

Crisis Triage and Hand-off Process

Minnesota Department of Human Services
Community Supports Administration
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Olmstead Plan Language

Supports and Services section

Action Three: Build effective systems for use of positive practices, early intervention, crisis reduction and return to stability after a crisis.

By August 1, 2014, a coordinated triage and “hand-off” process for crisis intervention will be developed and implemented across mental health services and home and community-based long-term supports and services with the goal of increasing timely access to the right service to stabilize the situation. Report will be delivered to the Olmstead Subcabinet.

-Minnesota’s Olmstead Plan – November 1, 2013 (proposed modifications July 10, 2014), page 66.

Introduction

Crisis is defined as a condition of instability or danger that constitutes a turning point in a person’s life. Crises occur where people live and work, in big cities and wide-open spaces, when people are alone or in community, during office hours and in the dead of night. The requirements for reliability across all support systems, ensuring that there is early crisis planning and immediate crisis response, as well as the gravity of the consequences if the response is not provided, demands extraordinary levels of systems coordination, integration, and synthesis.

The overarching goal of crisis services is to provide timely and appropriate support to people who are experiencing significant instability in their lives or are facing eminent danger. The term “crisis” covers a range of situations, such as those prompted by the loss of a caregiver or a significant change in a medical or health condition, that compromise the ability of a person or that person’s support system to manage their symptoms or behaviors to such an extent that there is potential for serious harm to the person or others.

A response that is activated only when physical safety of the person or others is compromised is often “too little, too late” or “no help at all” in addressing the root of the crisis.”¹ Effective crisis services, therefore, constitute an interconnected network of supports before, during, and after a crisis episode, during which appropriate responses must also meaningfully address the issues underlying the crisis.

Minnesota currently offers crisis services to people with disabilities through different service systems—community-based mental health services, home and community-based services, and state operated facilities. These three systems have different definitions of and responses to “crises.” These differences are part of the underlying issues that lead to gaps in the crisis response system.

¹ [Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009.](#)

Background Information

Current services

A number of existing efforts and planned initiatives are underway to serve people in crisis. There are themes around which these efforts and initiatives can be grouped, as follows:

Case Management: Related services include Community Support Services Crisis Teams; Metro Crisis Coordination Program in the seven county Twin Cities metro area; adult mental health crisis response teams, who routinely see clients in rural hospital emergency departments or jails; and an array of children's mental health services. Crisis response teams are expected to develop regional collaborations with law enforcement, probation officers, schools, case management, and emergency departments for referrals and to know when and how to access crisis services. Case managers are encouraged to develop crisis/relapse prevention plans as part of the individual's Community Support Plans. Crisis plans become part of a person-centered plan that seeks to proactively address both positive as well as challenging behaviors in the community. With the recipient's consent, these plans are shared with the mental health crisis response teams. Adult protective services is a 24/7 county-based common entry point for reporting suspected maltreatment of a vulnerable adult screening for immediate need for protective services or law enforcement, and referral to lead agency to investigate the alleged maltreatment. Additionally, there is a 2015 legislative proposal for enhanced crisis wrap-around services for persons with Community Alternatives for Disabled Individuals (CADI), Brain Injury (BI), and Development Disability (DD) waiver services that had two or more behavioral-related hospitalizations in the previous calendar year.

Mobile Crisis Response Services: The mental health services system includes mobile crisis response teams in 79 counties and one tribe.

Training for Community Capacity: Mental health crisis teams provide community intervention with families and other affected persons; children's mental health services include families and guardians in service design and evaluation; Community Support Services provides training, mentoring, and coaching to clients and others, technical assistance to divert commitments and address crises; and the Minnesota Family Investment Program is developing short- and long-term crisis planning for families with children with mental illness.

Short-term Residential Crisis Stabilization and Respite Capacity: Crisis stabilization beds are available for short-term crisis services for adults; Minnesota Intensive Therapeutic Homes (MITH) Respite offers 30-day crisis return to forensic transitions to prevent revocation of provisional discharge; residential crisis stabilization facilities (licensed as either Intensive Residential Treatment Services or Adult Foster Care) provide structured living for adults who are fragile or are experiencing a crisis; the state-operated Life Bridge program provides housing and support during transitions; currently there are 16 crisis respite beds (≤90 day stay) available statewide for persons with developmental disabilities. There is also in-home crisis respite service available for persons who are on the Developmental Disabilities waiver.

