of this workgroup.
3. **Cultural Lens Workgroup:** Tasked with further development and planning of Recommendation #3 on Page 8.
4. **Parity Workgroup:** Tasked with further development and planning of Recommendation #5 on Page 11.
5. **Inpatient Bed Capacity Workgroup:** Tasked with further development and planning of Recommendation #8 on Page 15.
6. **Crisis Response Workgroup:** Tasked with further development and planning of Recommendation #3 on Page 20.

The Governance Workgroup will be tasked with re-design of the governance structure for Minnesota's mental health system. The group will require staffing by people who are very familiar with the mental health system to convene, conduct, and coordinate the activities of the workgroup and any sub-groups needed. The work will involve:

1. Developing governance planning processes that are inclusive of those who have direct involvement in the mental health continuum of care, including those with lived experience of mental illness and their families. Ensure that processes enable effective collaboration among the various partners and stakeholders to reach desired outcomes. These should include mental health partners like the DHS Children and Adult Mental Health, Direct Care and Treatment, Disabilities Services, Alcohol and Drug Division, Department of Commerce, Department of Health, regional Adult Mental Health Initiatives and Children's Collaboratives, public health, counties (with geographic representation and inclusion of social services directors), tribes, managed care organizations (included state-funded and private market), private insurers, community mental health providers, people with lived experience and their families, _____. They should also include collaboration with other sectors, including primary care, education, criminal justice, employment, transportation, housing, etc.
2. Defining the purpose and scope, roles and responsibilities of governing the mental health continuum of care.
3. Researching other national and/or state models of governance for consideration.
4. Assigning oversight and accountability for the mental health continuum of care and ensuring the availability and accessibility of a basic set of mental health services and activities for all Minnesotans. Ensure that there are clear lines of reporting to the applicable entities based on authority, funding and accountability and that reporting is streamlined for efficiency and reduction of duplication. Strengthen current statutory language related to county and state partnerships, roles, and responsibilities.
5. Making recommendations that define regional boundaries (with consideration of Adult Mental Health Initiative boundaries, children's mental health collaborative boundaries, Alcohol and Drug Abuse Division boundaries, Disability Services regional boundaries, public health boundaries, etc.), and align those with accountability for services.
6. Developing, implementing, and sustaining the "Continuum Maps" as described in Recommendation #1.
7. Incorporating quality assurance and continuous quality improvement:
 - a. Collaborating with other quality organizations to identify desired outcomes and set benchmarks and process measures to be collected, analyzed and reported. For example, set expectations and measures for appropriate and timely transitions between services and/or between levels of care, or for acceptable wait times for key services.
 - b. Establishing the quality improvement structure, methods and strategies used that support genuine input from individuals and families impacted by mental illnesses.
 - c. Encouraging adoption of best practices (such as integrating care across mental health, chemical dependency, prevention/early intervention (public health) and social services), but also supporting practice-based evidence and promising practices, especially for populations for whom best practices have not been researched.

- d. Support innovation: Fund a Mental Health System Innovation Center to identify and/or develop innovative solutions to challenges in the continuum of care and share promising models across the state so they can be customized and implemented in other communities.
- 8. Establishing a process for the data-driven development of new services and activities. The process should include collecting, analyzing, and acting on data in order to identify, develop, implement, fund, and evaluate services driven by local need. Financial resources should be aligned to support this ongoing function.
- 9. Determining whether a “safety net” function should be part of the newly-defined governance model. If so, the roles and responsibilities for safety net service provision and oversight should be incorporated into the governance model, and funding for those roles should be prioritized. Take into account past recommendations about the safety net function, including the 2015 recommendations from the Community Based Steering Committee and the Legislative Auditor’s report on State Operated Services.
- 10. Collecting and analyzing data to assess the existing funding structures for mental health and develop recommendations for changes in funding that align with the proposed governance structure and the goals of health care reform.
- 11. Identifying funding and staffing needs for the development and ongoing operation of the governance structure (apart from the funding of particular mental health services and activities in the continuum).

C. Using a Cultural Lens to Reduce Mental Health Disparities

The social determinants of health help explain why diverse cultural communities often experience below average mental health outcomes. Not only do they experience more risk factors, but they also can find it difficult to engage in mental health treatment when the provider does not understand their language, cultural values, or perspectives on mental health. Without adequate engagement, treatment is less effective.

Recommendation #3: Using a Cultural Lens to Reduce Mental Health Disparities

The Governor and Legislatures should establish a workgroup of people from multiple cultural backgrounds to further explore how culture could enrich the current understanding of mental wellbeing and mental illness and to make recommendations for improving mental health services and activities for people who are not well served by the existing system. The group would develop expanded definitions of wellbeing, mental health, and mental illnesses that would be more responsive to individuals’ cultural backgrounds and self-understandings and make recommendations for incorporating those expanded definitions into the requirements and processes that shape the continuum of care. The group would develop more detailed recommendations on the specific opportunities listed below.

- 1. Especially in light of workforce shortages across Minnesota, the workgroup should develop strategies for incorporating cultural healers, cultural brokers, and elders into existing service structures as providers of mental health services. In addition, the workgroup should examine current provider standards, such as ones for certified peer specialists, peer recovery specialists, family peer specialists and mental health practitioners to identify barriers that may be

preventing the expansion and diversification of the workforce and make the changes needed in order to support this. This opportunity should allow for spiritual groups, minorities groups, and other systems to have input into setting credentialing standards for this process. This could be similar to eminence credentialing in teaching standards.

2. The workgroup should also look for ways to increase cultural diversity in health promotion, prevention and early childhood mental health. Many of the communities suffering the greatest inequities are not high utilizers of mental health services; however, they often enter the mental health system through other systems (child protection, special education, corrections, etc.). In alignment with Recommendation #6, it will be important to fund more extensive health promotion, prevention, and early childhood mental health services and activities that respond to the diversity within Minnesota's population. This work should be covered by both private and public health insurance.
3. It is likely that Minnesota will experience a shortage of culturally-specific providers for some time, so other ways of engaging culturally diverse people in treatment are needed. The mental health system should offer "cultural interpreters" or "cultural consultants," much as language interpreters are currently offered. These interpreters or consultants could be credentialed by the minority populations, cultural groups, and spiritual groups that they represent (one model would be the Qualified Expert Witnesses in the Indian Child Welfare Act court cases). When requested, these experts should be consulted in extended diagnostic assessments for adults and children and when individuals are committed by a court. Cultural interpretation and consultation should be reimbursable. This could be implemented through a higher rate of reimbursement for providers who use cultural interpretation or consultation in their treatment planning.
4. The workgroup should develop a strategy for including a reimbursable part of mental health treatment specific to engagement and incorporating cultural meaning and understanding into diagnostic assessments, particularly done pre-diagnosis. This will include multiple sessions needed pre-diagnosis to establish a therapeutic relationship prior to a formal diagnostic assessment. This reimbursement rate should take into consideration the need to pay the mental health providers and the cultural professional (if the provider is not culturally-specific).
5. There should be funding and support for trauma-focused modalities that are culturally specific and responsive. Some examples are: Trauma Systems Therapy for Refugees (TST-R), American Indian adapted Trauma Focused- Cognitive Behavioral Therapy (TF-CBT), and Parent Child Interactive Therapy (PCIT) with Dr. Dee Bigfoot in Oklahoma. Currently, many evidence-based practices are expensive and providers pay in two ways – for the trainings and follow-up certifications, and in lost revenue due to being in training. In order to continue to uphold the highest standards of treatment, providers and agencies must be able to afford to get and maintain training.
6. To improve engagement in treatment, the workgroup should recommend ways to support the expansion and implementation of feedback-informed treatments that involves creating an intentional process of engagement, feedback, and reparation in therapeutic relationships. Receiving feedback from clients has shown boost to the effectiveness of therapy, increasing client's wellbeing, and decreasing symptoms, dropout rates and no-shows. In order to create a

