

Offenders with Mental Illness

Community Supports Administration
January 2015



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¹ During the tenure of this workgroup, Matt Burdick left his position at NAMI-MN for a position with the Minnesota Department of Human Services.

I. Executive summary

In Minnesota, nearly 30 years after the passage of the Comprehensive Mental Health Act and over 25 years after the passage of the Children’s Mental Health Act, the state-wide system envisioned for mental health treatment is far from being fully developed. As with other States, Minnesota county jails are being overburdened by persons with mental illnesses because the State lacks a fully-funded infrastructure to stabilize their lives, including access to crisis services, treatment, healthcare, housing, employment, other therapeutic services, and community supports.²

Responding to these concerns, the 2014 Minnesota State Legislature directed the Department of Human Services (DHS) to convene a workgroup in partnership with the National Alliance on Mental Illness of Minnesota (NAMI MINNESOTA) to address issues related to offenders with mental illness who are arrested or subject to arrest.

In order to respond to the needs of the criminal justice, mental health, and substance abuse systems in Minnesota, the workgroup examined the entire system, from prevention and early intervention, treatment, and finally to recovery. From this, it is clear that seeing the entire system as a continuum of care is critical to meet the needs of both offenders and the community.

Building a continuum of mental health care for all Minnesotans



The workgroup was subdivided into six subgroups charged with examining specific steps in the criminal justice process as experienced by persons with mental illnesses. The subgroups were:

- Pre-Arrest/Arrest
- Urgent Care/Central Receiving Center
- Law enforcement /Hospital
- Jails and Courts
- Discharge
- Juvenile Justice

² See the Associated Press article by Patrick Condon. “Mentally Ill Inmates Overwhelming County Jails, Minnesota Lawmakers Told.” 2013. and the Star Tribune article by Paul McEnroe. “Mentall Ill Swamp Minnesota’s Jails and Courts.” 2013.

These subgroups were charged with identifying issues and gaps in the various stages of the criminal justice process and identifying strategies, methods, or recommendations for improving the results within each step. Each subgroup was charged with the task of identifying if these proposed solutions would allow persons with mental illnesses who had been charged with a crime to exit the system without further engagement of the criminal justice system. The members of the subgroups included experts of the step being examined.

From the work of the subgroups, the entire workgroup developed final recommendations. The most broadly supported (receiving 46% of the vote or better) of the recommendations were:

- Create sustainable funding methods for mental health urgent care services. Urgent care services include mental health crisis assessment, access to crisis psychiatry, chemical health screening, and crisis stabilization services.
- Encourage local jurisdictions to have regular meetings between law enforcement and mental health communities to facilitate dialogue and collaboration, identify trends, and address barriers.
- Continue medication for inmates after discharge.
- Establish a sustainable payment rate for mobile crisis services that covers not only face-to-face contact but other necessary service elements such as telephone/text support, engagement in treatment, service coordination, and travel.

Additional recommendations (those receiving less than 46% of the vote) included:

- Require insurance plans operating in Minnesota to include crisis response services as a benefit, or identify another method to compensate crisis programs for uncompensated services to people with private health insurance coverage.
- Define crisis response services as a preventive mental health service with no co-pays.
- Develop uniform service standards and training for mobile crisis teams.
- Include training and protocols for mobile crisis teams on how to work with law enforcement.
- Establish a single statewide phone number for mental health crisis services that links to local crisis resources.
- Explore use of GPS to enable monitoring of location and assure improved dispatching of mobile crisis teams.
- Clarify statute to indicate that mental health crisis teams can be dispatched in addition to law enforcement and/or other responders.
- Provide training to 911 operators on role of crisis response services.
- Address issues related to unsustainability for room and board costs for residential crisis providers.
- Increased funding for the stabilization component of crisis services.
- Establish a mental health urgent care in the west metro and other geographic areas where it could be beneficial and sustainable.
- Offer incentives for expanded use of Crisis Intervention Team (CIT) training.
- Promote CIT as an advanced training.

- Develop a one day CIT training.
- Provide additional training for how to respond to returning veterans who are in crisis.
- Integrate mental health into the educational coursework for law enforcement focusing on basic education about mental illnesses and de-escalation skills training.
- Utilize video and scenario-based training where possible.
- Integrate mental health and crisis de-escalation into required annual "use of force" training.
- Develop a Peace Officers Standards and Training (POST) model policy on responding to a mental health crisis. The POST Board develops, coordinates, and approves continuing education programs for peace officers and part-time peace officers.
- Educate law enforcement and emergency medical responders about the role/value of mental health urgent care.
- Develop a tool for law enforcement to facilitate better communication with health care professionals.
- Develop processes for clear communication when law enforcement is handing off an individual to a health care facility.
- Develop a systemic, real-time bed-tracking of available crisis residential beds and hospital beds.
- Utilize health information exchange to better share information, with person's consent and assuring that privacy safeguards are in place.
- Increase resources for mental health services in jails.
- Expand existing models for interagency collaboration between county social services and jails to other communities.
- Increase resources for probation to ensure reasonable caseloads, training, and access to pre-trial services.
- Develop capacity to perform necessary mental health assessments and facilitate timely access to records for individuals in jail to inform decisions around charges, pre-trial release, and potential diversion options.
- Establish more mental health courts.
- Establish discharge teams in jails to connect persons with community resources.
- Integrate peer specialists into jail discharge programs.
- Incorporate housing assistance into jail discharge planning.
- Invest in the creation of supportive housing options.
- Get medical consent forms as early as possible in the booking process.
- Establish responsibility and authority designating the Department of Human Services as the lead for oversight to improve the juvenile justice system.
- Work with schools and correctional facilities to ensure timely and adequate educational services are available and delivered for youth in custody.
- Pilot a new model to help schools support students with mental health and substance use disorders by connecting students to mental health and chemical health services.
- Focus on the legal aspect of the juvenile justice system to expedite the court process for youth and families, including parent engagement.

- Create an uniform statewide diversion model in partnership with the courts to keep kids out of the juvenile justice system; expand the use of the Juvenile Detention Alternative Initiative and National Cross Over models.
 - Commission a study to examine why youth are placed in detention and develop interventions.
 - The State should examine whether the 2011 legislative change requiring parental consent for screening juvenile justice youth has resulted in fewer eligible youth being screened, and if so, restore the "opt out" screening requirement.
 - Increase the number of children and youth who are screened within eligible populations by providing additional technical assistance and highlighting screening results statewide.
-

The correctional population tripled between 1982 and 2007. One in six of people in jail have serious mental illness, and within that group, over seven in ten have co-occurring substance use disorder.³ According to Sue Abderholden, Executive Director of NAMI Minnesota, in *Changes in the Mental Health System*:

The increasing numbers of people with serious mental illnesses in our criminal justice system has seriously strained the resources and staff. Police and sheriffs often cite their frustrations with having to respond to people with mental illnesses, often for public nuisance crimes but other times for a psychiatric crisis. Judges are overwhelmed with the volume of cases, often repeat offenders whose untreated mental illness results in numerous appearances before the court. Jail staff feel particularly lacking in the training and education needed to keep these individuals safe, including those who may be at risk for suicide. Local budgets are strained by the costs of providing medication. Prisons are also not well equipped to address the needs of these inmates.”⁴

It is clear we must address mental health all along the spectrum of prevention through treatment through recovery if we are to reduce the personal and community impact of incarceration. Offering the right services at the right time across the state is what individuals with mental illness need.

³Taken from <http://gainscenter.samhsa.gov/cms-assets/documents/131194-413326.guidelines-slides.pdf> 2/4/2015

⁴ From an article by Sue Abderholden, Executive Director of NAMI Minnesota. “Changes in the Mental Health System.” Published on the Council on Crime and Justice website at: <http://www.crimeandjustice.org/councilinfo.cfm?piD=55>

II. Legislation

Laws of Minnesota 2014, Chapter 312, Article 29, section 13

MENTALLY ILL OFFENDERS ARRESTED OR SUBJECT TO ARREST; WORKING GROUP.

Subdivision 1. **Working group established; study and draft legislation required.**

The commissioner of human services may convene a working group to address issues related to offenders with mental illness who are arrested or subject to arrest. The working group shall consider the special needs of these offenders and determine how best to provide for these needs. Specifically, the group shall consider the efficacy of a facility that would serve as a central point for accepting, assessing, and addressing the needs of offenders with mental illness brought in by law enforcement as an alternative to arrest or following arrest. The facility would consolidate and coordinate existing resources as well as offer new resources that would provide a continuum of care addressing the immediate, short-term, and long-term needs of these offenders. The facility would do the following for these offenders: perform timely, credible, and useful mental health assessments; identify community placement opportunities; coordinate community care; make recommendations concerning pretrial release when appropriate; and, in some cases, provide direct services to offenders at the facility or in nearby jails. The working group shall establish criteria to determine which offenders may be admitted to the facility. The facility would be located in the metropolitan region and serve the needs of nearby counties. The facility would represent a partnership between the state, local units of government, and the private sector. In addition, the working group may consider how similar facilities could function in outstate areas. When studying this issue, the working group shall examine what other states have done in this area to determine what programs have been successful and use those programs as models in developing the program in Minnesota. The working group may also study and make recommendations on other ways to improve the process for addressing and assisting these offenders. The commissioner shall enter into an agreement with NAMI Minnesota to carry out the work of the working group.

Subd. 2. **Membership.** The commissioner shall ensure that the working group has expertise and a broad range of interests represented, including, but not limited to: prosecutors; law enforcement, including jail staff; correctional officials; community corrections staff; probation officials; criminal defense attorneys; judges; county and city officials; mental health advocates; mental health professionals; and hospital and health care officials.

Subd. 3. **Administrative issues.** (a) The commissioner shall convene the first meeting of the working group by September 1, 2014. NAMI Minnesota shall provide meeting space and administrative support to the working group. The working group shall select a chair from among its members. (b) The commissioner may solicit in-kind support from workgroup member agencies to accomplish its assigned duties.

Subd. 4. Report required. By January 1, 2015, the working group shall submit a report to the chairs and ranking minority members of the senate and house of representatives committees and divisions having jurisdiction over human services and public safety. The report must summarize the working group's activities and include its recommendations and draft legislation. The recommendations must be specific and include estimates of the costs involved in implementing the recommendations, including the funding sources that might be used to pay for it. The working group shall explore potential funding sources at the federal, local, and private levels, and provide this information in the report. In addition, the report must include draft legislation to implement the recommendations.

EFFECTIVE DATE. This section is effective the day following final enactment.

III. Introduction

People with mental illness are falling through the cracks of this country's social safety net and are landing in the criminal justice system at an alarming rate. Each year, ten million people are booked into U.S. jails; studies indicate that rates of serious mental illness among these individuals are at least three to four times higher than the rates of serious mental illness in the general population.

—“Criminal Justice / Mental Health Consensus Project.” 2002⁵

A recent analysis found that between 1950 and 1980, there were virtually no shift between the institutional settings serving persons with mental illnesses and jails and prisons; however, this trend changed between 1980 and 2000 and showed that there was a significant shift.⁶ The study estimates that between 4 to 7 percent of incarcerations between 1980 and 2000 can be attributed to deinstitutionalization, meaning that between 40,000 and 72,000 people nationwide incarcerated in 2000 would have been treated in treatment centers in years past.⁷

*“The lack of a funded and coordinated mental health system and the prevailing stigma surrounding mental illness has resulted in an increasing reliance on our justice system as the safety net. Some might say our jails and prisons are our largest treatment centers, but it would be incorrect to imply that real treatment – evidence-based and effective—is being—or even can be—truly carried out in correctional facilities.”*⁸

—“Changes in the Mental Health System.” By Sue Abderholden, Executive Director of NAMI Minnesota.

According to the 2006 “Survey of Minnesota Jails: Inmates with Mental Illness” by the National Alliance on Mental Illness – Minnesota (NAMI-Minnesota):

- 25 percent of prison inmates currently take medications for mental illness.
- Inmates with mental illness often have a co-occurring substance abuse problem.
- Upon release, individuals with mental illness often find that their criminal records make it difficult to access necessary resources.

⁵ See “Criminal Justice / Mental Health Consensus Project.” 2002. Full report can be found at: <https://www.ncjrs.gov/pdffiles1/nij/grants/197103.pdf>

⁶Stephen Raphael and Michael Stoll, “Assessing the Contribution of the Deinstitutionalization of the Mentally Ill to Growth in the U.S. Incarceration Rate,” *Journal of Legal Studies* 42 (2013), 187.

⁷ Ibid., p. 187+.

⁸ From an article by Sue Abderholden, Executive Director of NAMI Minnesota. “Changes in the Mental Health System.” Published on the Council on Crime and Justice website at: <http://www.crimeandjustice.org/councilinfo.cfm?pID=55>

- Individuals who are incarcerated for over 30 days lose their federal benefits, such as Medical Assistance and Social Security Income. For many, these benefits are necessary to obtain mental health treatment and to help prevent further criminal justice contact.
- Little is known about the number of inmates with mental illness in Minnesota jails.⁹
- The majority of jail staff frequently recognized serious mental illness in the jail population.
- If jail staff are aware of an inmate's formal diagnosis of mental illness, it is somewhat easier for the inmate to receive treatment.
- The majority of respondents to the survey (58 percent) reported "never or rarely" doing discharge planning for inmates with mental illness.

Responding to these concerns, the 2014 Minnesota State Legislature directed the Department of Human Services to convene a workgroup in partnership with the NAMI-Minnesota to address issues related to offenders with mental illnesses who are arrested or subject to arrest.

The workgroup and its subgroups met ten times between July 2014 and January 2015. The workgroup included broad representation from:

- The Department of Human Services
- The Association of Minnesota Counties
- League of Minnesota Cities.
- Mental Health Provider Association of Minnesota
- Mental Health Consumer/Survivor Network
- Minnesota Association of Community Corrections Act Counties
- Minnesota Association of Community Mental Health Programs
- Minnesota Association of County Probation Officers
- Minnesota Association of County Social Services Administrators
- Minnesota Chiefs of Police Association
- Minnesota Community Corrections Association
- East Metro Crisis Alliance
- Minnesota Council of Health Plans
- Minnesota County Attorneys Association
- Minnesota Department of Corrections
- Minnesota Disability Law Center
- Minnesota Hospital Association
- Minnesota House of Representatives
- Minnesota Police and Peace Officers Association
- Minnesota Psychiatric Society
- Minnesota Psychological Association

⁹ Because jails rarely conduct mental health screens to identify inmates with mental illness and while each jail maintains information on their inmate population, there is not one identified source charged with obtaining and disseminating such information to policymakers.