Sustainable and Flexible Funding: A number of services are paid through federal waivers. In addition, services are funded through third-party payer billing, grant funding, county funding, state funding, medical assistance, and the Medicaid State Plan.

Technology-Assisted Consultations: Telepresence is implemented in 18 southwestern counties for Assertive Community Treatment teams, emergency rooms, and psychiatrists for consult; mental health crisis teams are beginning to use telepresence to assist mental health practitioners; Community Support Services Crisis consultation and telepresence is under expansion in the Southern Cities Clinic; and the Phase II Telepresence Option is being planned.

First Episode of Psychosis: A cross-divisional workgroup designed a proposal to strengthen the state's capacity to provide early identification and intensive intervention services for children and adults who have a first episode of psychosis.

Understandable and Accessible Information: The MNhelp.info Network provides objective information to individuals to help them make decisions about services; culturally-specific grants are available to help with outreach to diverse communities. There are recommendations in place for reforming case management to make services more accessible and less duplicative.

Help People Retain Housing: The Crisis Housing Fund provides temporary rental, mortgage, and utility assistance for persons with serious and persistent mental illness while they receive mental health treatment.

Provider Training: Positive support strategies and guidelines on emergency use of manual restraints, and a legislative proposal to provide training between Community Support Services teams, Metro Crisis Coordination Program, and Assertive Community Treatment teams to enhance competency of treating individuals with complex comorbid conditions.

Long-Term Monitoring: Community Support Services Extended Supports provides long-term monitoring for up to 75 individuals with clinical complexity and intellectual disabilities.

Post-Discharge Psychiatric Consultation: Consultation for individuals recently discharged from St. Peter Security Hospital, Anoka Metro Regional Center, and from community behavioral health hospitals where the discharge planning team determines that ongoing post discharge monitoring provided by psychiatrists and psychologists would be essential to successful community placement.

Crisis-related barriers to achieving integration

Although there are a number of crisis-related services, there are a number of barriers that currently exist in access, available services, and follow-up for people in crisis. The examples below help to illustrate the issues that are not yet adequately addressed.

Layering Effect: People with co-occurring conditions, such as those with both mental illness and developmental disabilities, may be treated and stabilized in crisis but end up back in the system because of the complexity of treating the co-occurring conditions. Or, in times of crisis they may not be able to

connect in a timely fashion with providers who have the necessary skills to support them, resulting in what may have been avoidable moves back to more restrictive settings. For example, at times the underlying mental health needs are not adequately addressed by providers of developmental disability services. Similarly, mental health providers may use talk-based therapies that are not well-targeted to the needs of people with developmental disabilities. If the mental health needs of people with developmental disabilities or brain injury are not met as they emerge, there can be further complications such as drug use, homelessness, and chronic physical disease. Another example is, when people are using services from different systems, there can be confusion about where to turn in a crisis. This can be particularly true for people who have recently transitioned from a more controlled setting to a more integrated setting.

Housing for Persons with Behavioral Issues: People with mental illnesses, dementia, developmental disabilities, or other disabilities who have experienced crisis may be admitted to psychiatric inpatient hospital units or other institutional settings without community options for re-establishing housing, or their options for future housing may be limited to sites far from their home communities when they can no longer stay in their former domiciles because of behavioral issues. There may be barriers to reestablishing housing, such as those found when subsidized housing sites screen out individuals with a history of violence or other behavioral issues.

Lack of Experienced, Trained Staff: Direct support workers may not have adequate training, experience, or assistance available to deal with crisis situations. When crisis situations arise, these staff may not be able to address the situation themselves, and also may not have access to someone in their organization with the appropriate skills. Providers may not be aware of the range of services that are available to help them with crisis incidents, and may not be knowledgeable about trauma-informed care, which can help providers identify the triggers of behavior that cause a life crisis.

Crises outside the Home: Crises may occur in the community, such as school, a day service program, or a vocation setting. Most interventions are focused on supporting the person in their home or residential setting.