“culture of feedback” and receive such feedback, the therapist has to present an environment that is supportive of honest feedback.²

7. The workgroup should recommend support mechanisms for providers from cultural communities who share histories with consumers and thus sometimes experience “secondary trauma” as they provide services to their clients. These support mechanisms should be developed in consultation with these healers themselves.
8. As new services are developed, policymakers should recognize “practice-based evidence”—evidence based on everyday clinical practices—as an important basis for deciding what services and models to follow, especially with cultural communities.³ As clinicians work with the many culturally diverse patients they encounter, cultural perspectives are exchanged and negotiated; the learning that comes from this process should inform DHS’s decisions about service definitions and requirements.
9. The workgroup should review state rules, statutes, and processes to identify opportunities to remove inadvertent barriers to access for people from culturally diverse communities. For example, the diagnostic assessments that have been written into Rule 47 (the outpatient mental health rule) have created additional barriers to services and are particularly pronounced in culturally diverse communities.
10. The workgroup should collaborate with other groups to explore possible changes to how the state administers Medicaid dollars. The goal should be a seamless, integrated payment mechanism for a system of care that is not based on what can be paid for through federal financial participation, but on what the individual and family needs. This will require changes in funding mechanisms to allow mental health providers to afford to provide treatment and ancillary services needed in order to increase the wellbeing of the person. For example, while Minnesota applies to become a demonstration state for the Certified Community Behavioral Health Clinics, we should also consider how we could support this type model with or without federal demonstration dollars.
11. The workgroups should explore the creation of a demonstration grant to gather evidence that could lead to more sustainable funding options. This should be done in collaboration with the Results First initiative and should make sure that return-on-investment analyses include consideration of impacts on culturally diverse communities.
12. A system is needed for providing feedback from providers and customers on changes in services and policies that are made by state agencies. This should focus on ensuring that diverse communities are represented, and that there is a shared system of accountability for providers

² Research shows clients who provide feedback about their treatment showed about twice as much improvement as clients who didn’t provide feedback and in fewer sessions (Reese ET. Al, 2009).

³ Includes 1) recognizing problems in daily practice that produce dissention between recommended and actual care, 2) examining whether treatments with proven efficacy are actually useful and sustainable in the context of real life, and 3) examining how structural and organizational factors may be shaped.

and government agencies to take action on the reduction of systemic barriers for diverse communities. This system should allow for criticism of services as well as feedback on what practices are being effective and meaningful for consumer and providers. Clinical expertise of providers must be a part of all of these conversations. We must not forget that providers at different levels already have requirements for training, supervision, or experience (depending on education, work class, etc.) and while we need to continue to refine a system to increase the effectiveness of services, we cannot create a system that becomes so over controlling and bureaucratic that it takes away individual clinical expertise.

13. The workgroup should collaborate with the Governance Re-design Workgroup of the Collaborative Oversight Body to assign responsibility for defining and supporting culturally-responsive mental health services and activities and clarify what agencies, organizations, providers, and consumer groups should be involved. The parties identified should paint a vision for a transformed mental health system that could be culturally-responsive and person-centered and that could reduce disparities. Lay out the range of roles for people in such a transformed system. Suggest concrete steps that could be taken to move toward this visions (including implementing the recommendations listed in this section).

D. Workforce Development

Workforce challenges are, and will continue to be, one of the most daunting barriers to development of a robust continuum of care.

Recommendation #4: Workforce Development

The Governor and Legislature should continue to support implementation of the recommendations in “Gearing Up for Action: Mental Health Workforce Plan for Minnesota.” The Collaborative Oversight Body should work with the Mental Health Steering Committee (responsible for the Mental Health Workforce Plan) to ensure progress on those recommendations.

Specifically, the Governor and Legislature should do the following:

1. Increase existing state investments in housing and support services serving people with mental illnesses, including Bridges, supportive housing and tenancy supports.
2. Support the 2017 policy and budget requests for housing and supports that are recommended by the Commissioners on the Interagency Council on Homelessness.
3. Request that DHS, Minnesota Housing, the State’s Office to Prevent and End Homelessness, and the Olmstead Office work together to provide an analysis (modeling) of existing resources, strategies to leverage additional housing opportunities utilizing existing resources, and to identify the remaining gap of supportive housing opportunities needed to ensure all Minnesotans living with mental illnesses have access to affordable and stable housing and services.

E. Parity

Parity—treating mental health services in the same way that physical healthcare services are treated—has not been achieved in either Minnesota law or in common practice. There are several ways that mental health services are treated differently: a) the financial requirements (e.g., deductibles and co-

payments) and treatment limitations (e.g., number of visits or days of coverage) for services; b) availability of providers and rules for out-of-network coverage; c) definitions of medical necessity and treatment denials; d) coverage for new treatments; and e) unequal coverage of similar services (for example, if a policy covers residential rehabilitation after heart surgery but does not cover residential rehabilitation after in an inpatient psychiatric hospital stay).

Treating mental health services differently in these ways limits access and system capacity. Private insurance must cover treatments and supports so that people with private insurance have access to services and so that the cost burdens of not providing services are not shifted to state government.

Recommendation #5: Parity

The Governor and Legislature should assign responsibility for planning and tracking progress on implementing parity and ending discrimination based on stigma to a workgroup of the Collaborative Oversight Body. It should establish a plan and funding/policy recommendations to implement parity in Minnesota statute and assign state agency accountability for ensuring that health plans provide the coverage required to meet mental health parity. This should include requiring that private insurers cover the same mental health benefits that are funded through Minnesota’s Medicaid program. The Governor and Legislature should also assign ongoing state agency responsibility for reviewing health plans to assess alignment with parity laws and establishing a complaint mechanism to enforce parity laws. This should include market conduct exams of insurers, evaluation of plans’ network adequacy, and a robust method of collecting, public reporting (including insurers’ information), and investigating complaints by consumers about coverage of mental health services and treatment. Any consumer complaints about coverage received should include a requirement for insurance providers to respond within an appropriate timeframe, as crisis situations require timely mental health treatment and services.

F. Health Promotion and Prevention

Minnesota cannot achieve a sustainable mental health continuum of care unless we can build a robust health promotion and prevention function within the state. Focusing on treatment is important for people who are experiencing mental illness, but “moving upstream” to address the social determinants of health and supporting healthy practices that promote wellbeing is also very important. As one Task Force member put it, “We will never be able to treat our way out of this problem. It’s too expensive, we don’t have the workforce to do it, and it allows unnecessary suffering.”

Recommendation #6: Health Promotion and Prevention of Mental Illness

To support the mental health of Minnesotans and invest public tax dollars wisely, the Governor and Legislature should implement policies that build understanding of mental health and mental illness and community capacity to promote mental health. They should address system-wide needs and gaps as well as focus on the particular needs of vulnerable populations, especially those that experience significant disparities in health outcomes. Across the health care system, support providers to develop trauma-informed organizational practices and health care services.

Responsibility for implementing each of the following recommendations should be assigned within state government, and funding and staffing to complete and oversee them should be allocated. Because these recommendations will require collaboration across agency and system boundaries, oversight should include representation from multiple agencies, partners, and stakeholders.