- Minnesota Senate
- Minnesota Sheriffs Association
- Minnesota State Board of Public Defense
- National Alliance on Mental Health Minnesota
- State Advisory Council on Mental Health
- State Advisory Council on Mental Health— Children’s Subcommittee
- Minnesota Fourth Judicial District
- Minnesota Seventh Judicial District
- COPE/Emergency Mental Health-Hennepin County

The workgroup was charged with:

- Considering the special needs of these offenders and determine how best to provide for these needs
- Considering the efficacy of a facility that would serve as a central point for accepting, assessing, and addressing the needs of offenders with mental illness brought in by law enforcement as an alternative to arrest or following arrest
- Establishing criteria to determine which offenders may be admitted to the facility
- Considering how similar facilities could function in outstate areas
- Examining what other states have done to determine what programs have been successful and use those programs as models in developing the program in Minnesota
- Studying and making recommendations on other ways to improve the process for addressing and assisting these offenders

The workgroup was subdivided into six subgroups charged with examining specific steps in the criminal justice process as experienced by persons with mental illnesses. These subgroups were charged with identifying issues and gaps in the various stages of the criminal justice process and identifying strategies, methods, or recommendations for improving the results within each step. Each subgroup was charged with the task of identifying if these proposed solutions would allow persons with mental illnesses who had been charged with a crime to exit the system without further engagement of the criminal justice system. The members of the subgroups included experts of the step being examined. These subgroups¹⁰ include:

¹⁰ Coincidentally, these subgroups are very similar to the points of contact identified in New York City Mayor Bill de Blasio’s action plan, “Mayor’s Task Force on Behavioral Health and the Criminal Justice System.” 2014. This report examined the number of people with behavioral health issues in the New York City criminal justice system.

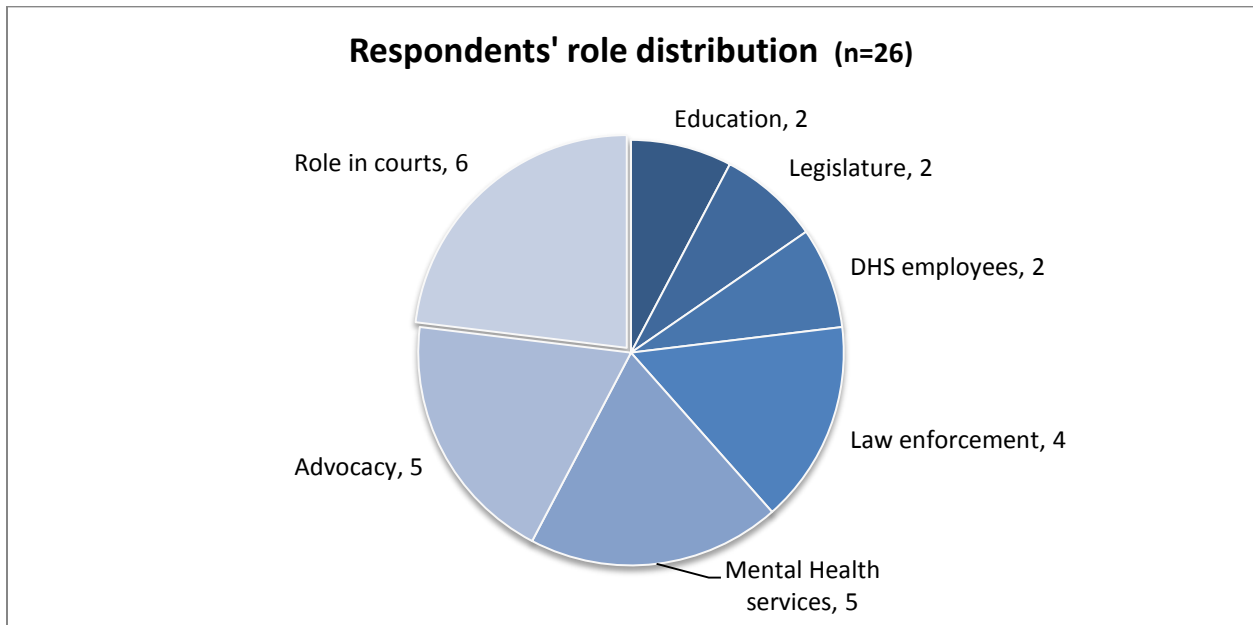


- The Pre-Arrest/Arrest subgroup was charged with identifying issues, gaps, problems and proposed solutions from the period of time of a first call for help to the time when law enforcement has made an arrest.
- The Law Enforcement/Hospital subgroup was charged with identifying issues, gaps, problems and proposed solutions from when law enforcement makes the arrest to the point where the officer decides to either initiate jail intake proceedings or transport the individual to a hospital emergency room.
- The Urgent Care/Central Receiving Center subgroup was charged with assessing the feasibility of establishing a facility, other than a hospital emergency room or a jail, where the individual with mental illness could be brought by law enforcement and receive immediate access to services.
- The Jails & Courts subgroup was charged with identifying issues, gaps, problems and proposed solutions from the period of time post jail intake through the completion of a court decision.
- The Juvenile Justice subgroup was charged with identifying issues, gaps, problems and proposed solutions when the first call for help involved a juvenile.
- The Discharge subgroup was charged with identifying issues, gaps, problems and proposed solutions once a decision has been made to discharge the individual with mental illness from custody.

The recommendations of each of these subgroups were reviewed by the broader workgroup for further discussion and refinement. In each discussion, the workgroup “considered the special needs of these offenders and determined how best to provide for those needs.”¹¹ Once all

¹¹ Laws of Minnesota 2014, Chapter 312, Article 29, section 13.

recommendations were reviewed, a survey of the recommendations was sent to workgroup so that preferences and priority could be evaluated. Just over half of the workgroup participants answered the survey with the respondents' role being evenly distributed.



The results of that survey appears in section VI.

The recommendations focused on ensuring that, when appropriate, persons with mental illnesses:

- Receive the appropriate service at the appropriate time prior to needing deeper level of services or prior to committing a crime that engages them in the criminal justice system
- Avoid the criminal justice system or provide appropriate avenues out of the system, when it has been engaged
- Have the ability to readily access coordinated services, when needed
- Have access to treatment settings outside of the jail if the person is charged
- Receive treatment in jail that meets specific standards if they are in jail
- Are connected to supports and services if they are released

While the enacting legislation required the workgroup to “consider the efficacy of a facility that would serve as a central point for accepting, assessing, and addressing the needs of offenders with mental illness brought in by law enforcement as an alternative to arrest or following arrest; establish criteria to determine which offenders may be admitted to the facility; and consider how similar facilities could function in outstate areas,” the workgroup did not reach full agreement on

the requirements related to establishing a specific type of central receiving facility, similar to the Orange County Central Receiving Center¹² or other models from other states.

The workgroup set as a goal establishing a method to assure a rapid handoff from law enforcement to mental health services and chemical health services and coordination of these services. The workgroup then considered:

- Co-located outpatient/community services, such as a mental health urgent care model with co-located scattered-site crisis beds,
- Psychiatric emergency department, and
- Mental health urgent care without co-located crisis beds.

In its assessment of the Central Receiving Center, the workgroup felt that, as has been stated in the case study of the services,¹³ community treatment capacity first needed to be expanded no matter what method was adopted to prevent persons with mental illnesses from experiencing an unnecessary involvement with the criminal justice system. The workgroup also felt that the other options were better solutions. One example could include establishing more Mental Health Urgent Cares, similar to the Urgent Care for Adult Mental Health in Ramsey, Dakota, and Washington Counties which offers an on-site team of psychiatrists, nurses, social workers, and trained peer support staff ready to provide crisis services for adults (ages 18 and older).¹⁴

The workgroup did reach agreement that the community mental health treatment capacity needs to be expanded and made recommendations on “what other states have done in this area to determine what programs have been successful and other ways to improve the process to address and assist these individuals.”¹⁵ As a result, this report identifies immediate and long term methods to address systems issues and gaps that could prevent an individual with mental illness from entering the criminal justice system as well as create avenues for an individual who have entered the criminal justice system to exit the system earlier. This report also identifies administrative changes than can occur within the system without additional investments or legal changes. Finally, this report identifies issues that were outside of the scope of this workgroup but also need further study.

¹² Minnesota’s legislation was specifically written with the Orange County Central Receiving Center in mind. This specific Central Receiving Center opened in April 2003 in Orange County, Florida after a Jail Oversight Commission published a report where it reviewed all aspects of jail operations in response to high numbers of persons with mental illnesses and co-occurring disorders were identified to be housed in local jails. The site has co-located services, including residential/crisis beds, under one roof. More information can be found in the report: Council of State Governments Justice Center. (2007). *Increasing Collaboration between Corrections and Mental Health Organizations: Orange County Case Study*. New York, NY: Council of State Governments Justice Center.

¹³ Council of State Governments Justice Center. (2007). *Increasing Collaboration between Corrections and Mental Health Organizations: Orange County Case Study*. New York, NY: Council of State Governments Justice Center. P.8.

¹⁴ See <http://mentalhealthcrisisalliance.org/> for more information.

¹⁵ Laws of Minnesota 2014, Chapter 312, Article 29, section 13.

IV. Contributing Systems Issues

The mental health service system for both children and adults in Minnesota has been constructed on the bases of mixed (local, state and federal) authority and funding, with intermittent attempts to survey the resulting infrastructure to determine its adequacy, effectiveness and stability. With a series of recent reports, it is clear that:

- The infrastructure is insufficiently funded thus limiting access
- There are too many gaps in the continuum of services and care
- Measurement of effectiveness is inconsistent
- The system is structurally and financially fragile.

In Minnesota, these issues are contributing to the fact that Minnesota's prisons, jails, and pretrial, probation, and parole agencies oversee a disproportionate number of individuals with mental health and substance use disorders, many churning through the criminal justice system over and over again.

“The corrections, mental health, and substance use disorder systems share a commitment to help these individuals successfully address their needs and avoid criminal justice involvement, yet each system has its own screening and assessment tools and research-based practices. Although there are many examples of innovative and effective collaborations among corrections, substance use disorder and mental health providers, what has been lacking is a truly integrated framework that can help officials at the systems level direct limited resources to where they can be most effective in achieving both public safety and healthcare goals.”¹⁶ —Council of State Governments Justice Center Criminal Justice/Mental Health Consensus Project

A recently completed 2013 Gaps Analysis Survey of counties, mandated by the Minnesota Legislature, revealed specific gaps and shortages in the adult mental health service array.¹⁷ Although many of these issues can be especially problematic in rural or frontier areas, others transcend geography. The Offenders with Mental Illness workgroup had significant discussions about these common mental health service gaps:

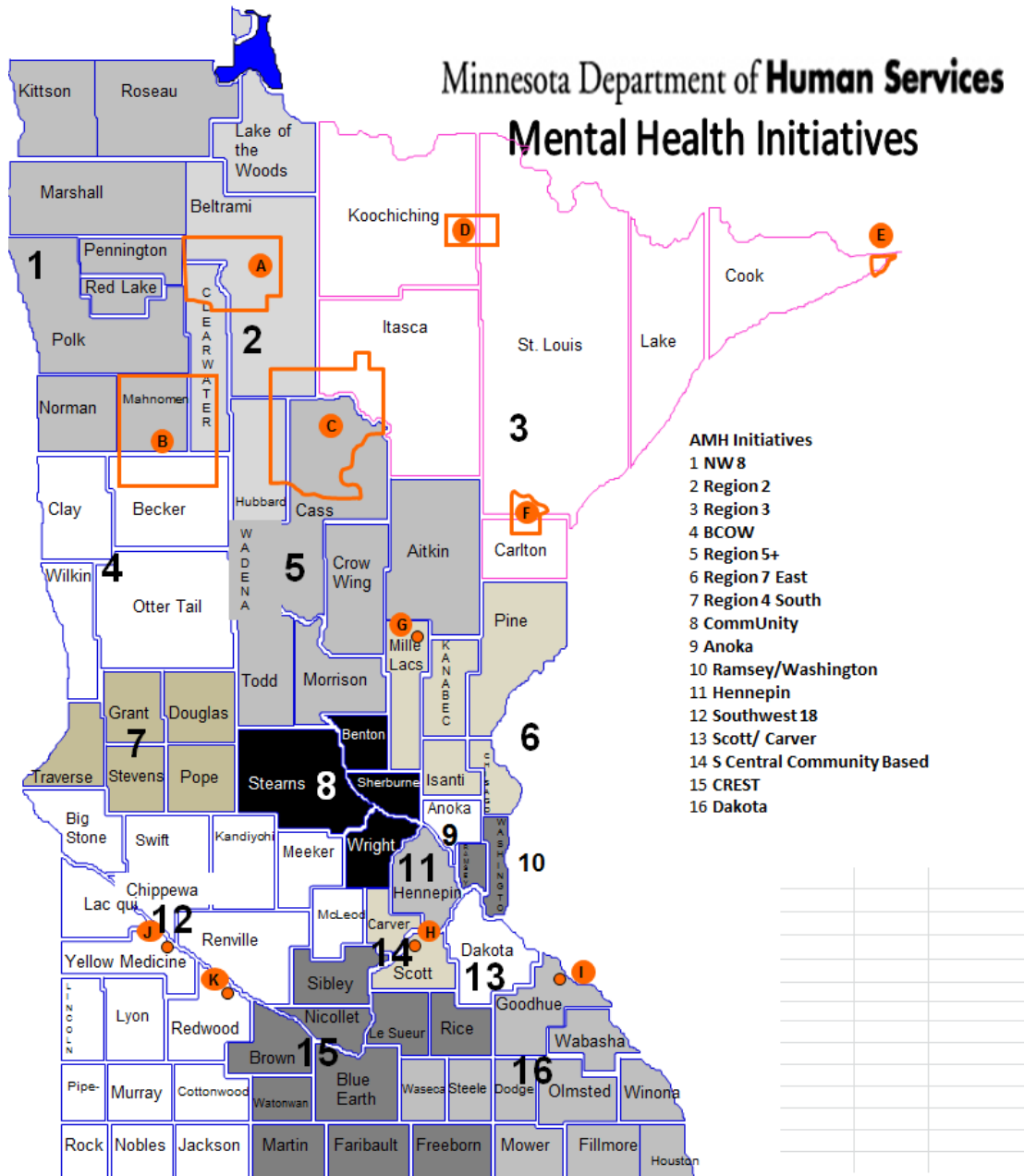
¹⁶ Fred Osher, MD; David A. D'Amora, MS; Martha Plotkin, JD; Nicole Jarrett, PhD; Alexa Eggleston, JD. Compton, “Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery,” *Council of State Governments Justice Center Criminal Justice/Mental Health Consensus Project* (2012), IV.