Measurable Goals

Following are measurable goals that will result from Minnesota's efforts to improve the crisis system for people with disabilities. **These goals are dependent on funding requests currently under consideration in the 2015 legislative session.** *Note: Goal below builds to an increase of 500 people.*

In 2015

- Baseline of 7,045 people will receive crisis services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention.
- Expand DHS data reporting system to include elements for tracking this goal.
- Metro Crisis Coordination Program (MCCP) will begin providing specialty telephone consultation 24 hours a day to mobile mental health crisis teams who are serving people with traumatic brain injury or intellectual disability who are experiencing a mental health crisis.

In 2016

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,170 metro-wide - 125 people over the baseline of 7,045).
- Of the additional 125 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation. (*Note: this is our baseline year. The number will be adjusted as needed.*)
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 38 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2017

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,295 metro-wide - 250 people over the baseline of 7,045).
- Of the additional 250 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 63 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2018

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,420 metro-wide - 375 people over the baseline of 7,045).
- Of the additional 375 people who will receive crisis response services, half will receive immediate face-to-face services and half will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as is safely possible given traffic and weather.
- 94 people who receive immediate face-to-face services will be able to remain in the community rather than be admitted to a hospital.

In 2019

- 125 more people will receive crisis response services: information and referral, phone consultation, face-to-face intervention within 24 hours, or immediate face-to-face intervention (7,545 metro-wide - 500 people over the baseline of 7,045).
- Of the additional 500 people who will receive a crisis response service, half (250) people will receive immediate face-to-face services and half (250) people will receive information/referral or consultation.
- Each person needing immediate face-to-face services will receive these services in 30 minutes or as soon as safely possible given the traffic and weather.
- 125 people who receive face-to-face services will be able to remain in the community rather than be admitted to a hospital.

Process to Develop Strategic Approach

Community participation

Community members, particularly those who use public services, their families, advocates, service providers, and community partners, such as counties and tribes, all play a critical role in helping shape how public services are designed and delivered.

Within the last couple of years, as the Olmstead Plan was written and implementation began, there have been numerous ways in which the public engaged in processes that contributed to the development of the framework described in this report. The following list highlights some of this work.

- The Department of Human Services conducted numerous focus groups with people who use services, such as those organized through the National Alliance on Mental Illness Minnesota in planning the Minnesota Behavioral Health Homes.
- People who use mental health services and their families meet (typically) monthly to discuss adult mental health initiatives.
- The State Advisory Council on Mental Health consists of stakeholders representing all facets of the mental health system. The Local Advisory Workgroup, a subset of the Council, is made up of individuals with a lived experience of a mental illness, family members, and a county provider. The Subcommittee on Children's Mental Health provides recommendations to the Council. It is comprised of parents, people who presently or formerly used adolescent mental health services, and other stakeholders.
- Certified Peer Specialists quarterly networking
- Offenders with Mental Illness Workgroup
- Mental Health Improvement Workgroup
- ADAD Tribal and Citizen Advisory Council
- Community First Services and Supports and Money Follows the Person Implementation Council
- State Quality Council
- Traumatic Brain Injury Advisory Committee
- Autism Spectrum Disorder Advisory Council
- Home and Community Based Services Settings Rule forums
- Autism public meetings and other input opportunities
- Tribal listening session on people with brain injury and releases from correctional facilities
- Gaps analysis surveys and focus groups
- Olmstead Plan development process, including Olmstead Plan Committee, public meetings, and public comment period

State work groups

State-led work groups contributed to the development of the plan presented here and included people from a broad array of perspectives, including from the following:

- Adult mental health
- Children’s mental health
- Disability services
- State-operated services
- County crisis services
- Youth services
- Minnesota Department of Health
- Minnesota Department of Education

In addition to participation in work groups, community subject matter experts contributed feedback and advice.

Strategic Approach to Crisis System

Minnesota is undertaking transformative systems change to achieve the goal of having people with disabilities living in the most integrated settings, being fully engaged in the community of their choice, and pursuing their own life goals and interests. This transformation will take years to fully realize, and our wide-reaching, cross-sector approach needs to be strategic to be feasible and successful. The crisis triage and hand-off concept, which is the focus of this report, fits within a broader strategic approach to crisis response and intervention. And, in turn, the crisis strategic approach interlocks with other key strategic focuses, such as building a person-centered culture, effective transitions, increased access to housing, and competitive employment. The barriers identified in the earlier section are addressed in various ways across these strategic focuses as well as in the crisis area.