1. Develop a statewide campaign to build understanding about what creates mental health and well-being, including communication and awareness about resilience, trauma, social determinants of health, positive psychology practices and anti-stigma. Target particular preparation to those who work directly with children and families (primary care, child care, schools, and local public health). Partner with existing efforts to implement and expand anti-stigma campaigns and include evidence based training models where feasible.
2. Increase public education about how to support people who are experiencing mental health challenges. Include information about where to go for help if needed and basic paths to accessing mental health services (based on the type of insurance one has).
3. Establish a network of local community initiatives to develop and implement community resilience plans aimed at improving mental health and well-being of residents. Local initiatives should focus on engaging and mobilizing residents, assessing local needs and resources, developing an action plan that includes multiple sectors, customizing models or policies in response to local needs and strengths, and evaluating progress. For example, a local initiative may focus on helping communities come together to address mental health risk and protective factors for adolescents.
4. Establish a statewide Community of Practice on resilience and well-being to facilitate and advance learning about community based and culturally specific strategies.
5. Integrate mental well-being, mental health, and trauma-informed strategies into primary care; develop mental health and well-being learning communities and fund implementation of identified best-practices for healthcare providers and community mental health partners. Support utilization of trauma and resilience assessment tools and an effective implementation process in health care facilities. Coordinate implementation with efforts on the social determinants of Health.
6. Develop infrastructure and implement mental well-being programs that are evidence based or promising, culturally responsive, multi-generational, and support individuals and families who are experiencing risk factors. Some examples include home visiting programs, Living Life to the Full, and the Mother and Babies Program.

7. Build capacity to collect and analyze population health data regarding risk and protective factors associated with mental well-being and illness, such as the Minnesota Student Survey, Pregnancy Risk Assessment Monitoring System, and Behavior Risk Factor Survey.
8. Expand programs to reach all newborns for anticipatory guidance, access to culturally and linguistically appropriate developmental and social emotional screenings and referral, including the Follow-Along program.
9. Develop supports and education for parents of adolescents that are accessible, evidence based, and teach positive parenting skills.
10. Expand transition supports for new immigrant and their families.
11. Develop resources and learning communities for organizations to engage in trauma informed organizational development, beginning with health care facilities. Organizations may include: health care clinics, early childhood providers, juvenile justice programs, schools, and other sectors. Models for supporting organizational change typically involve a multi-year process and require time and resources to fully engage in this effort. This includes activities such as training and assessment of policies, environments, practices, and organization culture.
12. Support development and implementation of trauma and resilience assessment tools in health care facilities.

G. Housing to Support Recovery

The entire mental health continuum of care cannot keep Minnesotans mentally healthy if the underlying social determinants of health continue to create stress and trauma for individuals and families, especially from generation to generation. The availability of affordable, safe, stable housing is the most basic of these determinants. For people with mental illnesses, the lack of affordable housing and community support services can impede recovery in many ways. For example, the daily stress of homelessness or the threat of homelessness makes it very difficult to maintain sobriety, get to treatment appointments, and maintain a medication regimen. In addition, the lack of appropriate housing and supports in their home communities can leave people trapped in treatment facilities whose services they no longer need. This severely compromises recovery and violates Minnesota's Olmstead policy against barriers that keep people with disabilities from pursuing recovery in the most integrated community settings of their choice.

Recommendation #7: Housing

The Governor and Legislature should ensure that housing—including housing with supports for people with mental illnesses—is available to all individuals and families who need it.

The Minnesota Interagency Council on Homelessness and the Minnesota Olmstead Plan have outlined dozens of strategies to increase the availability of safe, affordable housing. The Task Force supports these activities, specifically recommending that the Governor and Legislature do the following:

1. Protect existing state investments in housing and support services serving people with mental illnesses.
2. Support the 2017 policy and budget requests for housing and supports that are recommended by the Commissioners on the Interagency Council on Homelessness.

3. Direct that DHS, Minnesota Housing, the State’s Office to Prevent and End Homelessness, and the Olmstead Office work together to provide an analysis (modeling) of existing resources, identify strategies to leverage additional housing opportunities utilizing existing resources, and describe the remaining gap of supportive housing opportunities needed to ensure all Minnesotans living with mental illnesses have access to affordable and stable housing and supports.

H. Inpatient Psychiatric Bed Capacity and Level-of-Care Transitions

1. Issue Overview

The mental health system challenge that generated the most written comments to the Task Force involved the problems related to inpatient psychiatric bed capacity and the attendant difficulties with level of care transitions. Most simply, the problem is that there are waiting lists for inpatient psychiatric beds, especially at hospitals that serve people with mental illnesses and complex co-occurring conditions that include substance use disorders, chronic physical illnesses, intellectual disabilities, and mental illness systems that include aggression and violence. People in mental health crises are forced to wait in inappropriate locations (emergency departments, jails, general hospital wards, at home, and other community settings) for inpatient psychiatric treatment. This creates a host of secondary problems for the patients involved and for the people in all of those other settings.

The inpatient psychiatric bed problem can be best understood as a “patient flow” problem. Seen at the system level, when people cannot access the treatment they need in a timely manner, the flow of people through the system is impeded. Like a traffic jam caused by construction, the slow-down reverberates through the system and multiple roads are soon affected. Minnesota’s patient flow problem is actually a complex set of intertwined problems (see the Appendix on page **Error! Bookmark not defined.** for more information) that include the following:

- Inadequate community-based services and recovery supports such that a person does not receive the support they need when mental health symptoms first arise and they thus get sicker until they are in a mental health crisis.
- Inadequate coordination of services to support individuals toward recovery.
- Inadequate crisis-response services that could help divert some individuals from needing inpatient psychiatric care.
- Problems with discharge planning, which should start at admission, resulting in people being ready for discharge but not having a destination in their home community (with whatever level of supports required) to go to.
- Inefficient administrative processes (especially in the commitment process, funding eligibility determinations, and community placements) that delay both treatment and recovery in community settings.
- The long waiting times for admission to community psychiatric inpatient beds and especially for state-operated psychiatric beds for people who are under commitment.
- The “cycling” of some patients through Emergency Departments, inpatient hospital stays, and discharge back to the community without adequate supports.

- The “trickle down” effects of these psychiatric patient flow problems on other people and services, including friends and families, community hospitals and their other patients, lower intensity psychiatric services, law enforcement, courts, etc. These patient flow problems reverberate throughout the service system, creating backups at community hospitals and preventing people from receiving the ‘right time, right place” care they need to successfully pursue recovery.
- Questions about what the appropriate number of inpatient psychiatric hospital beds in Minnesota should be and about where policymakers should best invest in order to ensure that people receive “right place, right time” care.

2. Recommendations

The Task Force considered solutions to the inpatient bed capacity problem that it considered to be implementable within one to two years. They do not see these as total solutions, but as strong first steps to take while the Governor and Legislature also undertake the more comprehensive planning and coordination needed to solve the larger systemic issues.

Recommendation #8: Inpatient Psychiatric Bed Capacity and Levels-of-Care Transitions

The Governor and Legislature should fund and assign responsibility for several short-term solutions to the patient flow problems implicit in the shortage of inpatient psychiatric beds. These can help ameliorate the situation and build collaborative capacity while longer-term solutions and more extensive solutions are developed.

a. Strengthen Housing and Supports (see Recommendation #7 for more information)

The Task Force recommends expansion of evidence-based intervention housing models, such as permanent supportive housing. In permanent supportive housing models, affordable housing is paired with or linked to services to assist individuals to remain in their homes. Providing housing with supports has been shown to create a level of stability that serves as a basis for recovery. In addition, bringing services to a person’s home lessens the need for transportation which can help someone who is experiencing a mental health crisis. Supportive housing has been shown to decrease the need for hospitalizations and involvement with law enforcement.⁴

The Task Force also recommends that the Governor and Legislature pursue Medicaid coverage for housing supports, also called individualized community living. Services provided under individualized supports will help people with disabilities, including mental illnesses, live independently in their own homes. Medicaid coverage will provide a stable and sustainable funding source to providers to offer these services.