¹⁷ *2013 County Long-Term Services and Supports Gaps Analysis Survey: Adult Mental Health, Full Report* (Saint Paul: Adult Mental Health Division, Chemical and Mental Health Services Administration, Department of Human Services, August 2013), 33.

- **Minnesota lacks enough community-based services to appropriately and comprehensively support adults living in the community**, especially those with the greatest needs. The Community Alternatives for Disabled Individuals waiver and Personal Care Assistant services are not available when needed and there is a lack of supportive housing arrangements.
- **Prevention & early intervention resources are limited.** The focus has been on funding intensive supports once someone has been hospitalized many times instead of providing intensive supports early on, such as provided in programs such as First Episode of Psychosis programs.
- **Minnesota has a severe mental health workforce shortage.** With most of Minnesota designated as a Mental Health Professional Shortage Area, there are chronic shortages of certain types of mental health professionals, especially psychiatrists and other qualified psychiatric care providers. This contributes to the inability of the system to adequately respond to the needs of individuals with mental illness in local jails.
- There is a need for **better integration and care coordination** across the traditional service delivery “silos”: mental health, substance use disorder services, primary care, public health, and others.
- **There is a serious shortage of decent, affordable housing with supports.** Over 50 percent of children and adults in Minnesota who are homeless live with a mental illness. A long wait list exists for Bridges housing funds.
- **Only three counties (Hennepin, Ramsey, and St. Louis) have specialized mental health courts** for people who have been charged with crimes and also have mental health service needs, despite the obvious advantages of this effective and person-centered approach to problem resolution.
- **There is only one Mental Health Urgent Care in the state.** Located in the east metro, this program serves as a model, but has not identified a permanent and sustainable source of funding.
- System benefits have been seen through the use of Certified Peer Specialists (especially, in the case of the warm handoffs they can provide) in the mental health system; unfortunately, **the locations where Certified Peer Specialists are used are limited and reimbursement for services by Certified Peer Specialists is not available in every setting.**
- **Often privacy standards create barriers towards individuals receiving the right care, at the right time, in the right way.** Data sharing is needed in order to improve the timeliness and quality of services being delivered to an individual in a mental health crisis.

Under Minnesota’s Comprehensive Mental Health Acts, Counties act as the local mental health authority. Over time, Counties have organized themselves regionally in groupings called mental health initiatives. Figure 2.0 depicts these groupings.

Figure 2.0: Mental Health Initiatives:



The Children’s and Adult Mental Health Divisions have collected data from a wide variety of sources including Medical Assistance claims data, county and tribal reporting, and surveys of counties, providers and those using mental health services to estimate the availability of services

along the continuum of care in each county. The gaps and shortages in the mental health system serving both Children and Adults in Minnesota can best be depicted in Figures 2.1 and 2.2 below. While some services are widely available, others—particularly those designed to serve persons with the most severe or complex needs—are not. It is important to note that services which could effectively prevent or delay the emergence of mental health problems are not consistently tracked at all, although they have been a traditional component of the work of both local collaboratives and local public health.

Figure 2.1: Children’s Mental Health Provider Availability:

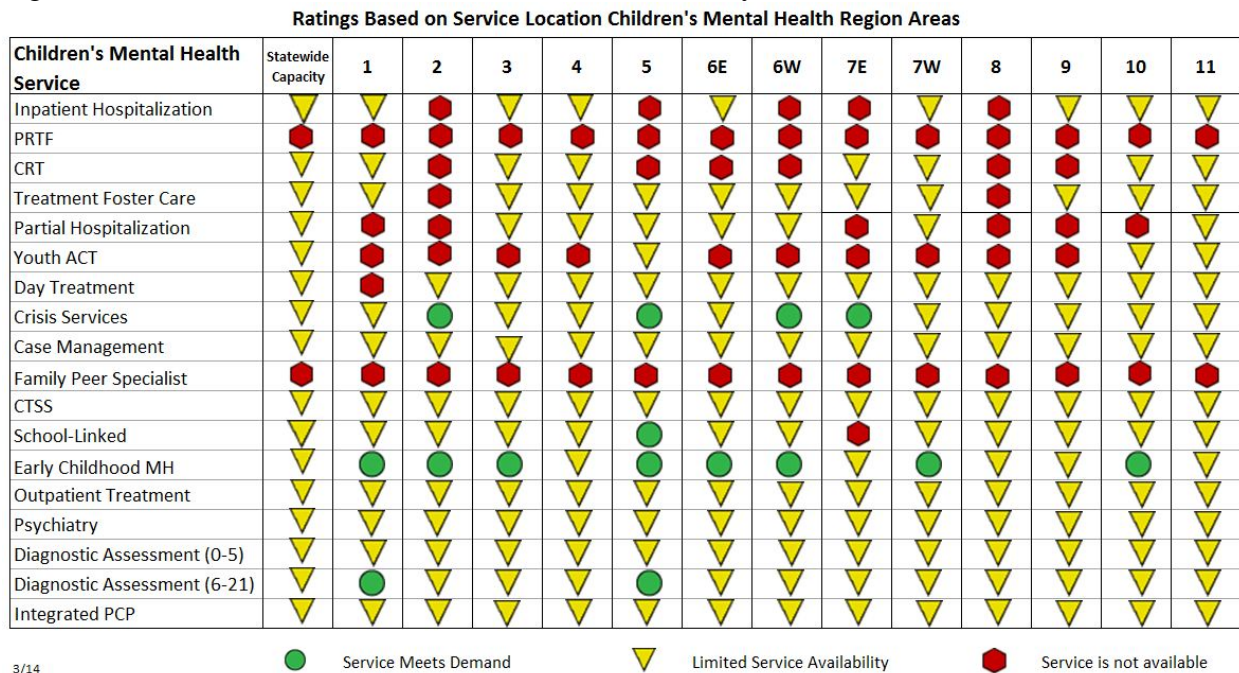
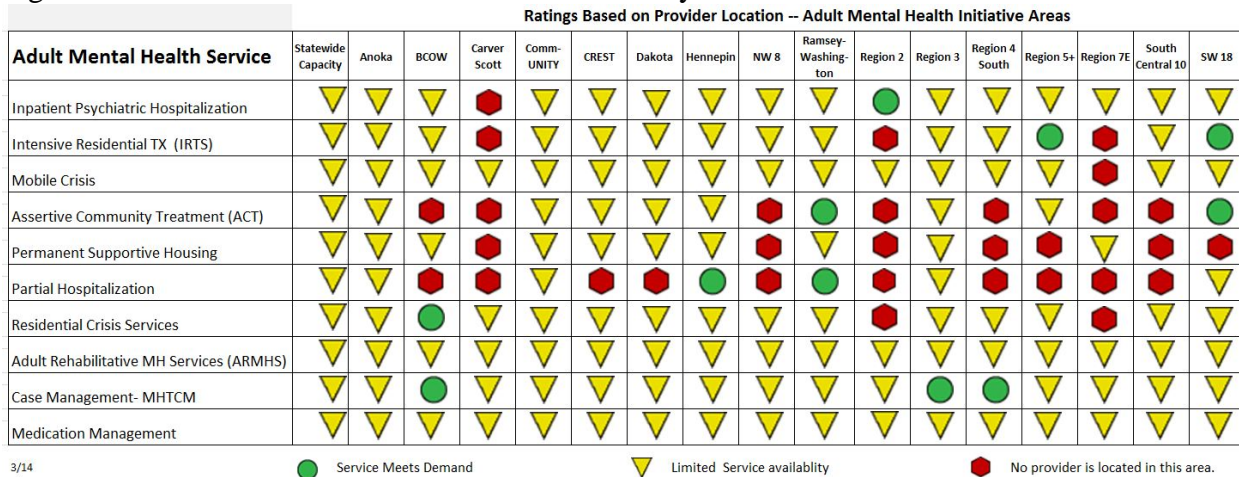


Figure 2.2: Adult Mental Health Provider Availability:



V. Recommendations

The gaps in the mental health system clearly contribute to a larger number of individuals with mental illness entering the criminal justice system. This workgroup worked within its narrow charge:

“to address issues related to offenders with mental illness who are arrested or subject to arrest and consider the special needs of these offenders and determine how best to provide for these needs.”

In order for any positive impacts to be realized in Minnesota, appropriate investment in a comprehensive continuum of care is needed. Only through appropriate treatment, supports, and placement can persons receive care in the most appropriate place at the most appropriate time in the most appropriate manner. These investments will create a mental health system that is responsive and that persons with mental illnesses will not be inappropriately placed in jails. Minnesota focuses efforts in the three areas depicted in figure 6.1.

Figure 6.1:

Building a continuum of mental health care for all Minnesotans



In order to build a method to respond to the discrete needs of the criminal justice, mental health, and substance abuse systems in Minnesota, the workgroup considered the following issues and made the following recommendations. Each recommendation was evaluated by workgroup members individually so that preferences and priority could be shared as part of this report.

Mobile Mental Health Crisis Response Services

For a person with a mental illness who is experiencing a mental health crisis, a mobile mental health crisis response team can be an effective first responder and key to preventing contact with law enforcement and/or avoiding arrest. These teams can assess the person who is experiencing a mental health crisis, provide rapid access to psychiatry and provide stabilization services to those that need them. Conversely, if only option is to call 911 and have law enforcement respond, then a likely result will be that the person will be brought to jail.

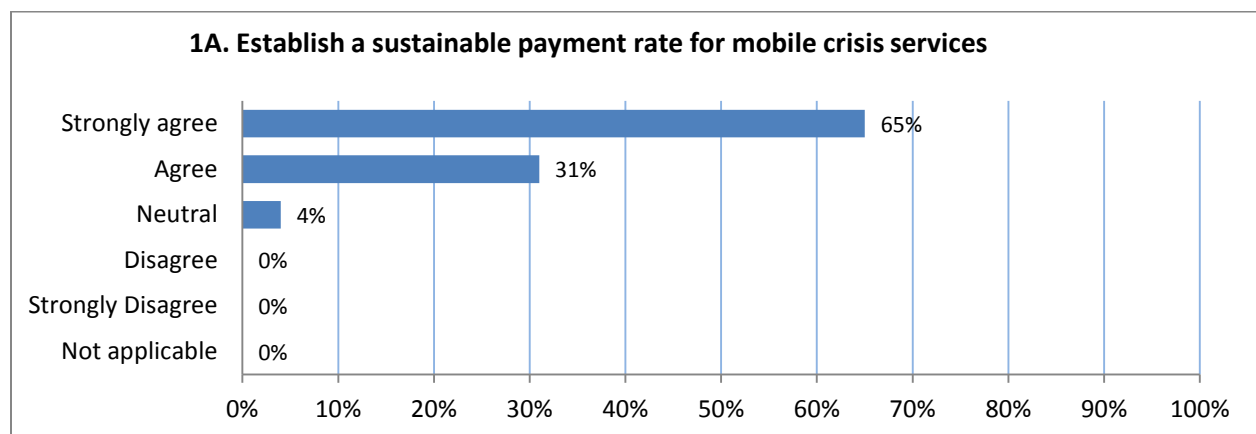
Since 2006, Minnesota has been gradually building an infrastructure of mobile mental health crisis response services throughout the state. While Minnesota has made progress in expanding access to publically-paid mental health crisis response services, the quality and availability of crisis services still varies greatly throughout the state and many private health plans do not cover mobile mental health crisis response services.

Current services vary from region to region and county to county in a number of ways. There is very little comparability in the hours of services and the criteria for when mobile crisis response services are dispatched. In the rural areas, many mobile crisis teams have a broad geographic area for which to serve, often not being close to a person who is having a mental health crisis. Metro county residents and some rural residents have mental health crisis response services available to them 24 hours a day, every day of the year, while other regions do not offer services around the clock. In addition, there is no single statewide telephone number for accessing mental health crisis response services, which creates confusion for individuals attempting to utilize these services. 911 Operators also rarely dispatch mobile crisis teams directly.

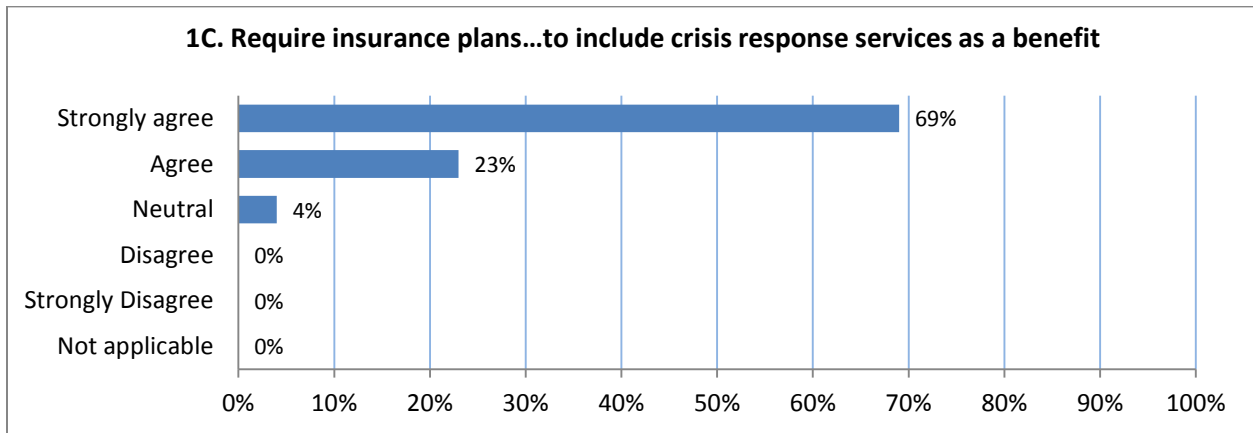
Some of this variability in response is because mobile crisis response services are struggling due to inadequate payment rates. These rates negatively impact the quality and hinder further expansion of the service. Crisis response services involve high stress, including work that is side by side with law enforcement and other first responders, often under taxing conditions. However, these services receive a far lower payment rate than for an office visit. In addition, crisis teams can seldom afford to add staff and are challenged to pay competitive salaries, leading to higher than usual turnover and reduced service quality. Some providers are not able to offer true “mobile” crisis intervention, but instead try to deal with the crisis over the phone, in large part due to the financial constraints.