The three-pronged approach to improving crisis response and intervention services includes: 1) improving crisis triage and hand-off; 2) use of positive supports and person-centered planning; and 3) mental health system reform.

Crisis triage and hand-off

The intent of the statewide crisis triage and hand-off system is to efficiently get people to the best service for them in times of crisis, and to ensure that the hand-off between providers is effective. To do this, the state must develop a statewide, integrated, crisis information, intake, referral, and assessment network model. The intent is to have a centralized point of entry, that people in crisis contact in a crisis, regardless of their diagnosis or what type of services they provide (e.g., community-based mental health services, state-operated services, waiver services).

This is envisioned as a single statewide phone number. The people staffing the phone/portal will provide an immediate response to requests for crisis services statewide with appropriate triage and coordination among crisis services. They will be skilled in crisis assessment and determine both the urgency of the need intervention, and the most appropriate provider for that intervention. They will be well-versed in the services that are available across the state and who they serve.

The access, intake, and processes for service delivery determination and authorization will be seamless to the person. Having a single point of entry, staffed by skilled providers, will decrease confusion, duplication of effort and gaps, resulting in callers getting to the right service in a timely manner. This is crucial as timely, appropriate intervention is the best way to stabilize crisis situations.

In addition to getting the person to necessary services, the intent of the centralized triage system is to ensure that crisis services are delivered in the least restrictive setting possible.

Another key feature of the centralized system is that the triage providers will follow-up with the callers to see if the person actually connected with and received the appropriate service in a timely manner. If there are problems identified, the triage system can work to resolve them, if that is possible, or, at a minimum, record the system failure.

One of the benefits of a centralized system will be the opportunity to track meaningful data that will be used to help us measure the success of the system, identify gaps, and continuously improve the state triage system.

For example, the system will be designed to track data, such as:

- Response times
- Crisis resolutions
 - Resolutions that result in the person remaining in their home, returning home from a medical facility, i.e. ER/urgent care, etc.
- Outcome comparisons by access route, geographic location, population, etc.
- Crisis interventions initiated in psychiatric hospitals, other hospitals and other facilities despite the individual not meeting requirements for those levels of care

While the current system is fragmented, it does have strengths upon which the model can be built. The state will strategically develop this network in phases, using the opportunities and strengths that are available.

Developments in technology in recent years are a great boon to this kind of effort.² Some parts of the crisis response system are already beginning to make use of tele-presence technology.³ Another existing strength is that Minnesota already has pieces of a 'centralized' system for crisis response. Specifically, within the Twin Cities metropolitan area, mental health services are already using a central point of access and triage protocols.

² For example, Minnesota operates technologically integrated systems (i.e., MNhelp.info Network and its Senior Linkage Line, Disability Linkage Line, and Veterans Linkage Line) that support people, help them navigate complex service systems, connect policy and service professionals in 'real time', follow-up with them, and track/measure the effectiveness in achieving meaningful outcomes for people.

³ Community Support Services (CSS) Crisis Teams, Southern Cities Clinic use telepresence and 18 counties in southwestern Minnesota also telepresence for consultation between Assertive Community Treatment (ACT) teams, emergency rooms, and psychiatrists.

The first phase of developing a statewide triage system is currently underway and expected to last through June 2015. This work centers on defining the roles and responsibilities within the state-operated services and county and provider system of waiver services. These two systems are administered by the Department of Human Services Direct Care and Treatment Administration and the Disability Services Division of the Community Supports Administration, respectively. They support many people with co-occurring conditions, people who are moving from segregated settings to more integrated settings and people who are at high risk of experiencing crises and returning to segregated settings.

Building upon the first phase, also in 2015, the second phase will involve building the statewide triage and hand-off system. This work will center on adding mental health services that are administered through the Adult and Children's Mental Health Divisions of the Community Supports Administration into the project. This phase will include planning and initial implementation. Implementation will begin with realigning currently available resources and continue as resources and opportunities become available.

Also in 2015, there is proposed legislation to build a single statewide number for all mental health crisis services. If this is enacted, it will provide a significant platform upon which to build the single triage system for all disability-related crises (i.e., mental health and/or behavior-related crises).