⁴ For more information see <https://www.usich.gov/solutions/housing/supportive-housing>.

b. [Improve Local Coordination around Crisis Response \(see Recommendation #9 for more information\)](#)

The Task Force recommends strengthening crisis response services, as detailed in Recommendation #9 on page __. Strengthening connections between mobile crisis teams, hospitals and law enforcement will assure individuals experiencing a crisis receive the right care, while relieving the pressure on hospitals and law enforcement to address acute crises with limited resources. There is also an opportunity for strengthening crisis teams to work with families, along with children and youth. Effective mobile and respite crisis services can prevent unnecessary hospitalizations and emergency department visits for both adults and children, thus both supporting recovery and helping to ensure that hospital beds are available for people who truly need them.

c. [Competency Restoration](#)

The Task Force recommends expansion of community-based competency restoration services. There are opportunities to expand community-based competency restoration that would open up beds at the Minnesota Security Hospital in St. Peter and at AMRTC, which would make those beds more available for others.

d. [Establish an Ongoing Body to Coordinate and Oversee Work on Inpatient Bed Capacity](#)

The Task Force recommends that the Collaborative Oversight Body establish a workgroup to coordinate and oversee work on inpatient hospital bed capacity for the state of Minnesota. Part of the difficulty of addressing inpatient bed capacity is the fact that the problem is so multi-faceted and that many stakeholders are involved, each with their own missions and goals, legal and administrative requirements, funding models, work processes, and professional perspectives. An ongoing body of these stakeholders would provide the opportunity for a multi-faceted approach to the issue. That work should include:

- Use of data to determine what kinds of adult and children/adolescent inpatient services are needed and where.
- Use of data to determine what capacity of adult and children/adolescent inpatient services is needed and where.
- Collaboration with other Collaborative Oversight Body workgroups on data collection to better plan and coordinate the continuum of care across the state.
- Discussion of roles and accountability of the Anoka Metro Regional Treatment Center and community hospitals in providing services, particularly for acute care for adults living with serious mental illnesses and complex co-occurring conditions, including symptoms of violence and aggression. (This should coordinate with the “safety net” discussions recommended in the Governance section above).
- Addressing the 48 hour law’s unintended consequences, particularly for community hospitals and Anoka Metro Regional Treatment Center.
- Utilizing existing resources differently, such as encouraging critical access hospitals to create inpatient or crisis mental health services coupled with tele-psychiatry and increased psychiatric training for hospital staff.
- Inpatient and intensive mental health treatment for families.
- Discussion of financial disincentives to serving people with complex co-occurring conditions.

- Discussion of operational and financial barriers to the development of more step-down community-based services for people leaving inpatient hospital stays.

e. [Increase Intensive Residential Treatment Services and Require Private Insurance Coverage for Services](#)

The Task Force recommends an increase in Intensive Residential Treatment Services (IRTS), including exploring the development of IRTS that offer different levels of service intensity or are different sizes.⁵ This may involve removing impediments to IRTS development, which can include the requirement for county _____ and the rates paid for IRTS services. In addition, private commercial insurance should be required to cover treatment in IRTS settings. This coverage is a matter of parity with physical rehabilitative services. Implementing this requirement will require work at the state and federal level, as well as with companies that self-insure and determine their own benefits.

f. [Civil Commitment](#)

The Task Force recommends that the Legislature clarify Minnesota's Civil Commitment Act to emphasize the option of committing individuals to lesser-restrictive settings than inpatient hospitals. The Act should also be amended to allow the option of dual-commitments to hospitals and to the Commissioner of Human Services. This option would give hospitals the opportunity to discharge individuals without waiting for a remote provisional discharge from the State, thereby speeding up the discharge process from a hospital.

g. [Expand Options for Parents and their Children](#)

The Task Force recommends expanding options for families and children who need inpatient psychiatric hospitalization. Models to consider include:

- Intensive mother-baby postpartum mental health treatment that allows mothers to receive mental health treatment while caring for their infants, such as Hennepin County Medical Center's Mother Baby Partial Hospitalization, Intensive Outpatient, and Outpatient treatment programs.
- Inpatient mother-baby postpartum units, such as those in the United Kingdom, Australia, Canada, New Zealand, France, and Belgium.⁶

⁵ Increasing IRTS capacity does not preclude the importance of increasing the capacity of other intensive community-based service such as Assertive Community Treatment (ACT) teams.

⁶ Nicole Vlieghe, Sara Casalin, Patrick Luyten, Ria Docx, Marijs Lenaerts, Eileen Tang, Stefan Kempe (2013) Hospitalization-Based Treatment for Postpartum Depressed Mothers and Their Babies: Rationale, Principles, and Preliminary Follow-Up Data, *Psychiatry: Interpersonal and Biological Processes*, 76:2, 150-268. Maeve Kenny, Susan Conroy, Carmine M. Pariante, Gertrude Seneviratne (2013) Mother-Infant Interaction in Mother and Baby Unit Patients: Before and After Treatment, *Journal of Psychiatric Research*, 47, 1192-1198. N.M.-C Glangeaud-Freudenthal, A.-L. Sutter, A.-C. Thieulin, V. Dagens-Lafont, M.-A. Zimmerman, A. Debourg, B. Massari, O. Cazas, R. Cammas, C. Rainelli, F. Poinso, M. Maron, S. Nezelof, P.-Y. Ancel, B.

- Services to allow parents to remain close to, or stay with, children who are hospitalized for mental health treatment.

The Task Force also recommends that the Governor and Legislature ensure the implementation of Psychiatric Residential Treatment Facilities (PRTFs) for children and adolescents who need intensive residential treatment. In addition to increasing overall residential treatment capacity, this option does not require families to go through out-of-home placement for their children, as existing children's residential treatment requires. Implementation of PRTFs will be even more important if Minnesota loses federal funding for current children's residential treatment services.⁷

h. Support Efforts to Reform Addiction Treatment

The Task Force supports efforts to reform Minnesota's addiction treatment system. A current reform effort will move Minnesota's substance use disorder (SUD) treatment system from an acute, episodic-based system to a modern, client-centered, and equitable model of care with an emphasis on care for a chronic disease. It will establish a streamlined, client-centered process for accessing SUD services; expand the continuum of care to include withdrawal management, peer recovery support and care coordination services and allow SUD treatment to be delivered outside of a licensed setting. These changes are necessary to advance the integration of SUD services with the rest of the behavioral health care and physical health care system, which should reduce mental health crises and the need for inpatient hospitalization. They will also help remove one barrier to people leaving hospitals when they no longer need a hospital level of care. Waiting for an available addiction treatment setting has been cited as one reason why individuals become stuck in inpatient hospital unit after they no longer need hospital level care. According to the MHA/Wilder study, 11 percent of potentially avoidable days were due to a lack of availability of addiction treatment settings.⁸

i. Adopt Previous Recommendations on Discharge Planning

Improving discharge planning is a key strategy for ensuring that people can leave hospitals when they no longer meet the criteria for a hospital level of care. Minnesota has already made some strides in this area, and the Task Force recommends that these promising approaches be explored or expanded:

Expand the Transitions to Community Initiative to include individuals in community hospitals who are on the Anoka Metro Regional Treatment Center (AMRTC) waiting list.

Adopt recommendations of Minnesota's Reducing Avoidable Readmissions Effectively (RARE) campaign on transitions of care for individuals leaving inpatient mental health treatment, particularly those on effective medication management and engagement in medication treatment.

Khoshnood (2011) Inpatient Mother and Child Postpartum Psychiatric Care: Factors Associated with Improvement in Maternal Mental Health, *European Psychiatry*, 26, 2215-223.

⁷ The federal Center for Medicare and Medicaid Services has expressed concerns that Minnesota's children's residential treatment settings have the characteristics of "Institutes of Mental Disease," or IMDs, and could therefore be ruled ineligible for federal reimbursement.