Recommendation 1A:

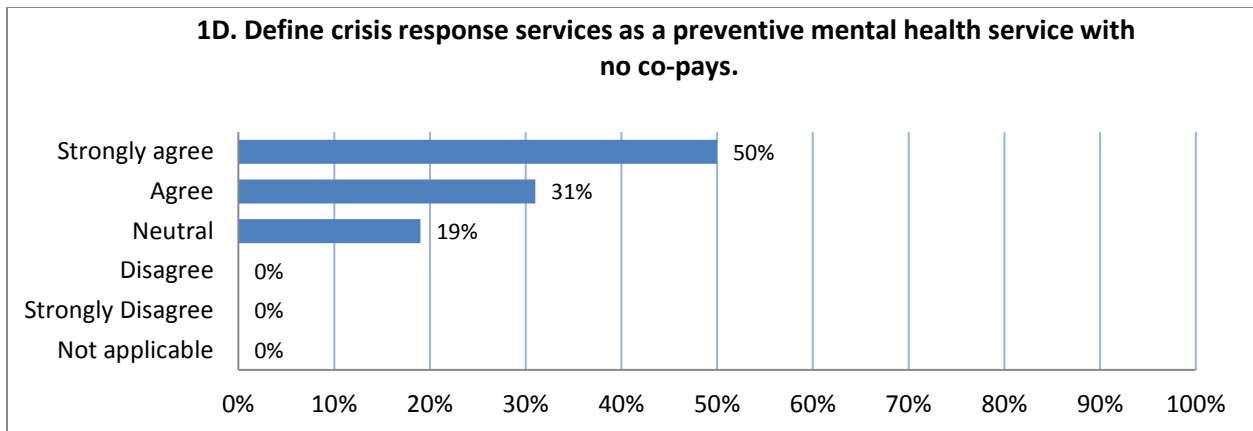
Establish a sustainable payment rate for mobile crisis services that covers not only face-to-face contact but other necessary service elements such as telephone/text support, engagement in treatment, service coordination, and travel.



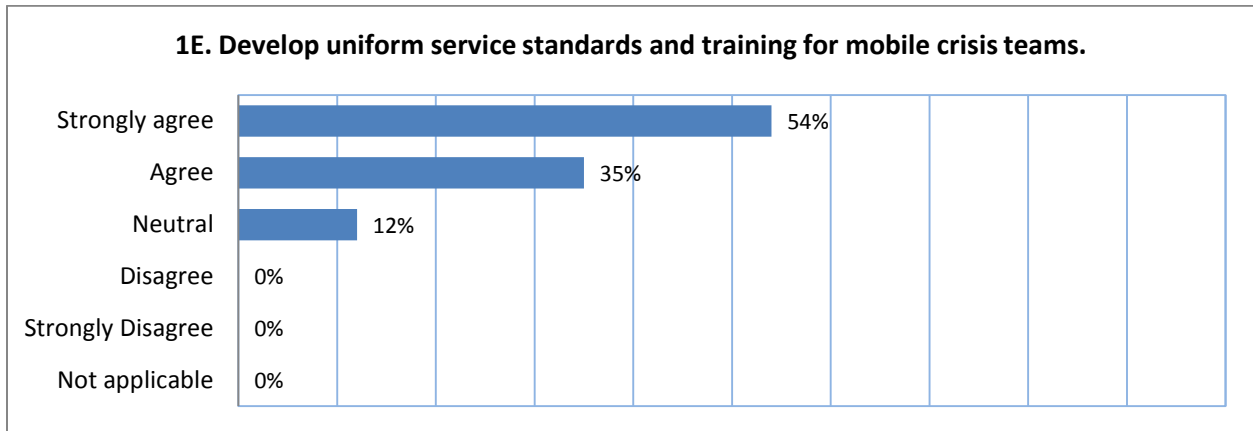
Recommendation 1C: Require insurance plans operating in Minnesota to include crisis response services as a benefit or identify another method to compensate crisis programs for uncompensated services to people with private health insurance coverage.



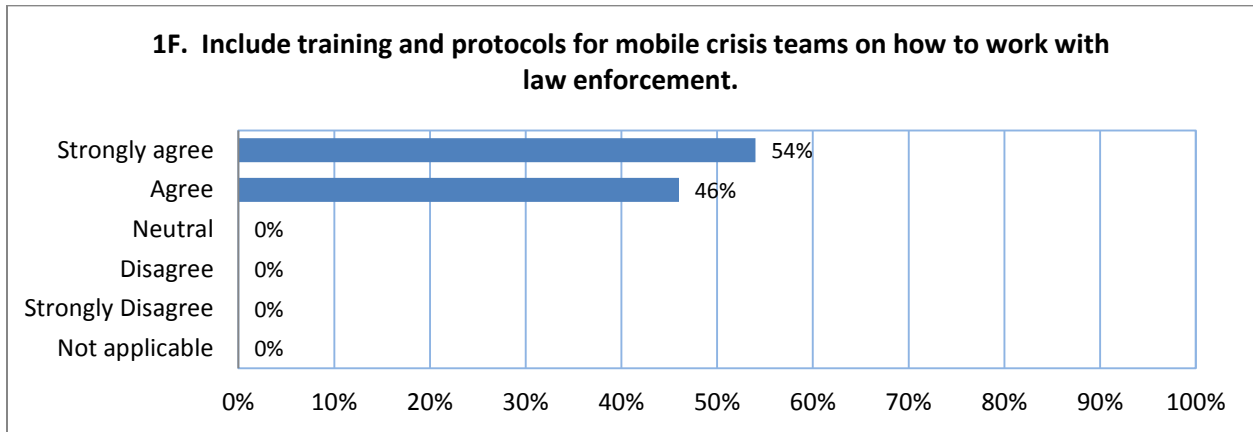
Recommendation 1D: Define crisis response services as a preventive mental health service with no co-pays.



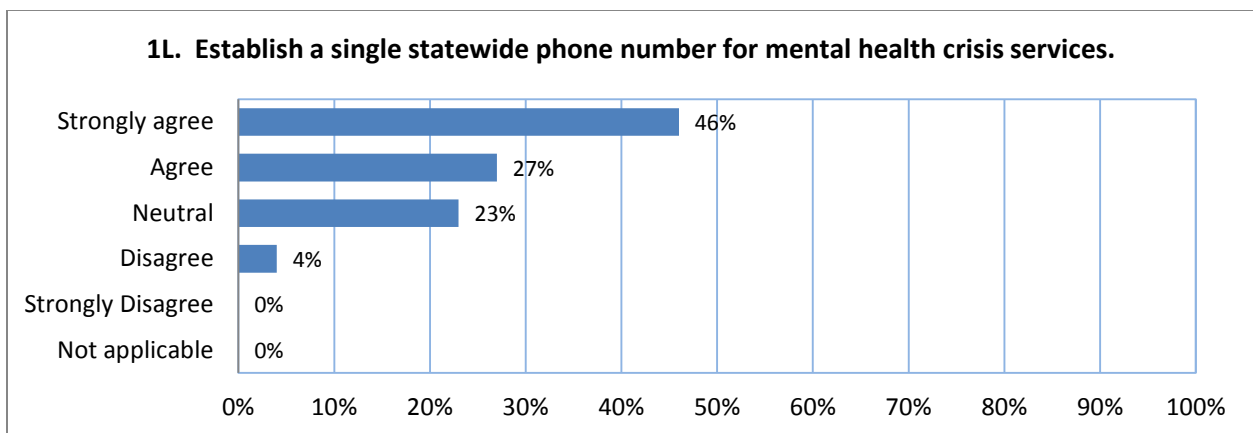
Recommendation 1E: Develop uniform service standards and training for mobile crisis teams.



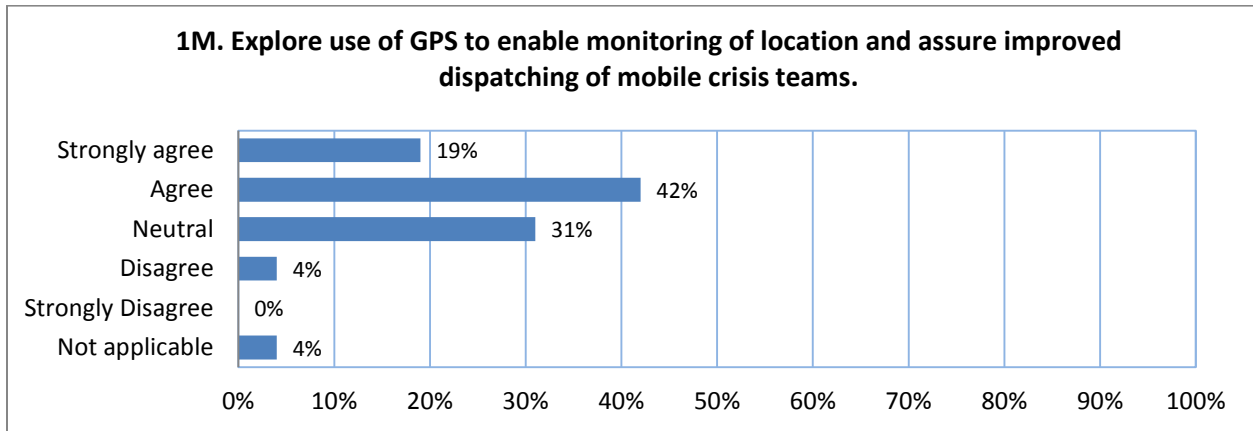
Recommendation 1F: Include training and protocols for mobile crisis teams on how to work with law enforcement.



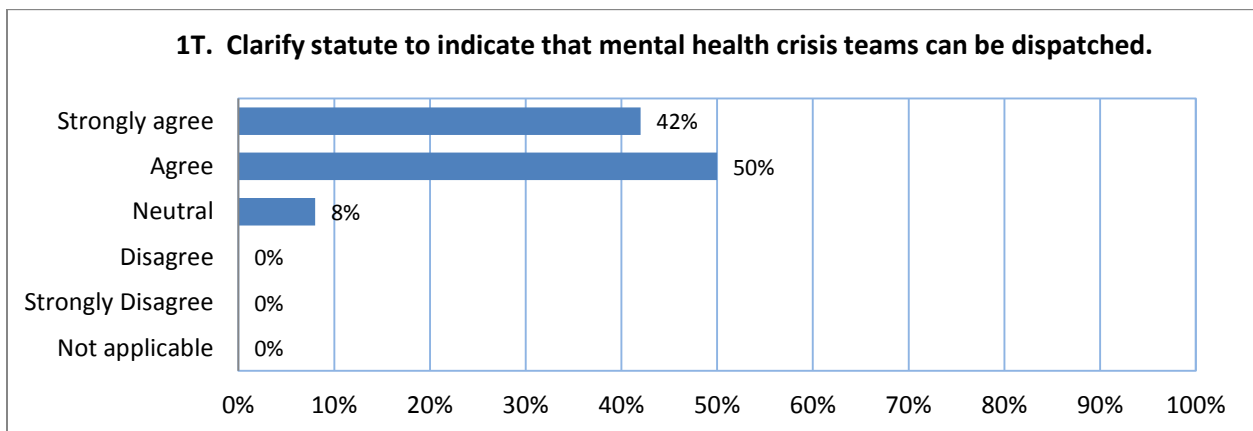
Recommendation 1L: Establish a single statewide phone number for mental health crisis services that links to local crisis resources.



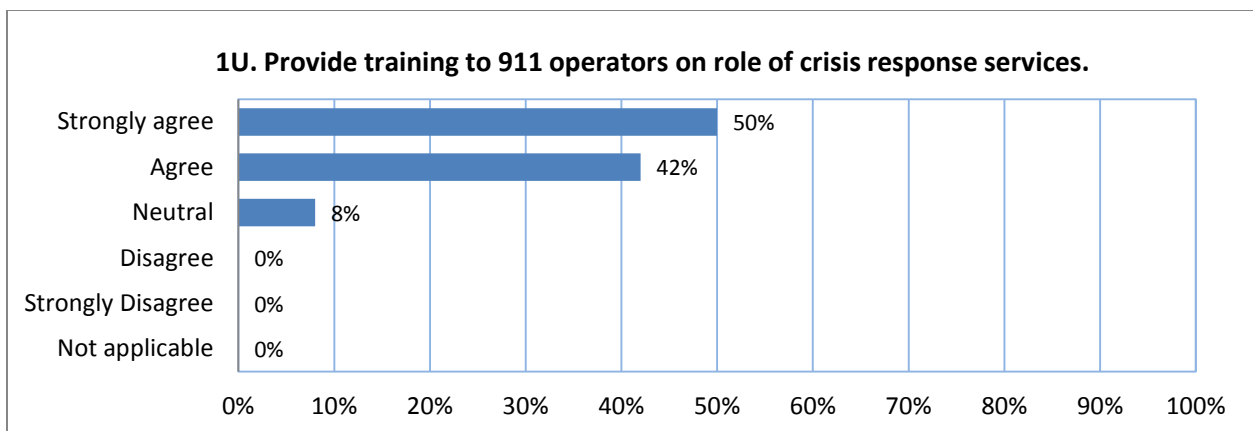
Recommendation 1M: Explore use of GPS to enable monitoring of location and assure improved dispatching of mobile crisis teams.