Positive supports and person-centered planning

Promoting statewide use of positive supports is one of the three-prongs of Minnesota's crisis strategy. The term *positive supports* refer to practices that are person-centered, encourage self-determined behavior, build on social and emotional skills, and take a person's physical, social and mental health into consideration. Positive supports include strategies that teach people productive ways to deal with stress. These supports are essential to eliminate the use of prohibited procedures, avoid emergency use of manual restraints, and prevent physical harm to the individual and others.

The use of positive supports has been proven to be effective in preventing problem behavior and helping a person gain new skills or alternative behaviors to participate effectively in community life. Problem behavior can trigger a crisis situation; the use of positive supports, therefore, is a strategy for avoiding crises.

Person-centered planning is the foundation for positive support practices. Pro-active person-centered planning and assessment anticipates, prevents, and/or responds in a timely way to potential or actual crisis situations, in a way that promotes maintaining individuals in the community, particularly for people with co-occurring conditions.

In October 2014, the Minnesota Departments of Human Services and Education produced a report entitled *Minnesota's Statewide Plan: Building Effective Systems for Implementing Positive Practices and Supports*. The report provides a framework for organizing policies, technical assistance, and resources to ensure people receiving services, are treated with respect, and receive the support they need to live independent, self-determined, and meaningful lives in their home communities. The plan described in

the report will be successful by a) designing and implementing technical assistance that involves teaching organizations to embed the values and vision outlined in the Minnesota Olmstead plan into the everyday actions taken by individuals providing services, and b) working collaboratively with stakeholders who represent people receiving services across the lifespan, family members, caregivers, advocates, practitioners, and community members. The report represents a first step in the state-wide planning process. The plan itself will continue to be refined and updated as it is implemented.

The plan identifies six implementation goals: 1) establishing a technical assistance infrastructure across agencies, 2) designing and implementing strategies for data-based decision making and evaluation, 3) creating a marketing plan for increasing awareness of positive supports across the state, 4) expanding pre-service and aligning in-service training systems state-wide, 5) developing and maintaining an inventory of policies related to restrictive practices and positive supports, and 6) expanding interagency crisis prevention planning. A graphic illustration of the logic model for the plan appears in Appendix A.

Mental health system reform

Minnesota's mental health infrastructure is insufficient with many gaps, poor measurement, and insufficient service availability. Gaps in the system can mean that opportunities for early intervention are missed and crisis situations arise. Gaps in the system can mean that when there is a crisis situation the intervention takes place in a more restrictive setting than is necessary. Sometimes people in crisis go into a segregated setting and, once there, encounter barriers to moving back into integrated settings.

Minnesota has a package of mental health reforms before the Legislature in 2015 that address several of the gaps listed on page 3 in this report. More information about these reforms is in Appendix B.

Prevention and early intervention

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.
- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.
- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.
- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all mental health crisis services.
- Improve consistency and quality of crisis services.
- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.
- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

Reform and enhance Minnesota's mental health treatment system

- Analyze the state's payment structure for mental health services and develop reforms to stabilize the state's financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.
- Enhance the state's community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.
- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