⁸ Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot, 1.

Develop and expand culturally-sensitive and culturally-relevant discharge planning.

Support and increase county involvement in discharge planning for individuals admitted to an inpatient setting. Counties should be involved in discharge planning upon an individual's admission, but barriers of distance, high caseloads, and lack of experience can make this difficult. County liaisons to AMRTC have successfully assisted individuals to make timely transitions from AMRTC back to their communities, and some rural counties have collaborated to share liaison case managers to make this approach viable where no single county can sustain a full-time liaison.

j. For Longer-term Consideration

The Task Force considered additional promising options but felt that they required more analysis than the Task Force had time to complete. Those options could be considered in the future, or initial steps could be taken now with the understanding that full implementation could extend beyond 1-2 years.

Assess the impact of the recent increase in the county share. The Task Force recommends that DHS should assess the impact of recent increases in the amounts that counties pay to the state for patients at AMRTC and the CBHHS who no longer meet criteria for a hospital level of care. Counties now pay 100 percent of costs for county residents who are served in a state hospital without meeting criteria for that level of care. All of the funds collected go into the state's General Fund. Has the increase driven a decrease in non-acute bed days while maintaining or improving stability in the community? Are there ways to further incentivize the development of community-based services? For example, re-investing those dollars into community services is one possible option for strengthening the community-based mental health system that could be considered.

Study transition issues for patients residing in residential settings and nursing homes. Providers have told the Task Force that individuals from residential settings and nursing homes are being admitted to inpatient psychiatric hospitals and then are facing barriers to discharge when they are ready to return to their previous living situation or treatment setting. This raises questions about possible gaps in care or funding such that residential settings are not able to prevent the need for hospitalization, and also about situations in which residential settings are not willing to accept patients back after they no longer require hospitalization.

l. Implement Short-Term Solutions to Improve Crisis Response

One of the priority areas that the Task Force identified for immediate action was to make immediate improvements to crisis response, including intersections with criminal justice and 911 responders. Minnesota has made significant investments in crisis services, and is on track to achieve 24/7 mobile crisis response statewide by January, 2018. However, challenges remain. Travel times in rural areas present significant challenges to timely response. Suburban teams may lack some of the specialized resources that teams need to refer to. Urban teams can struggle with a call volume that outpaces available staffing. In all areas of the state, stakeholders have raised concerns about the impacts of law enforcement responding to calls that involve significant mental health concerns.

Crisis situations are emergent events. Individuals frequently have several predecessor events: loss of housing, an unclear discharge plan, a missed psychiatry appointment, a conflict with a family member. The culmination of these stressors can be a highly visible event: notable symptoms, behavior that results

in police response, the point at which a person becomes a danger to themselves or others. But underneath that were likely an entire set of unmet needs. In order to be effective, crisis response cannot be confined to the most acute needs.

As SAMHSA has reported, "Adults, children and older adults with a serious mental illness or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization. Homelessness, police contact, institutionalization and other adverse events are in themselves crises, and may also contribute to further crises."⁹

Within the Task Force, members discussed the need to clarify roles and responsibilities in crisis response. Too often, the system responds to the immediate crisis but fails to provide the necessary follow-up that could support the person's recovery and prevent further crises. Once a person is transferred or discharged, the crisis often becomes someone else's concern. Collaboratively and holistically sharing responsibility is the only way Minnesota can address the root causes of crisis events.

Recommendation #9: Crisis Response

The Governor and Legislature should fund and assign responsibility for several short-term improvements to Minnesota's system for responding to mental health crises. These extend ongoing work in the crisis response system and build further capacity and collaboration across the state.

1. Use of Telehealth

Crisis providers are already using telehealth services to expand their reach, and mitigate workforce shortages and long travel times. The following are potential strategies for building on this.

a. Build out common network and protocols

Minnesota could adopt a unified network for telehealth services relating to mental health crisis. This would include expansion of the DHS hosted network, identifying a model for other emergency responders to bring a connection out into the field through tablet or other device, as well as protocols for timelines and responsibilities each partner has in crisis telehealth. This will build on prior work in several areas. Northwestern Mental Health Center has invested significant effort into developing protocols and workflows to support the deployment of telehealth connections between the crisis team and small hospitals in the area.¹⁰

DHS and AMHI Region 3 (Northeast MN) have partnered to pilot the deployment of a common standard and network for telehealth connections. Hospitals, schools, and clinics all can gain access to the DHS network which allows for fast and easy connections. One of the core principles that the group has

⁹ Bernstein, R. (2009). Practice Guidelines: Core Elements For Responding To Mental Health Crises. Retrieved October 11, 2016, from <http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf>

¹⁰ Reitmeier, S. Chief Executive Officer, Northwestern Mental Health. Correspondence. 9/9/16.

affirmed is that telehealth services should adapt to the needs of individuals, not be limited to fixed locations.

Some examples of use: One member of a crisis team can stay in contact with a child in crisis at a school, while another travels to meet them in person. A psychiatrist from HDC, the community mental health center, can provide a diagnostic assessment and start an individual at the Carlton County Jail on medication without any transportation time or cost.¹¹ MN.IT provides helpdesk to support for all users.

Objectives: Expand a single, interoperable network standard for telehealth and identify sustainable allocation for those infrastructure costs. Establish best practices for the workflows used to implement telehealth for crisis situations.

Timeline: *Incoming information from Roger Root, MN.IT.*

Resources: Variable. Identification of best practices for use and deployment would require relatively few resources. Building out broadband connectivity and the infrastructure could be far more ambitious. *Incoming information from Roger Root, MN.IT.*

Partners: MDH Office of Rural Health has experience managing grants for capital expenditures rural health systems would otherwise be unable to afford. MN.IT has managed the expansion of the DHS hosted telehealth network to mental health providers in Region Three. Further stakeholder work would require broader representation: more hospital systems, crisis teams, other telehealth implementers. Establishing a statewide conference or community of practice could help develop and spread best practices.

b. Reserve Capacity for Crisis Response via Telehealth

Minnesota should establish a common pool of telehealth resources for urgent mental health needs. An RFP process would identify a provider to function as a reserve, available when local resources are not able to respond quickly.

If a person calls in to a crisis team during a busy time, a shortage of available responders might mean that they are told that the team cannot respond in a timely fashion. Instead, callers could be presented with options: a timeframe for mobile response, or directions to a site where they could access the telehealth team. Potential local sites could be clinics offering physical urgent care, a hospital without dedicated psychiatric resources, or fire station/paramedic base. The local site would need to be able to provide some level of support: paramedic or triage nurse, and the ability to call for further resources when required. A framework for responsibilities, reimbursement to the local site, and other funding considerations would need to be developed.

¹¹ Lee, D. Director of Public Health & Human Services, Carlton County. "Vidyo Telepresence System Live Demonstration- State Advisory Council and Children's Subcommittee." 10/6/16.

Drawing from a larger pool of potential callers, a more predictable staffing model could be developed for this reserve. Depending on the needs and staffing models of existing teams, they could potentially chose to cover calls from other areas during times when they have additional capacity.

Objectives: Decrease the number of instances where a potential recipient is told that crisis services are unavailable because all staff are already committed to calls. Utilization data from telehealth team would drive further development of the mobile teams.

Timeline: Would require funding, the development of a new team, and the identification of appropriate sites to host the connections in the community. Due to the workforce issues around the state, the location would probably need to be in an area not currently identified as a shortage area: either Metro or southeast MN. It would take approximately 3-6 months post signing of contract to get staff hired, get the equipment up and running and get staff trained in crisis response and in using the telehealth equipment. Host sites may take longer to develop, and host sites will need to train/collaborate with the telehealth crisis providers to work out logistics and team protocols.