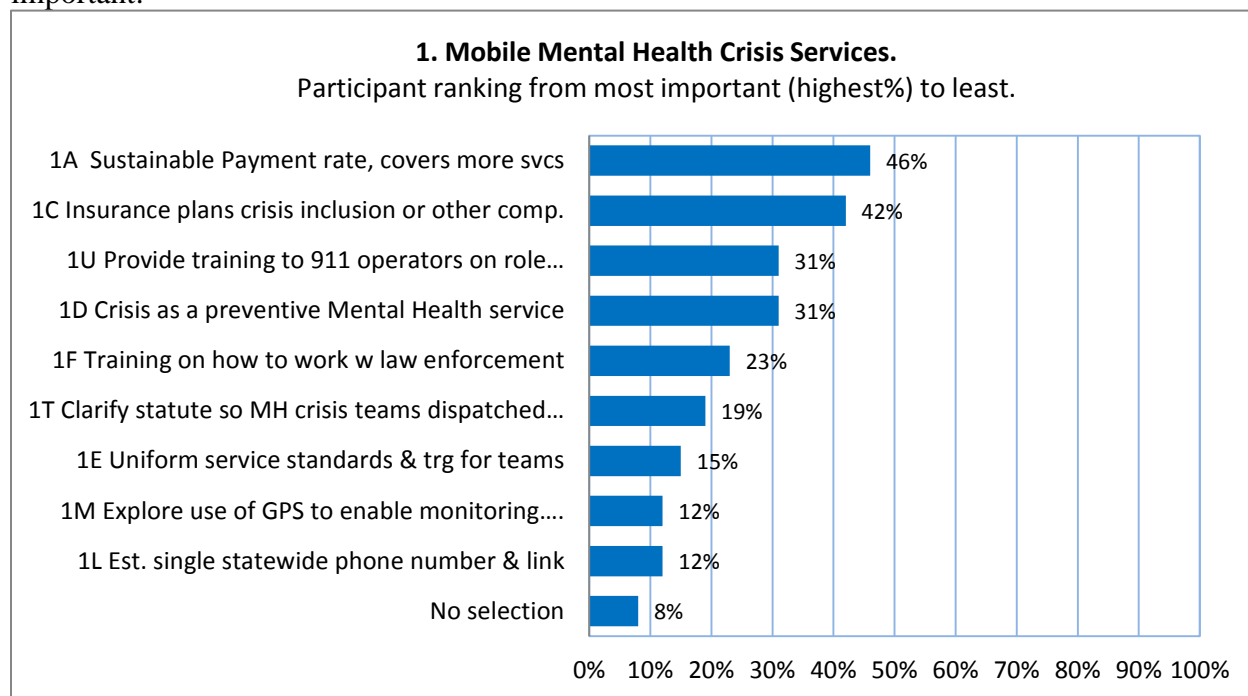
Recommendation 1T: Clarify statute to indicate that mental health crisis teams can be dispatched in addition to law enforcement and/or other responders.



Recommendation 1U: Provide training to 911 operators on role of crisis response services.



Workgroup participants then ranked each recommendation from most important to least important:



Residential Crisis Services

Minnesota has residential crisis services for people who do not meet hospital level of care but are in a mental health crisis. Residential Crisis Services are time-limited within a residential setting. The average length of stay in fiscal 2014 was 6.2 days. Services include crisis assessment, intervention services and crisis stabilization; including referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training and collaboration with other service providers in the community. These services must be individualized and designed to restore the person to his/her prior level of functioning. These programs can also be the first step out of a community hospital for individuals who continue to need support. People stay at the programs on a short term basis, usually seven days or less.

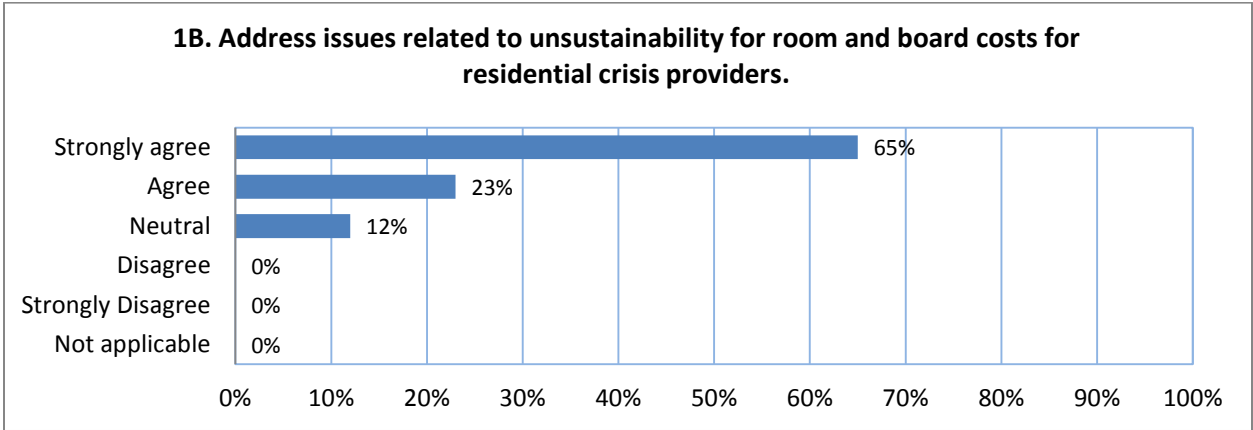
There are:

- 137 crisis residential beds statewide.
- 73 beds are in seven programs that are licensed as Intensive Residential Treatment Services (IRTS) programs with a crisis stabilization variance and provide only crisis stabilization services.
- Six beds are in four licensed Adult Foster Care facilities.
- There are an additional 16 beds in seven facilities that provide a combination of IRTS and Crisis Stabilization services. These 19 programs provided over 2500 episodes of service in calendar year 2013.

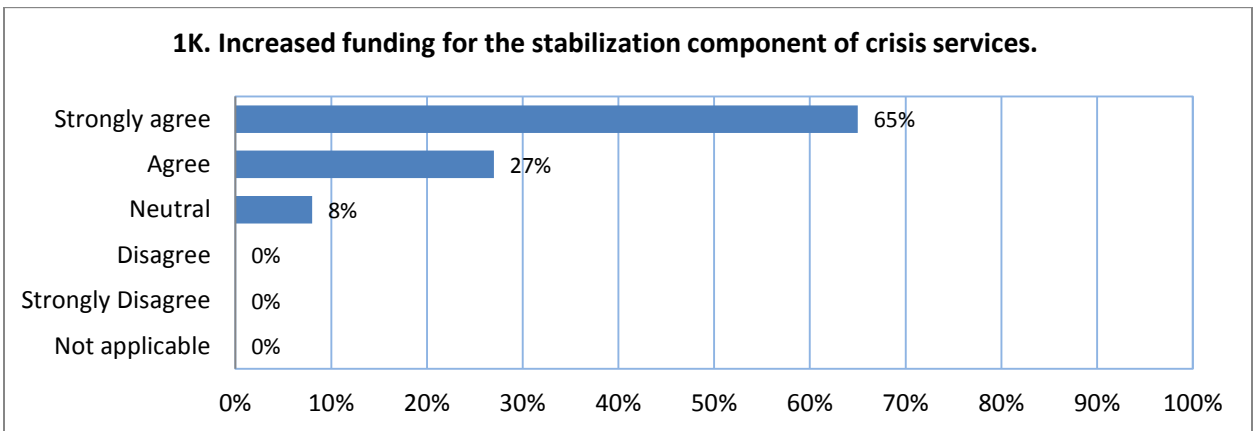
Presently, residential crisis services are being reimbursed low rates. The following items are causing access issues.

- **Difficulty of receiving funding for room and board costs.** Group Residential Housing eligibility may not be confirmed before the person is discharged from the program. This is especially problematic due to the nature of the crisis stabilization episode lasting on average 3-4 days.
- **Short term stays increase administrative, billing and program costs.** On average, two people use each crisis bed in each month. This high turnover service use creates high costs for admission and discharge procedures and billing. Some of the time, an individual will be admitted to the program but not stay overnight. However, the time spent at the facility is enough to help the person stabilize and return to their own home
- **People who use residential crisis stabilization programs have a high level of symptoms and support needs.** These programs are used in lieu of a hospital. Many of the people that are served would have gone to a hospital for services in the past. Because of the high needs, highly-trained staff people are required for these programs. Individuals who use residential crisis services also need more one-to-one time with staff people. This need creates a requirement for a higher ratio of staff people to the number of people receiving services.
- **Crisis programs admit on a 24-hour basis.** This admission policy requires staff with practitioner or professional credentials to be available to perform the admission process. The programs need to have 24-hour nursing staff available to assure that the people at the program, especially new admissions, get the correct medication and are not a health risk to others in the programs.
- **Crisis programs need to have program capacity available when a person is in crisis.** Because they need to keep space available, their overall occupancy is lower and their income is less than a program that is consistently full.
- **Crisis programs serve more people who have commercial insurance.** Commercial insurance plans usually cover a more limited set of services for mental health issues than publicly funded programs. Many of the commercial plans do not cover residential crisis stabilization programs.
- **The rates for the small crisis programs do not support the cost of providing the services.** Programs licensed as Adult Foster Care programs (five beds and under) are not required to meet the IRTS variance standards, therefore are not eligible for the cost-based rate. The two residential crisis programs that have recently closed have been receiving the non-negotiated per diem of \$262 per day. Low reimbursement rate prompted the program closures.

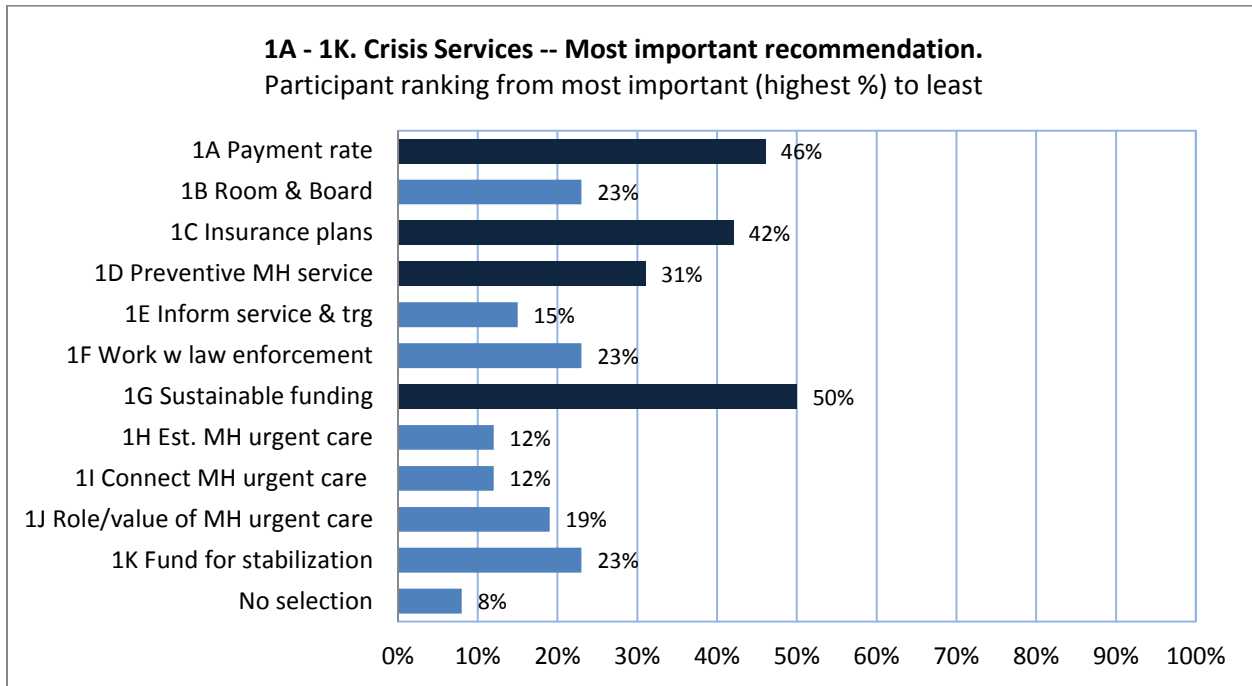
Recommendation 1B: Address issues related to unsustainability for room and board costs for residential crisis providers.



Recommendation 1K: Increased funding for the stabilization component of crisis residential services.



Workgroup participants ranked each recommendation from most important to least important:



Central Receiving Center

The enacting legislation required the workgroup to “consider the efficacy of a facility that would serve as a central point for accepting, assessing, and addressing the needs of offenders with mental illness brought in by law enforcement as an alternative to arrest or following arrest; establish criteria to determine which offenders may be admitted to the facility; and consider how similar facilities could function in outstate areas.” Presently, in Minnesota, there are two main options available to law enforcement—the Emergency Room or the local jail.

The original intent of the legislation was orientated towards the Central Receiving Center model. This model is an acute crisis assessment location for individuals with mental illness and/or substance abuse disorders who would otherwise be taken to the jail or local emergency room. The model was conceptualized to respond to the vision that “Health services at the jail cannot be divorced from the community. The services at the Jail impact the community – the services in the community impact the Jail. In other words, the existing initiatives in the county were essentially efforts to identify and refer people in contact with law enforcement to mental health

services and were dependent entirely on the accessibility and quality of services in the community.”¹⁸

In Orange County, the purpose of the Central Receiving Facility was to avoid:

1. The emergency room, where an officer could wait with a person in crisis for significant amounts of time before being seen and admitted by a doctor, commit the individual to involuntary treatment, or simply return the individual to the street,
2. Doing nothing for the individual or the public, or
3. Booking the person into jail, where the individuals are required to receive mental health services.

The Orange County Central Receiving Center Model creation and operation was “not inexpensive—the yearly budget topping \$1.752 Million.”¹⁹

The workgroup recognized that the goal of the Central Receiving Center to achieve a rapid handoff from law enforcement to mental health services and chemical health services could be made possible by a variety of other options. Members of the group felt that targeting funding to current providers could improve service access and prevent the need to engage law enforcement, thereby diverting people from going to jail. Members of the group also identified that the Orange County Central Receiving Center model opened in 2003 and that the Minnesota system has more community-based services than Florida.