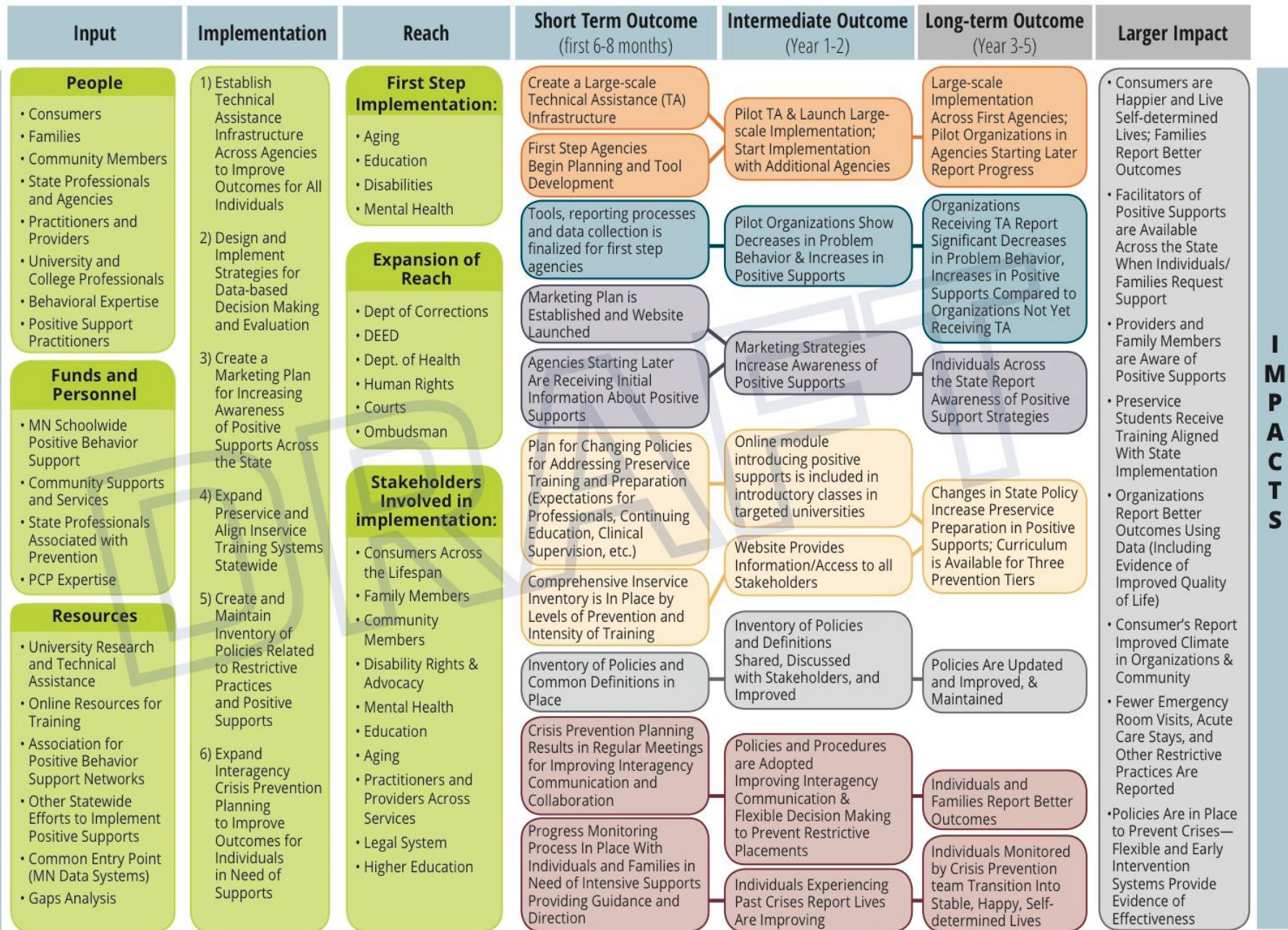
Expand capacity to care for children and adults with complex needs

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.
- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.
- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.
- Create a public psychiatry track in the University of Minnesota's residency program.

Promote and support recovery

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.
- Enhance the quality of current Assertive Community Treatment services.
- Expand high quality Assertive Community Treatment services across Minnesota.
- Develop a Forensic Assertive Community Treatment Team to serve people involved with the criminal justice system.
- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.