Resources: An initial target would be 13 to 15 staff. This would allow 3-4 providers to be available at a time for 3 shifts per day to provide assessments via telehealth.

Staff Costs (Professionals and practitioners available to provide telehealth services)	\$364,000
Administration staff costs	\$24,000
Other Administration/overhead	\$61,000
Total Team Cost:	\$550,000

To develop a new remote site in areas that do not already have the capability, costs for equipment and overhead might be around \$33,000/year based on prior expansions. The staffing needs at those locations could vary based on what services were already present.

Some of these timeframes could be accelerated if teams with existing telehealth capacity were able to contract for portions of this coverage. In some cases it might be more cost effective or expedient to pay for additional capacity in an already existing team.

Partners: 911 responding agencies, counties, existing mobile crisis teams, host site locations, DHS. Implementing hospitals would need buy in from internal stakeholders, especially at the remote sites: physicians, nurses.

2. Pre-service Crisis Intervention Team Training as Required Training for Law Enforcement

Minnesota should implement 40 hours of pre-service CIT training for all officers through the Law Enforcement Academy. In service officers would get 4-8 hours of refresher training every 3 years. Because of the high cost of taking in service officers off patrol for 40 hours, pre-service training is the best approach as Minnesota seeks 100% CIT training for law enforcement. In addition, courses would be

made available for Fire/EMS responders and 911 dispatch staff. Formulation group members expressed interest in integrating training on trauma, including sexual assault.¹²

New officers may be more receptive to training, but each agency will need veteran officers or leadership who are trained and invested in the CIT model. Changes in policy may be needed to realize best outcomes, including clarifying who is the lead officer at a scene involving a mental health crisis.¹³ Trainees should also get information about coping skills and resources for themselves, so that they are better equipped to handle the stresses of responding to crisis situations.

Parallel to this, educators may need more resources and training to help support positive crisis interventions. Minnesota has about 55,000 teachers licensed, with 2400 new teachers in a year.¹⁴ Foundational training, such as mental health first aid, is about \$80/trainee.

Objectives: Increase community and officer safety when responding to mental health related calls by providing CIT training to law enforcement pre-service, and to Fire/EMS responders and 911 dispatchers.

Timeline: Training could be started relatively quickly. However, a focus on pre-service training would mean a lag time before a critical mass of officers would have the training. Current practice has been to restrict the 40 hour course to in-service officers since they have additional context for the training. The Task Force will need to consider this tension.

Resources: Contracts for CIT training have typically been \$650 for a 40 hour training with actors, which is recognized as the highest quality training. 30 people can be trained in a cohort. Minnesota has approximately 650 officers entering service each year, and about 11,000 in service.

Training Type	Persons being trained	Cost per seat	Total per year
Pre-service 40 hour course	800-1300 peace officer candidates, Fire/EMS/911 dispatch personnel in training	\$650 (training cost only, no salary or travel)	\$500,000-\$850,000
4 or 8 Hour refresher, 3 year cycle	3666 currently serving peace officers	\$415 -\$760 (includes salary and travel)	\$1,200,000 to \$2,800,000

¹² Sara Suerth recommended “Understanding Trauma” as presented by Central Minnesota Sexual Assault Center.

¹³ Dupont, R., Cochran, M. S., & Pillsbury, S. (2007, September). Crisis Intervention Team Core Elements. Retrieved October 2016, from University of Memphis CIT Center, http://www.cit.memphis.edu/information_files/CoreElements.pdf

¹⁴ Schools, districts and teachers at a glance. Retrieved October 11, 2016, from Minnesota Education Statistics Summary, <http://w20.education.state.mn.us/MDEAnalytics/Summary.jsp>

Partners: Law enforcement agencies, schools, cities, counties, Fire/EMS services, MnSCU, CIT training organizations, individuals with lived experience, DHS, DPS.

3. Additional Resources Where People Already Seek Help

a. Co-location of Community Mental Health Center staff in Critical Access Hospitals

Minnesota should prioritize the co-location of outpatient mental health services delivered by Community Mental Health Centers into Critical Access Hospitals (CAH). CAH's are 25 bed or smaller hospitals and are eligible for cost-based payment for Medicare/Medicaid. They must be a certain distance from the next available hospital, and most provide primary care and outpatient services in attached or satellite clinics. The underlying value is the recognized need to maintain some level of access to treatment, even in less densely populated areas. Residents of these areas are used to going to the hospital for regular outpatient services, as providers see a mix of clinic and hospital patients throughout the day. Sometimes, it may be the only primary care provider located nearby. Both providers and clients benefit from ease of accessing multiple kinds of care from a single site. Better care of mutual clients, and opportunities for joint system engagement. In crisis situations, mental health staff are on site and can offer consultation. In some CAHs, hospital staff also comprise the local Crisis Intervention Team.

Objectives: Significantly increase access in rural communities to mental health care located in Critical Access Hospitals. As a secondary benefit, those providers would be better able to offer consultation or services on an as needed basis to patients presenting through the emergency department.

Timeline: Prior projects have taken about one year to implement.¹⁵

Resources: Workforce is and will continue to be a significant barrier. Recommendations in the Workforce Report may assist in this process, including development of more rural-focused programs and clinical training through the University and MnSCU systems. Additional funds for targeted student loan forgiveness could also be used. Co-location can reduce capital/overhead expense for the Community Mental Health Center, and can help drive additional patient volume to the local hospital and clinic.

Partners: This proposal would require significant partnership and buy in between hospitals/health systems and Rule 29 Community Mental Health Centers. DHS and MDH would have roles in supporting and monitoring this work.

b. Urgent Care for Mental Health: Integrated Crisis, Psychiatry, and Chemical Health

Minnesota should develop more Urgent Care for Mental Health settings, combining detox (and/or withdrawal management), crisis response team, and urgent access to psychiatry (medication). This model does not have a locked or secure unit, and operates below the inpatient level of care. Data from the East Metro Crisis Alliance shows promising outcomes for individuals who access crisis stabilization. Individuals who infrequently access care saw gains in their connection to ongoing outpatient services. Both low and high frequency service recipients had fewer visits to the Emergency Department as well as

¹⁵ Reitmeier, S. Chief Executive Officer, Northwestern Mental Health. Correspondence. 10/3/16.

inpatient hospitalizations. For patients receiving urgent or gap psychiatry, 1/3rd would have otherwise presented in an emergency department.

This model is focused on Medicaid and other publically funded care. Clinic networks and healthcare systems that focus on individuals with private insurance are more likely to offer reserve appointments in general purpose clinic during daytime hours than a more narrowly focused standalone.¹⁶ The governance group may wish to consider what barriers may exist for such models to adapt for greater integration with health plans and clinic networks.

In 2011-2012, the East Metro Crisis Alliance commissioned a study by Wilder Research to understand the costs and results for the Urgent Care for Adult Mental Health program.¹⁷

- Emergency department utilization decreased significantly post-crisis stabilization for all patients, including “high-frequency” patients.
- Use of outpatient mental health services increased significantly for low-frequency patients following stabilization; no statistically significant change in utilization was observed for high-frequency patients.
- All-cause inpatient hospitalization decreased significantly for all patients, including high-frequency patients. In addition, significant decreases in mental health-related admissions were observed for patients as well.
- A cost-benefit analysis found that for every one dollar spent on Crisis Stabilization services, there is a savings of \$2.00 - 3.00 in hospitalization costs.

Additional data suggests a higher diversion rate (did not need to use Emergency Room or in-patient) among clients who saw a psychiatric provider (able to prescribe medication when appropriate.) In addition, the Urgent Care could connect people with medication assistance programs.¹⁸ As teams reach 24/7 mobile coverage, Minnesota could commit to integrated psychiatry within crisis response as the next benchmark for service.