Central Receiving Center Options:

1. Co-located services including residential/crisis beds, under one roof (Orange County “hub” model). This model was discussed above.
2. Co-located outpatient/community services, such as a mental health urgent care model with co-located scattered-site crisis beds. This model is very similar to the Minnesota Urgent Care for Adult Mental Health which offers an on-site team of psychiatrists, nurses, social workers, and trained peer support staff ready to provide crisis services for adults (ages 18 and older) in Ramsey, Dakota, and Washington Counties.
3. Psychiatric emergency department. Similar to Hennepin County Medical Center’s Acute Psychiatric Services center,²⁰ serves those in emotional crisis with 24-hour, seven-day-a-week crisis counseling, assessment, and referral with a fast hand-off for law enforcement.

Of these options, the following was determined to best provide for a rapid handoff from police to mental health services and chemical health services and coordination of these services.

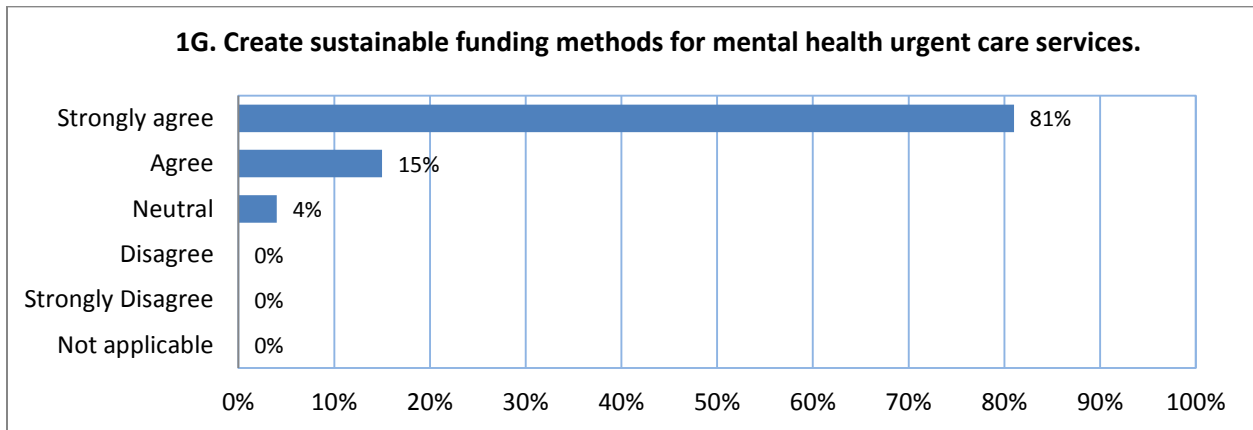
¹⁸ Council of State Governments Justice Center. (2007). *Increasing Collaboration between Corrections and Mental Health Organizations: Orange County Case Study*. New York, NY: Council of State Governments Justice Center.

¹⁹ Ibid.

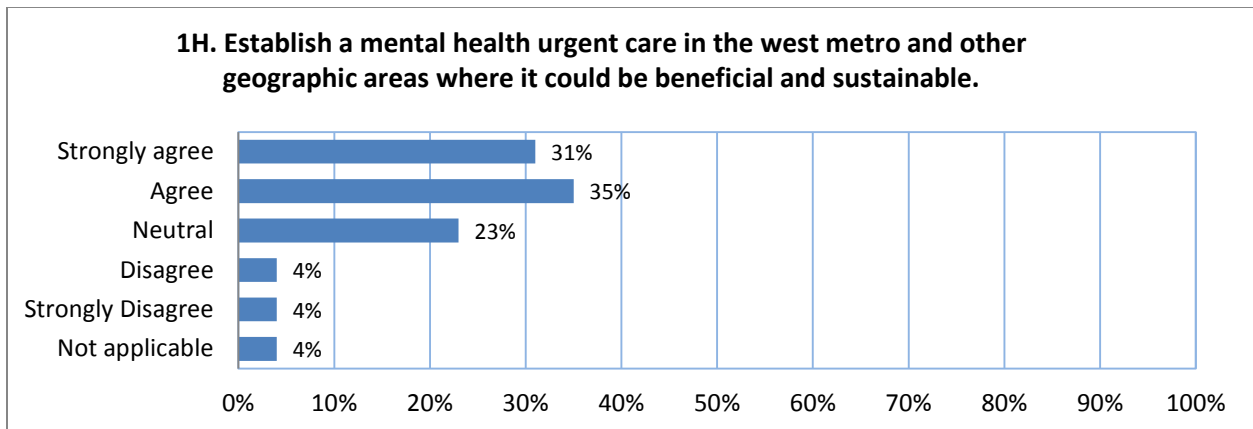
²⁰ For more information see:

http://www.hcmc.org/clinics/AdultPsychiatryClinicMedication/psychiatricservices/HCMC_MAINCONTENT_425.

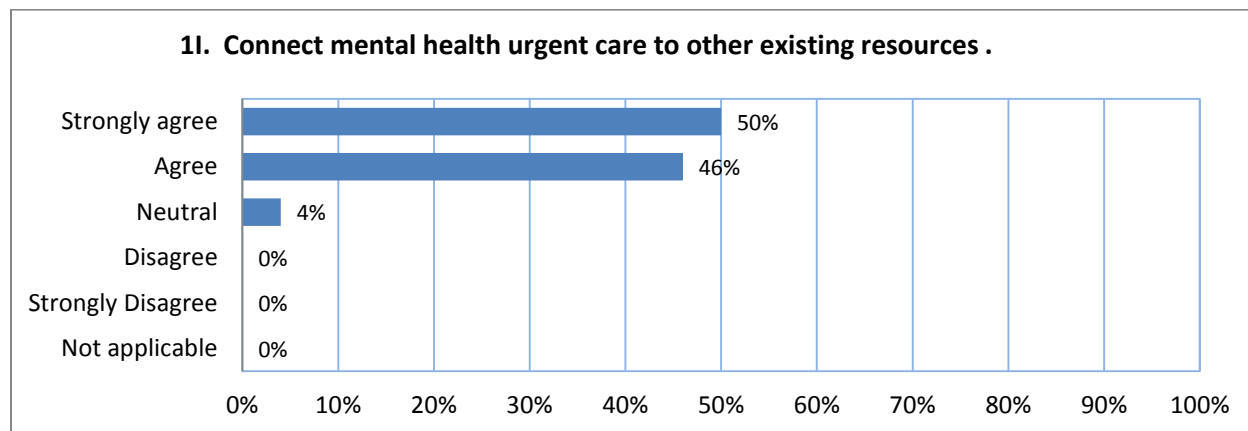
Recommendation 1G: Create sustainable funding methods for mental health urgent care services. Urgent care services include: Mental health crisis assessment; Access to crisis psychiatry; Chemical health screening; and crisis stabilization services.



Recommendation 1H: Establish a mental health urgent care in the west metro and other geographic areas where it could be beneficial and sustainable.



Recommendation II: Connect mental health urgent care to other existing resources (e.g., detox, mobile crisis/crisis residential, hospitals) if feasible.



First Responder/Law Enforcement

911 is often the first call for help and often law enforcement is dispatched as a first responder to an individual who is having a mental health crisis. In order for law enforcement to more quickly assess a situation, recognize mental health symptoms, and respond appropriately, he or she needs to learn techniques for engaging people in respectful, non-stigmatizing manners that help to quickly de-escalate the crisis.

According to the National Alliance on Mental Illness, “The Crisis Intervention Team (CIT) model, a form of pre-booking jail diversion for people with mental illnesses, is in the process of being implemented in parts of Minnesota. The CIT model involves a 40-hour training that teaches law enforcement officers how to recognize the signs and symptoms of a mental illness, safely de-escalate a mental health crisis and connect people to local mental health resources. A successful CIT program will also go beyond this training to ensure that law enforcement officers build strong partnerships with community-based organizations, as well as with individuals and families impacted by mental illness.”²¹

Law enforcement officers who have gone through CIT training give it high praise. “Many report that the training changes their outlook on how they do their jobs, shifting away from the view that “a crime is a crime” and toward the view that behaviors can be symptoms of a mental illness.”²²

Unfortunately, allowing law enforcement time away from day to day work to engage in trainings such as these is costly and a sacrifice of the agency for which they work.

²¹National Alliance on Mental Illness. (2010). State of the State: Addressing Mental Health Disparities in the Minnesota Criminal Justice System. St. Paul, MN: NAMI-MN.

²²Ibid.

In addition, the knowledge of first responders of other options than the local Hospital Emergency Department or the jail is limited. In addition to CIT, Minnesota also has mobile mental health crisis teams statewide. Some of the crisis teams in the state have established agreements with their local emergency rooms so that they have options available to them to accelerate the speed of admissions to a hospital when they bring in a client experiencing a mental health crisis. These agreements make the crisis teams an invaluable tool to law enforcement, helping to relieve the need for officers to spend hours waiting for people in crisis to be seen in their local emergency rooms.

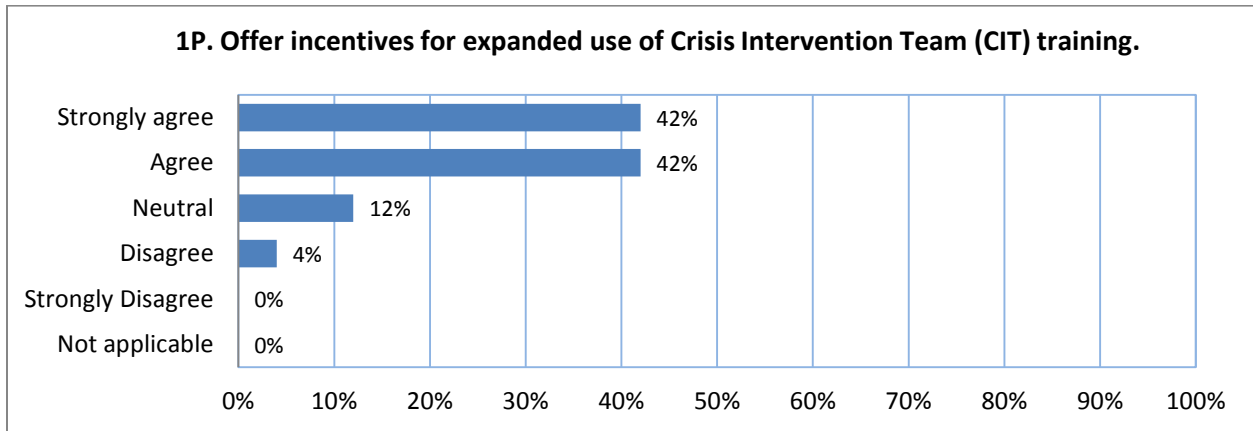
Some of Minnesota's crisis teams have also developed partnerships with local law enforcement, enabling them to respond either along with or instead of law enforcement, depending on the situation. Unfortunately, as stated earlier in this report, these services vary from region to region and county to county in a number of ways. There is very little comparability in the hours of services and the criteria for when mobile crisis response services are dispatched. In the rural areas of the state, many mobile crisis teams have a broad geographic area for which to serve – often not being close to a person who is having a mental health crisis. As a result, most 911 operators are unaware of their local mobile crisis teams or how to contact them. They also do not typically have a protocol for identifying when a particular call is mental health related, let alone referring to the appropriate community-based crisis resource.

Finally, first responders may not know about the role/value of available mental health urgent care options. As mentioned earlier in this report, the east metro has one such site. Called the Urgent Care for Adult Mental Health, this site offers an on-site team of psychiatrists, nurses, social workers, and trained peer support staff ready to provide crisis services for adults (ages 18 and older) in Ramsey, Dakota, and Washington Counties. Such a program could be available in other areas of the state where population need could sustain the program.

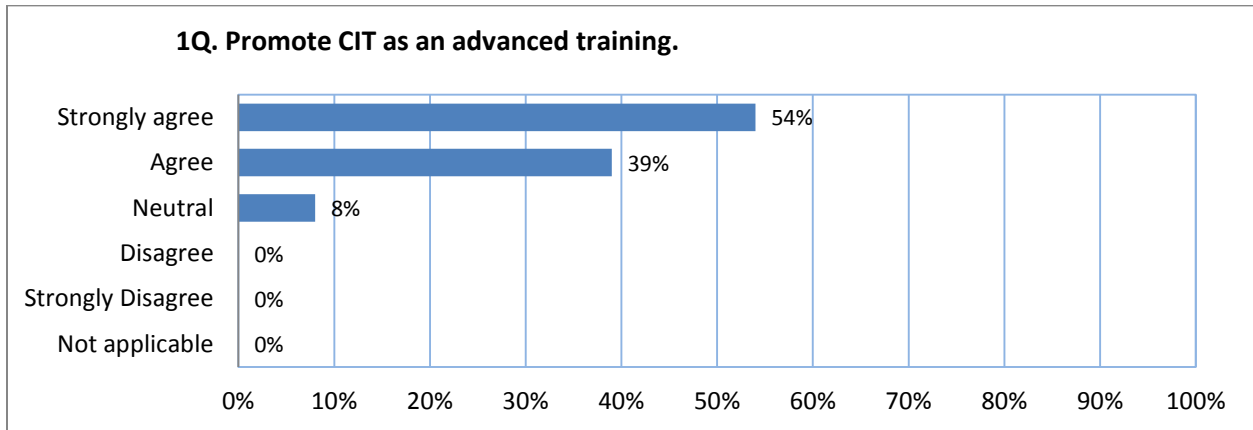
Another model that has shown promise is psychiatric emergency departments. These are emergency departments specifically tailored to meet the needs of psychiatric patients and have similar functionality as a central receiving center with respect to rapid hand-off from law enforcement. An example of this model is the Hennepin County Medical Center—Acute Psychiatric Services, which some members of the workgroup toured.

Some law enforcement departments have noted that CIT training is less effective when made part of the new officer training and have observed attrition in the ranks of CIT trained officers.