Appendix A: Positive Supports Implementation Plan Logic Model

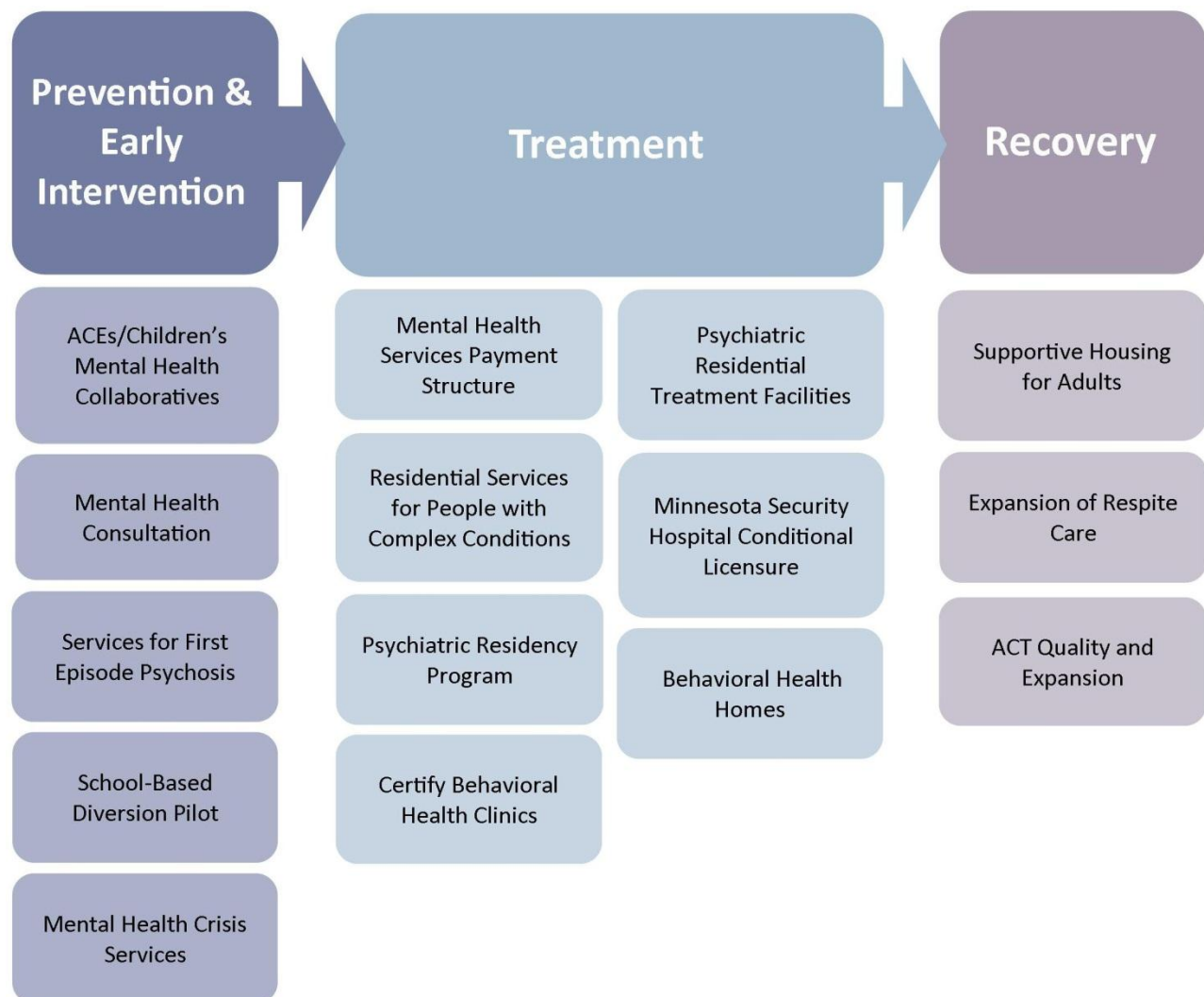


Appendix B: Mental Health System Reform Proposals

2015 Mental Health Reform

The Problem	The Solution	The Impact
Minnesota's mental health infrastructure is insufficient with too many gaps, poor measurement, and insufficient service availability.	A continuum of care that includes: <ul style="list-style-type: none"> • Mental health promotion and mental illness prevention • Clinical service stability and quality • Community supports 	More than 230,000 adults and 75,000 children with mental illness and their families will have the services available they need.

Building a continuum of mental health care for all Minnesotans



Current opportunities

Problem:

Minnesota's Mental Health System is Fragile:

- Residential services are in demand but capacity is shrinking. The Woodlands Center Intensive Mental Health Service (IRTS) closed earlier this year and others are in financially precarious positions.
- Community mental health services are vulnerable. Riverwood Community Mental Health Center, which served some 3,000 clients, closed suddenly in 2014.

Problem:

Existing Community Capacity Does Not Meet Needs:

- Minnesota lacks community-based services for adults, especially those with the greatest needs. Anoka Metro Regional Treatment Center has a waiting list of over 75.
- Intensive children's services are not available in Minnesota. There are between 300-400 children each year with aggressive or self-injurious behaviors whose needs cannot be met.
- Prevention resources are limited. Focus has been on treatment and interventions, leaving prevention and early interventions behind.
- Minnesota has a severe mental health workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.
- Employment supports need to be expanded. People with serious mental illnesses in Minnesota have an 80 percent unemployment rate.