Objectives: Provide rapid access to psychiatry, crisis stabilization, and urgent chemical healthcare, in a less intensive setting than an inpatient unit.

Timeline: The Urgent Care for Adult Mental Health in St. Paul took about three years from idea to opening. A similar project might proceed somewhat faster based on lessons learned, but construction alone took 20 months.

¹⁶ M. Trangle. Senior Medical Director for Behavioral Health, HealthPartners. Interview. 9/20/16.

¹⁷ Bennett, A. L., & Diaz, J. (2013, May). The Impact of Community-Based Mental Health Crisis Stabilization. Retrieved October 3, 2016, from Wilder Research, <http://www.wilder.org/Wilder-Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/The%20Impact%20of%20Community-Based%20Mental%20Health%20Crisis%20Stabilization,%20Brief.pdf>

¹⁸ M. Trangle.

Resources: This model may be better suited to a broader range of communities than dedicated psychiatric emergency rooms. Some population center is needed to sustain the volume, but it is not as resource intensive as an in-patient unit. The building cost \$9M, and ongoing operations break out as:

- Crisis (includes 24/7 phone services, crisis assessment, crisis stabilization): \$3.2 Million
- Detox: \$3.6 Million
- Chemical Health Placement and assessment unit: \$800,000

These costs were in-line with prior spending in each of these areas when they were not physically collocated. As the project continues, Ramsey County has experienced significant operational improvements and efficiencies. Staff are now being cross trained between programs and better able to respond to ebbs and flows in the needs of the programs. More coordinated and integrated care is being provided, and the collaboration has advanced their ability to achieve a recovery focused model of care.¹⁹

Partners: Counties, Health Plans, DHS, Hospitals, Community Mental Health Centers. Workforce would remain a key issue, additional funds could expand the psychiatry residencies offered at the University of Minnesota.

4. Intersections between Mental Health and Criminal Justice

a. Mental Health/Law Enforcement Co-responder Models

Minnesota should pilot models for embedded mental health providers within law enforcement. While national models are available, some questions will need to be answered as we map those ideas to Minnesota's service spectrum. One major concern will be the availability of a qualified workforce. Nationally, models for co-responders have emphasized having a master's level provider as the embedded person. They have a more significant clinical background, are better equipped to accurately assess risk, and have a licensing board to whom they are also accountable.²⁰ Members of the group affirmed this as an important principle.

One of the key needs that a collaborative or co-responder model can meet is in informing police about the decision making process for assessment and intervention. Law enforcement officers frequently reference the experience of bringing an individual to the hospital, only to encounter them again in a short time period. Without a solid assessment of what (if anything) a hospital might reasonably provide to an individual, the officer's decisions tend to be made on the side of caution, bringing that person to the ER. This gap in expectations results in lost time, inferior outcomes, and significant costs. Minnesota should make a careful assessment of how to best provide for collaboration and communication that addresses that gap. The required workforce is in short supply across the state, with most areas being

¹⁹ Conducy, A. Chemical and Adult Mental Health Manager, Ramsey County Community Human Services. Correspondence. 10/7/16.

²⁰ Smith-Kea, N., Yarbrough, M., & Myers, S. (2016, September 28). Police-Mental Health Collaboration Programs: A Different Way of Policing. Retrieved October 04, 2016, from <https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/>

designated as Mental Health Professional Shortage Areas (MHPSA).²¹ The time that the embedded mental health professional spends in ride-alongs and engaged in other non-clinical work can help bridge healthcare and law enforcement cultures. However, many communities already struggle to hire and retain the workforce needed for clinical services.

The other major need addressed by different co-responder models is proactive outreach to individuals who come in frequent contact with crisis providers and law enforcement. Models in Texas and California emphasize this function. In most cases the mental health provider is leading the conversation, and the officer is there to build trust in the event law enforcement does have to respond to that person in the future. Health providers, such as case managers, seek a release of information that covers the mental health team on the law enforcement agency.²² Another related service can be follow up to communities or individuals affected by trauma and violence in the community, even if the original incident was not related to mental health. Minnesota should carefully consider how closely these roles should be tied to law enforcement. Case management and ACT teams should be accepting referrals for service from police. But it is not always clear where that service benefits from additional police involvement.

Some co-responder models are a standalone unit within a police department. The mental health provider is directly hired and is accountable to that agency. Others are a collaboration between mental health crisis services and law enforcement. These providers already have expertise in crisis assessment, intervention and stabilization. They cover distinct geographic regions, and have 24/7 access to a mental health professional, even if the assigned “embedded” clinician is not on duty.²³ Because Minnesota already has a county based mental health crisis response infrastructure, this may be a better match. This may reduce the likelihood of co-responders becoming another service silo that is not connected with other resources. Minnesota could focus additional grant funding to support co-location of existing crisis teams with law enforcement, or to pay for time spent in ride-alongs or other collaboration.

With any of these models, racial disparities are a possible collateral consequence. Communities that have significant levels of mistrust towards police may be less likely to call for crisis services if they believe that they are connected to law enforcement. Another significant factor in long-term outcomes is the strength of the community services to which individuals are being redirected. Despite differences in various co-responder models, a common point is that a mental health provider assists law enforcement in making choices about disposition related to mental health. If the choices they have available are insufficient, the co-responder model will struggle.²⁴

²¹ Health Resources and Services Administration.

https://datawarehouse.hrsa.gov/ExportedMaps/HPSAs/HGDWMapGallery_BHPR_HPSAs_MH.pdf

²² Smith-Kea, N., Yarbrough, M., & Myers, S.

²³ Abbott, S. Advocates Jail Diversion Program: A Step by Step Toolkit. Page 4.

²⁴ Helfgott, J.B., et al., A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program, *International Journal of Law and Psychiatry* (2015), <http://dx.doi.org/10.1016/j.ijlp.2015.08.038>

Objectives: Provide timely, on-scene assessment of an individual's needs and possibilities for diversion to community resources. Proactive outreach to individuals who come into frequent contact with hospitals, crisis services, and law enforcement.

Timeline: From planning to operation, co-responder programs have taken 1-2 years to develop. Workforce will be a significant challenge.

Resources: A mental health professional's salary/benefits might run from 90,000-104,000/year. Staffing levels might vary significantly based on population density.

Partners: Law enforcement, crisis teams, community mental health providers.

b. [Expand Diversion Options for Juveniles in the Criminal Justice System](#)

Minnesota should build on diversion programs to address the needs of children whose primary need is mental health treatment. When a juvenile has mental health needs and is involved in the criminal justice system, the existing tools don't always work to provide best outcomes. Using delinquency proceedings can mean significant collateral consequences for the child: self-identification as a delinquent, restricted access to therapeutic settings, family separation, and additional stress from an uncertain process.

A Child in Need of Protection (CHIPS) petition is framed for children whose needs include an unsafe home environment. The enforcement mechanisms are about actions the parents will take, not the child. A child with serious emotional disturbance may not be safe to return home, not because their family is neglectful or abusive: simply because their needs dictate a different setting. After 12 months, a CHIPS petition must be considered for permanency, which can lead to termination of parental rights. Children and families dealing with significant emotional disturbance need services, not separation.

Meanwhile, if a child is directed into Rule 20 proceedings, some parents may be less supportive of treatment because they wish to prevent the consequences of the criminal proceeding for their child. A child with significant needs might not be able to meet the standards for competency, and stay in limbo through Rule 20. Some of the best therapeutic settings a child might be placed into are not open to individuals with prior delinquency proceedings.²⁵

Objectives: Provide high quality diversion options for youth with mental health needs and criminal justice involvement, following model developed in Stearns County. Identify services and supports needed to maximize safe and therapeutic outcomes for high needs children.

Timeline: Prior projects have taken 1-2 years to develop.