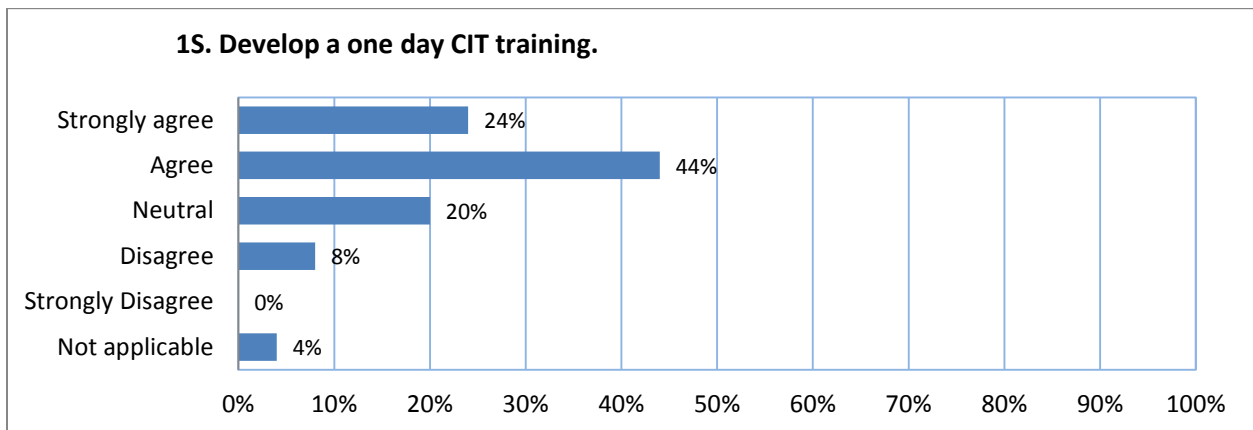
Recommendation 1P: Offer Incentives for expanded use of Crisis Intervention Team (CIT) training.



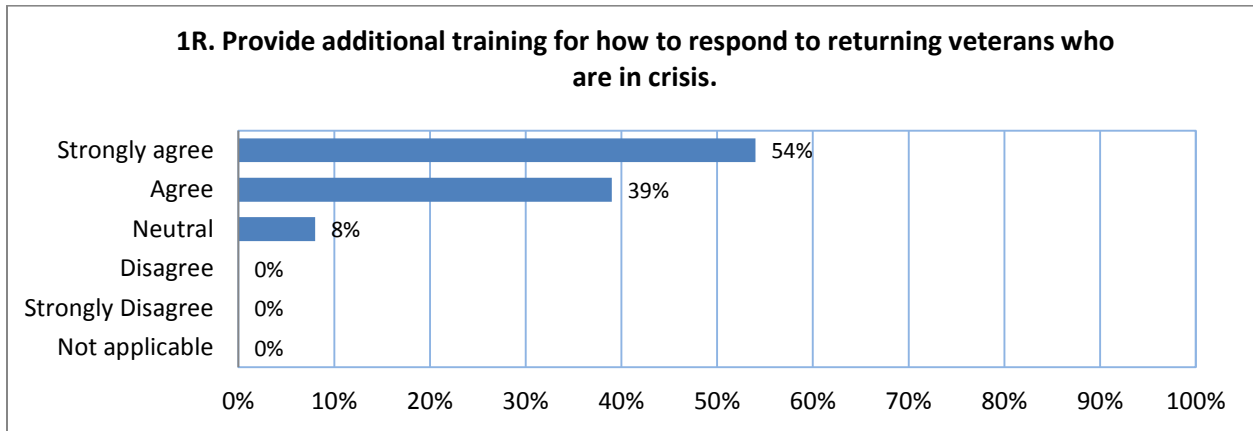
Recommendation 1Q: Promote CIT as an advanced training.



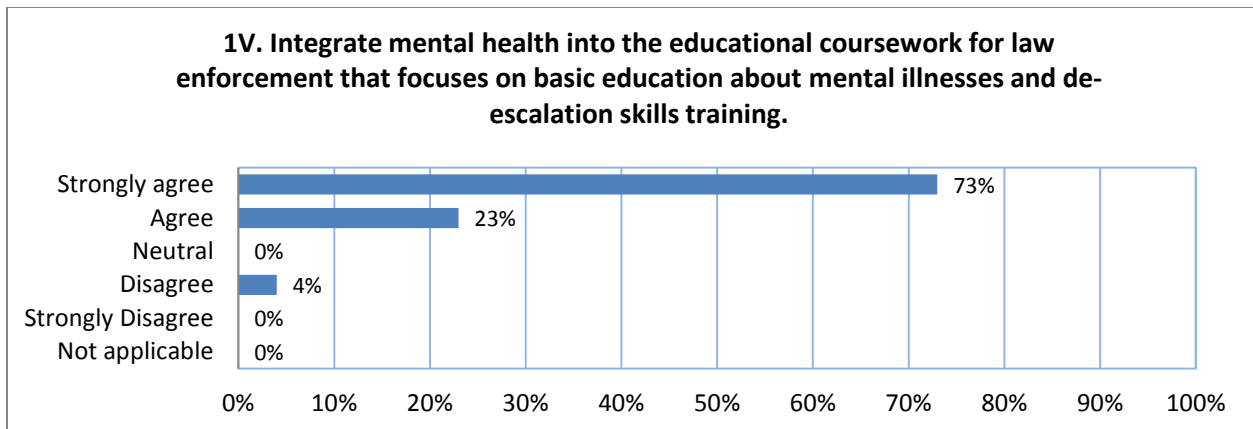
Recommendation 1S: Develop a one day CIT training.



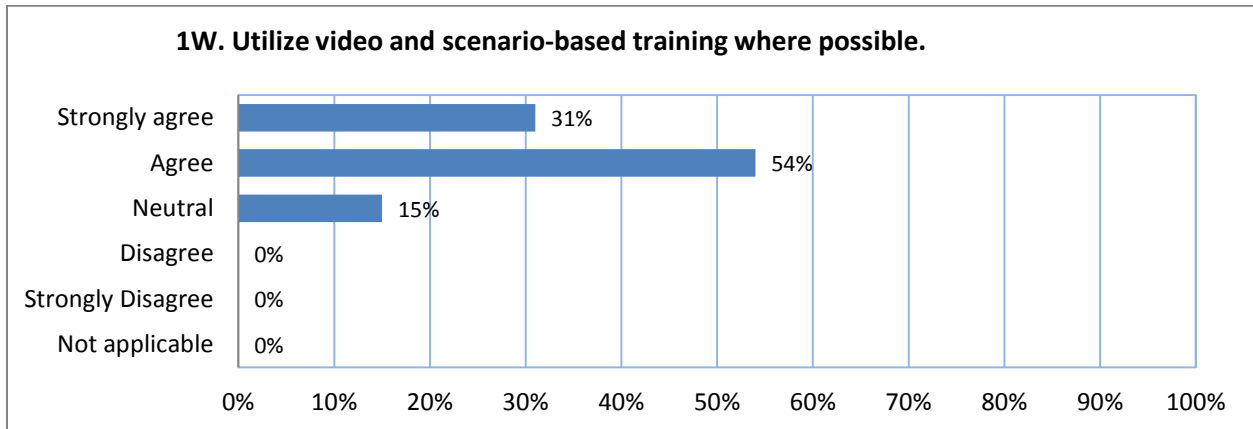
Recommendation 1R: Provide additional training for how to respond to returning veterans who are in crisis.



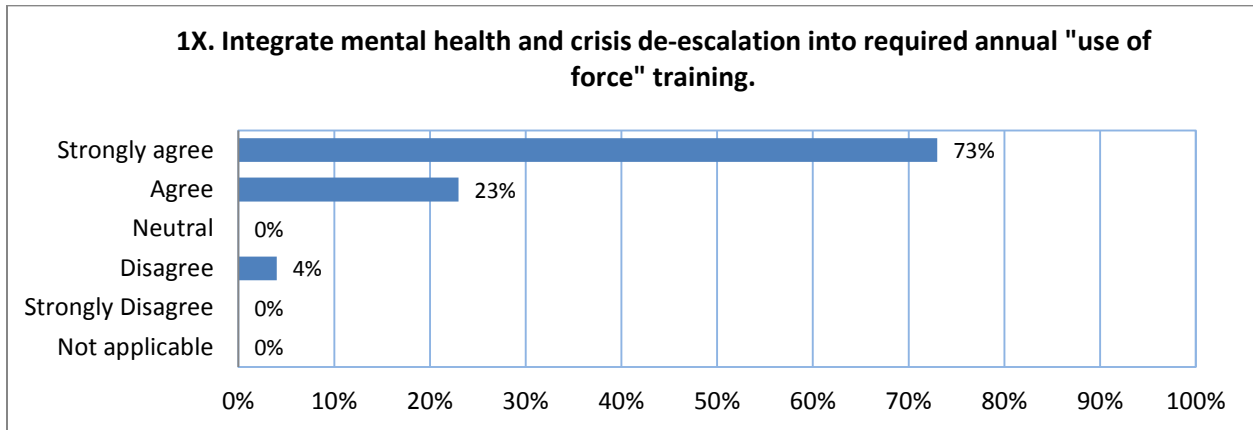
Recommendation 1V: Integrate mental health into the educational coursework for law enforcement that focuses on basic education about mental illnesses and de-escalation skills training.



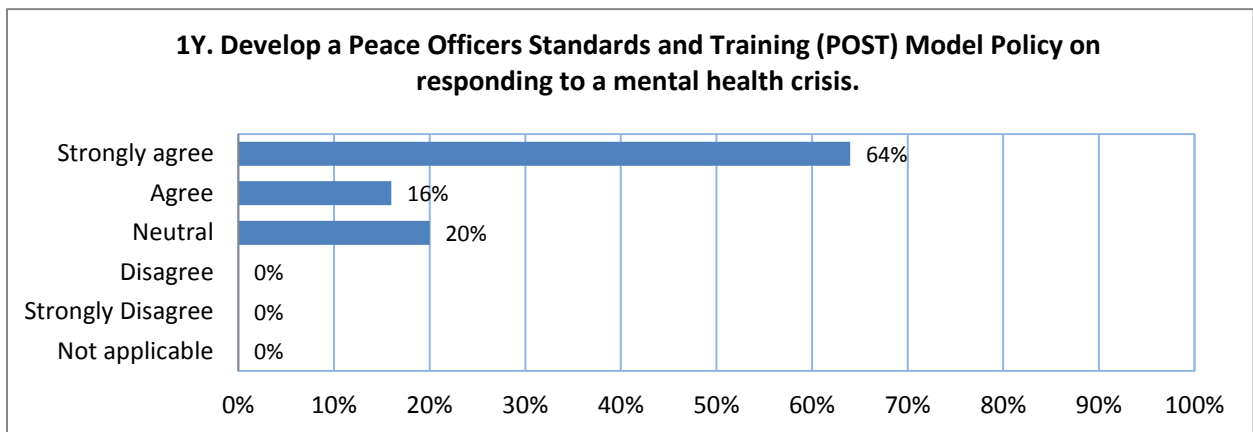
Recommendation 1W: Utilize video and scenario-based training where possible.



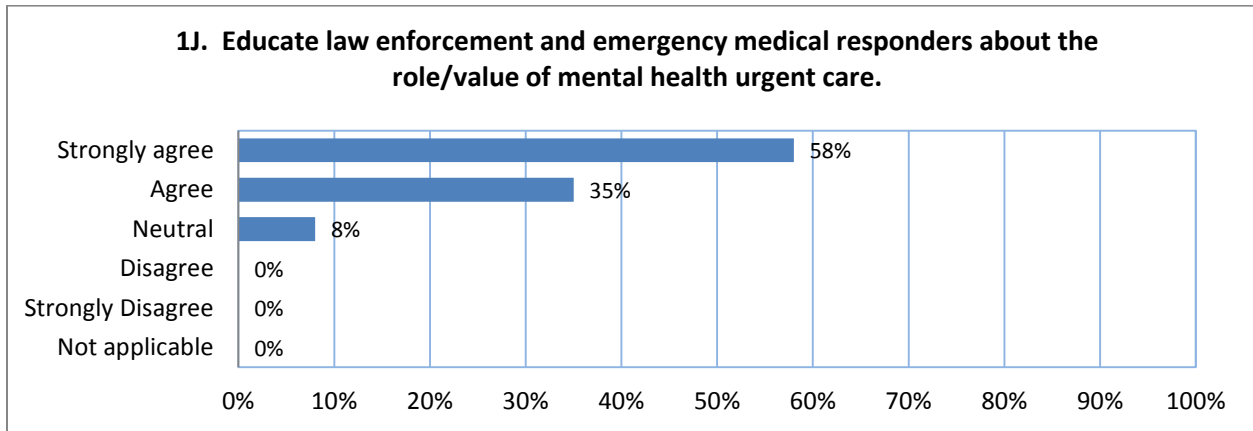
Recommendation 1X: Integrate mental health and crisis de-escalation into required annual "use of force" training.



Recommendation 1Y: Develop a Peace Officers Standards and Training (POST) Model Policy on responding to a mental health crisis. The POST Board develops, coordinates, and approves continuing education programs for peace officers and part-time peace officers.

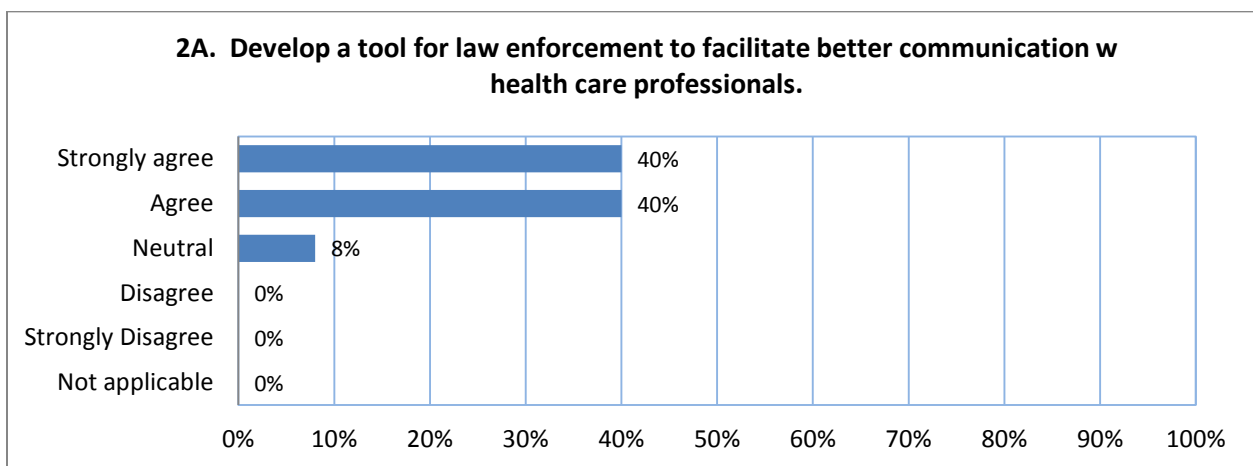


Recommendation 1J: Educate law enforcement and emergency medical responders about the role/value of mental health urgent care.