Problem:

Housing services are insufficient for those with multiple service needs

- Over 50 percent of children and adults in Minnesota who are homeless live with a mental illness.
- Residential reimbursement rates are inadequate. The average monthly room and board costs for Intensive Residential Treatment Services (IRTS) and residential crisis providers are \$1,210 per client. The current monthly group residential housing rate is \$876 per client.
- Capital improvements are not covered in current rate structure.
- Lack of treatment services for the most acute children and adults. The system does not have adequate resources for the most aggressive clients.
- Some children's services are not available in Minnesota. We have between 300-400 children each year who would be best served in Psychiatric Residential Treatment Facilities
- There is a workforce shortage. Most of Minnesota is designated as a Mental Health Professional Shortage Area.

2015 Reform Initiatives

Build a More Solid Foundation of Prevention and Early Intervention

Mental Health Consultation for Early Childhood Providers

- Offer training and consultation for staff at 250 child care centers. Provide assessments and treatment for 1,250-2,500 children with mental health concerns.

School-Based Diversion Pilot for Students w/Co-Occurring Disorders

- Pilot a new model to help schools support students with mental health and substance use disorders in order to reduce arrests, expulsions and suspensions, while increasing referrals for treatment and services.

Services and Supports for First Episode Psychosis

- Strengthen the state's capacity to serve youth (16-26) with early signs of psychosis and bridge gaps between children's and adult mental health services.

Mental Health Crisis Services

- Increase availability of mental health crisis services, moving toward a goal of 24 hours statewide coverage for both children and adults.
- Establish one statewide number for all crisis services.
- Improve consistency and quality of crisis services

Expansion of Respite Care

- Expand children's mental health respite care grants to serve 500-1,000 additional children and their families.

ACEs/Children's Mental Health & Family Services Collaboratives

- Provide training on Adverse Childhood Experiences to 5,000 community partners, parents, and providers. Support local efforts to provide earlier intervention.

Reform and Enhance Minnesota’s Mental Health Treatment System

Stabilize and Reform Mental Health Services Payment Structure

- Analyze the state’s payment structure for mental health services and develop reforms to stabilize the state’s financially fragile mental health system.
- Provide grant funding to stabilize intensive mental health services infrastructure (IRTS/RCS/ACT).
- Provide an immediate rate increase for mobile crisis services to retain current services and promote expansion.

Certify Behavioral Health Clinics

- Enhance the state’s community mental health centers, which are the foundation of the public mental health safety net.
- Apply for Federal demonstration project to implement improvements and receive 90 percent federal financial match.

Behavioral Health Homes

- Implement Behavioral Health Homes to provide integrated psychical and mental health care.

Expand Capacity to Care for Children and Adults with Complex Needs

Establish Psychiatric Residential Treatment Facilities

- Establish Psychiatric Residential Treatment Facilities (PRTF) to support children with very serious mental illnesses who are going unserved.
- Establish extended-stay hospital psychiatric beds, on a contract basis, for youth in need of intensive services on a longer term basis, including those currently served at the Child and Adolescent Behavioral Health Services (CABHS) program.

Residential Services for People with Complex Conditions

- Create three new Intensive Residential Treatment Service (IRTS) programs for people transitioning from Anoka-Metro Regional Treatment Center.

Minnesota Security Hospital (MSH) Conditional Licensure

- Sustain improvements at MSH including more clinical services, strengthened treatment teams, and increased programming opportunities for patients.

Psychiatric Residency Program

- Create a public psychiatry track in the University of Minnesota’s residency program.

Promote and Support Recovery

Supportive Housing for Adults with Serious Mental Illness

- Expand housing with supports grants to serve 1,260 adults with serious mental illness in permanent supportive housing.

Assertive Community Treatment (ACT) Quality and Expansion

- Enhance the quality of current ACT services.
- Expand high quality ACT services across Minnesota.
- Develop a Forensic ACT Team to serve people involved with the criminal justice system.

Increase Flexibility for Transitions to Community Initiative

- Allow greater flexibility to use current funding to help more people exit institutional settings and return to the community.