Resources: Significant realignment of current resources. Adding specialized mental health expertise into juvenile courts.

Partners: Law enforcement, child protection, residential programs for children, courts, community mental health providers, schools.

²⁵ Mahoney, B. Family & Children Services Division Director, Stearns County. Interview. 10/6/16.

5. Improved Data Sharing and Collaboration

a. Continue to Build on RARE and e-Health Roadmap

Between 2011 and 2014, the Institute for Clinical Systems Improvement (ICSI), the Minnesota Hospital Association (MHA) and Stratis Health embarked on an initiative to reduce avoidable hospital readmissions: the Reducing Avoidable Readmissions Effectively (RARE) campaign. They focused on comprehensive discharge planning, medication management, patient and family engagement, transition care support, and transition communications. All of these are factors for individuals at risk of mental health crisis, or who have recently experienced one. The campaign enjoyed significant success, and is credited with preventing 7,975 readmissions for a total of 31,900 avoided bed days (all causes).

Staff turnover or a lack of identified ownership for these projects can undo progress. Minnesota can continue to improve by increasing the quality of resource databases, seeking longer staff retention in care planning roles, and reinforcing recovery and coping skills in discharge plans.²⁶

As part of a State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and of Human Services in 2013 by the Center for Medicare & Medicaid Innovation (CMMI), stakeholders have created the Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services. The Roadmap process was structured, sequential, and integrated the diverse issues of priority settings, including mental health. The steering team, with 25 individuals, and the workgroups, with over 50 subject matter experts from the priority settings, met over 40 times from January 2015 to June 2016.²⁷

Minnesota will need to dedicate time and resources to implementing these findings to better use health information. This includes significant impacts on crisis situations. If healthcare and social service resources are not coordinating efforts, a breakdown in supports can easily trigger a crisis. A lack of understanding where else a person has sought help might mean missing the red flags that a person is at significant risk.

b. Uniform Storage and Access of Advance Directives/Crisis Plans

Some states have created a centralized registry of advance directives. Individuals complete their plans and store them through a secure online portal.²⁸ They may print a wallet card with a bar code or store information on their phone that links their name and registry ID. In case of an emergency, a healthcare provider can access their documents with the individual's name and registry ID or date of birth. Minnesota could implement an option for individuals declare that they wish to have information disclosed to law enforcement in a crisis situation. While a registry does not necessarily mean the

²⁶ Kemper, J. Health Care Consultant, Institute for Clinical Systems Improvement. Interview. 10/5/16.

²⁷ "Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services." Published June 6, 2016. <http://www.health.state.mn.us/e-health/ehealthdocs/roadmap.pdf>

²⁸ Models reviewed: Virginia, California, Idaho.

advance directive is integrated directly into the patient record, it does allow for the person to present at any healthcare provider and still have that information be accessible.

Objective: Provide a centralized location for Minnesotans to store their advance directive or crisis plan, and know that it will be accessible to the proper responders in an emergency.

Timeline: The Virginia registry took about three years from legislation to launch.

Resources: Various funding models exist for registries. Idaho charges \$10 to file a directive, Virginia has entered into a public/private partnership to cover the costs, and Arizona makes a general fund allocation of ~\$60,000/year.

Partners: MDHS, MDH, stakeholder community from prior work.

6. Further Improvements to Community Services

a. Expand Forensic ACT Capacity

Minnesota should invest in specialized Forensic Assertive Community Treatment teams to meet the needs of individuals at risk of future/continued involvement in the justice system due to their mental health needs. This follows a recommendation in the 2016 Office of the Legislative Auditor report on mental health care in jails.²⁹

Assertive Community Treatment (ACT) is an evidence based service for people with severe mental illness (specifically schizophrenia and bipolar disorders) and is a multidisciplinary, team-based approach with a small staff to client ratio and 24/7 hour staff availability. ACT is a non-residential service, working with clients in the community, and provides all treatment, rehabilitation, and support needs from within the team (e.g., services not brokered out to other providers). ACT is sometimes described as a “hospital without walls”.

Forensic assertive community treatment (FACT) is an adaptation of the traditional model that is designed to help clients that have higher risk of repeated involvement with the criminal justice system or incarceration, than traditional ACT clients. This is a highly underserved population with complex challenges that require a high level of treatment, rehabilitation and services in order to more successfully re-integrate back into their communities. One FACT team is already operating, as a collaboration between the Department of Corrections, Department of Human Services, Ramsey County, and South Metro Human Services. Hennepin County is also starting a FACT team to work with clients who enter the county jail or are involved in the Mental Health Court.

Objectives: Provide high quality community based mental health services to individuals at high risk of future involvement in the criminal justice system. Reduce jail and hospital bed days among individuals served.

²⁹ Alter, J. (2016, March 3). Mental Health Services in County Jails. 41. Retrieved October 11, 2016, from <http://www.auditor.leg.state.mn.us/ped/2016/mhjails.htm>

Timeline: Prior expansion has been done at about 1-2 teams per year. The staffing requirements to meet fidelity standards are rigorous, and it may be difficult to find qualified individuals any faster.

Resources: Prior ACT team expansion has required technical assistance and grant funding from DHS. The rate a team has is based on prior costs, and so the year in which they build up to a full case load can require additional funding. Adding 4 teams, each with the capacity to serve about 70 individuals in a year would cost approximately \$5M.

Partners: Counties, jails, Department of Corrections, DHS, community mental health providers.

b. [Expand Pre-Crisis Services](#)

Many individuals are frequently near a crisis state, and it may take them time to begin to find and accept resources for change. One way to augment clinical services and help individuals reach the next goal in their recovery is the use of Certified Peer Specialists (CPS). Mental Health Minnesota operates a “warmline,” which provides a safe, accessible resource for individuals working on their recovery. As the name implies, it is not intended as a “hotline” capable of responding to individuals who are feeling suicidal. It fills an important gap between outpatient care and crisis response.

The Minnesota Warmline is currently available statewide during evening hours (4pm – 10pm) Tuesday-Saturday, and provides support and stability for callers who need to connect with someone urgently. Individuals may call anonymously if they wish, and get the support they need to use their own resources and problem solving skills to address their immediate needs. Approximately half of the callers are experiencing significant stress or anxiety when they call, while the other half are reaching out to break isolation. Nearly 90% of callers report feeling calmer by the end of the call.

Warmline operators are CPS trained. The CPS model gives individuals who have experienced mental illness the framework for *supporting* others by modeling healthy behaviors, asking the individual to recall previous tools or strategies that have been successful, and offering hope that recovery is possible. Minnesota should support and promote warmline services as an adjunct to crisis services to help individuals avoid more intense needs.

Objectives: Provide one number access to moderate intensity peer services for all Minnesota residents.

Timeline: Hiring and training additional peers and additional clinical supervision may take 2-3 months after funding is allocated.

Resources: This program handles nearly 500 calls/month during its open hours (30 hours/week), with the number of calls increasing every month. The Warmline currently operates on a monthly budget of \$8,000. Goals for continued expansion would include adding expansion of hours (adding Mondays, 4-10 PM), increasing the number of operators available (minimum of three operators instead of the current two), and clinical supervision. An expanded program would require additional Certified Peer Specialists, and clinical supervision to support them (with an estimated need of \$170,000 in additional annual funding necessary for expanded service).

Partners: Counties, mobile crisis teams, health systems, certified peer specialists.

c. [Support Inpatient Formulation Group on expanding capacity and discharge options](#)

The crisis formulation group voices support for the recommendations forwarded by the inpatient group on IRTS expansion and permanent supportive housing. Many communities in Minnesota lack sufficient in-patient or residential capacity for individuals in crisis. These steps are needed to ensure the availability of the right services at the right time for individuals with acute needs.