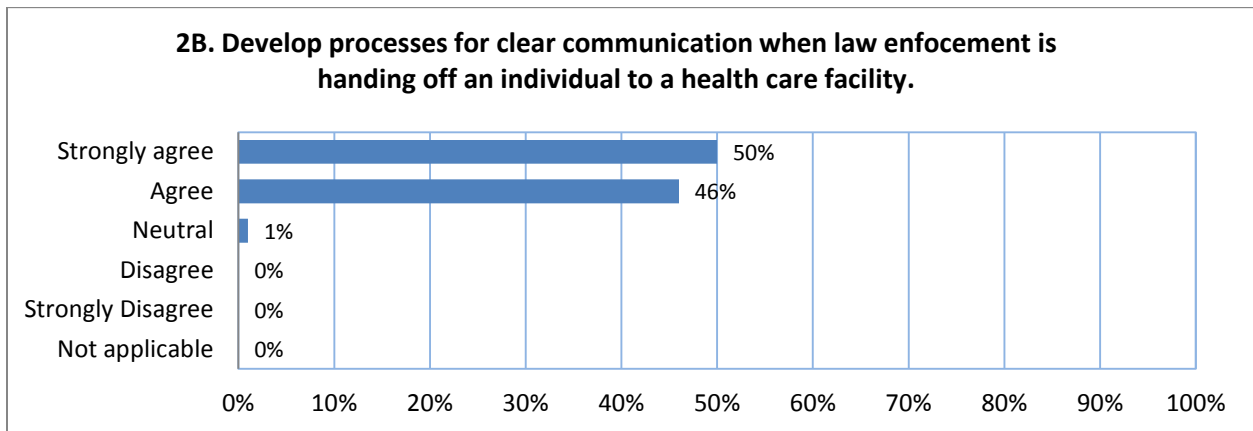
In addition, the workgroup identified other barriers between law enforcement and health care professionals that appear to prevent an individual who is experiencing a mental health crisis from receiving the most appropriate service at the most appropriate location and the most appropriate time. Effective communication being the key; it is important to recognize that there are language barriers between law enforcement professionals and those who work in the health care or mental health profession. Understanding each other in situations where an individual is having a mental health crisis is vastly important. The intersection between the criminal justice system and the health care and/or mental health system requires that each use common language and assure methods that information is understood.

Recommendation 2A: Develop a tool for law enforcement to facilitate better communication with health care professionals.

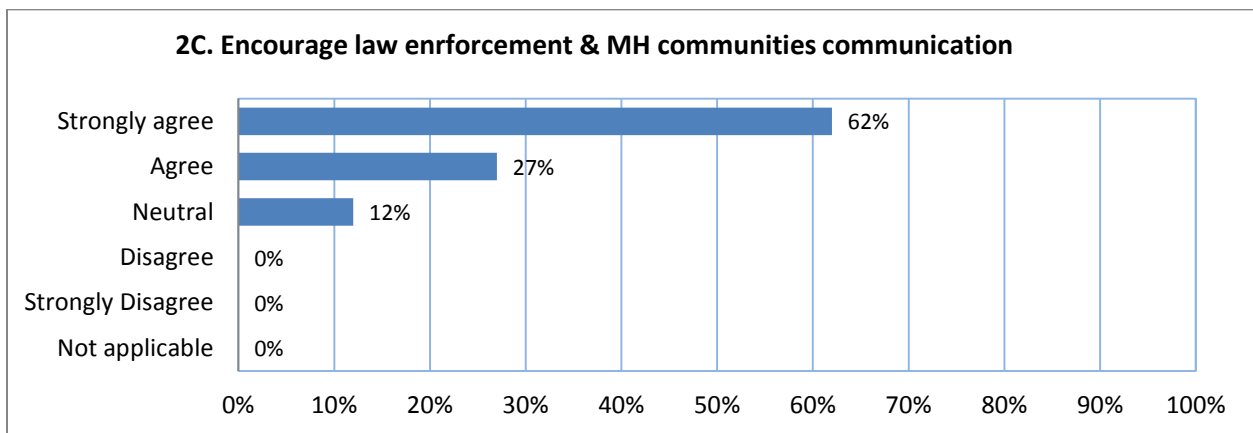


Such a tool could look similar to the interRAI Brief Mental Health Screener (BMHS).²³ BMHS was developed to provide police officers with a tool that would help them to identify persons in the community with mental health problems and to assist them in communicating their observations to appropriate health care professionals. The ultimate goal underlying the development and use of the BMHS is to ensure that people with mental health problems who come in contact with the police receive prompt access to appropriate mental health services, reducing the risk of criminalization.

Recommendation 2B: Develop processes for clear communication when law enforcement is handing off an individual to a health care facility.

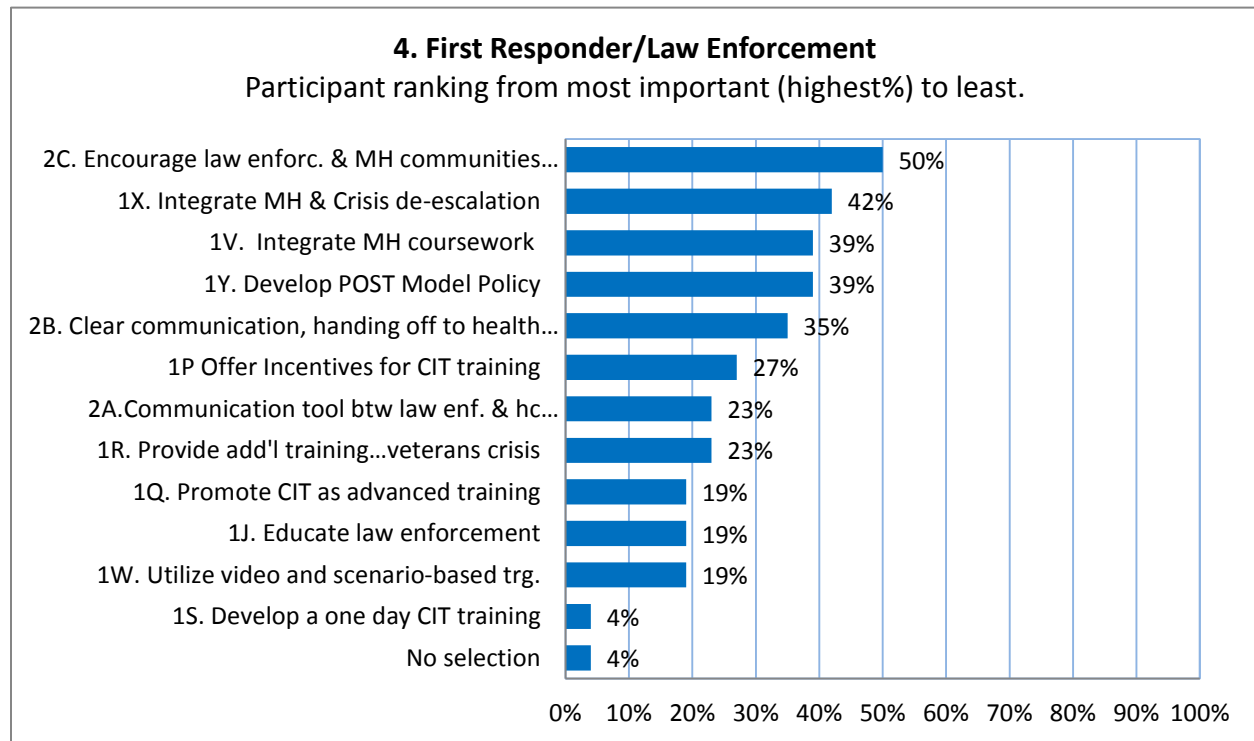


Recommendation 2C: Encourage local jurisdictions to have regular meetings between law enforcement and mental health communities to facilitate dialogue and collaboration, identify trends, and address barriers.



²³ See <http://www.interrai.org/mental-health.html>

Workgroup participants then ranked each recommendation from most important to least important:



Data Management

Presently, the Minnesota Hospital Association (MHA) has partnered with DHS to operate the Minnesota Mental Health Access website (mnmhaccess.com), which provides updated information on availability of inpatient psychiatric hospital beds in the state. This site was primarily designed to assist health care providers to locate potential openings in mental health services for the purpose of referring patients for care. This web site locates inpatient acute care mental health beds as well as community-based services. The service locator is limited to the state of Minnesota so it cannot be used to locate inpatient beds in another state.

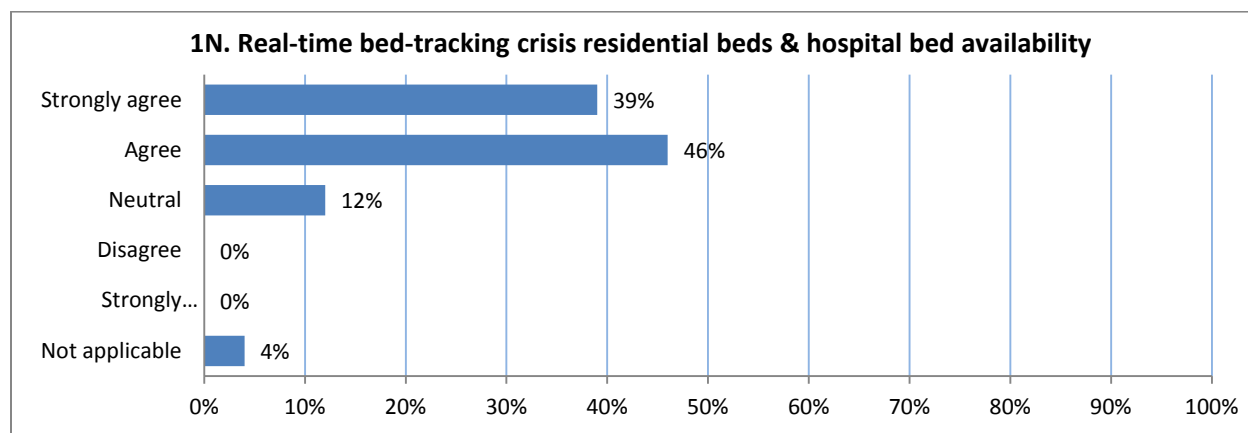
The site, as it presently has been created, has strengths and limitations. The strength of the web site is that it is fast and easy for providers to locate openings for services such as inpatient mental health hospital beds, saving hours of calling facilities to locate openings. The information contained in this web site will prevent the need to call facilities that are full to capacity in order to determine that they cannot take any new admissions. Once services are located, essential information including contact names and numbers and directions to the facility, are easy to obtain on this site.

The main limitation is that the web site is not designed to manage admissions or transfers of patients. When a service is located on this web site, providers must still contact the facility to

discuss potential patient transfers and to make arrangements for services. All of the facilities' admission and transfer policies will continue to apply. Each facility will continue to manage their facility openings and admissions. If this locator service indicates a bed opening, it does not mean that this bed is guaranteed. Providers must not send patients directly to a facility based upon the indication that there is a bed open from this web site. It is essential to first contact the facility to arrange for patient transfer and admission and to be sure that the patient is appropriate for admission in the facility.

While MHA has worked with hospitals and other providers to update their availability as quickly as possible, there still is a need to identify a process that allows for the posting of real-time availability of inpatient psychiatric hospital beds or other community mental health services.

Recommendation 1N: Develop a systemic, real-time bed-tracking of available crisis residential beds and hospital beds.



An electronic health information exchange allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient’s vital medical information electronically, improving the speed, quality, safety and cost of patient care.

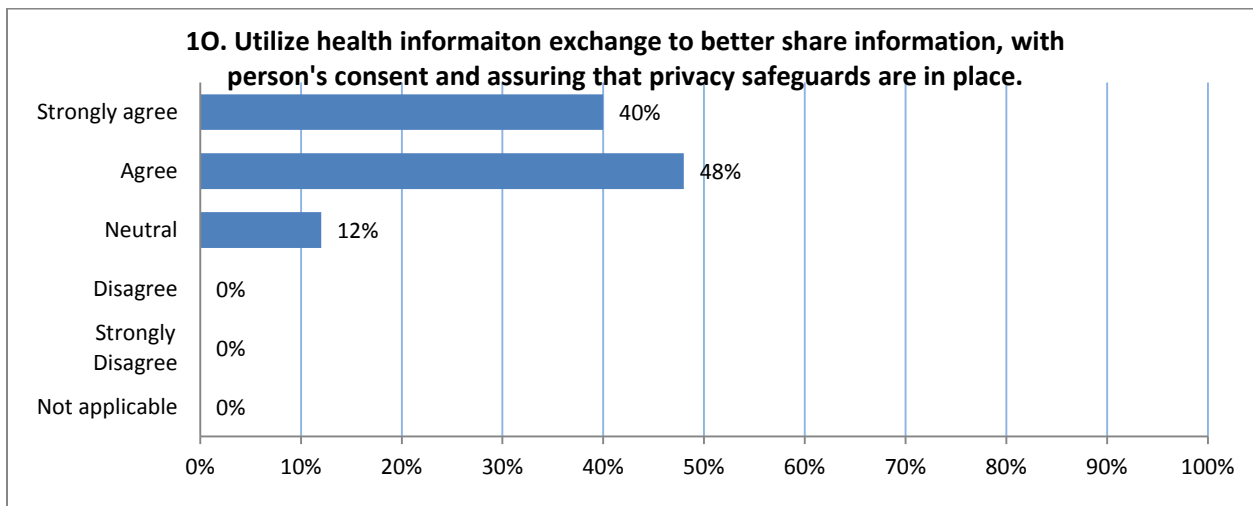
Presently, most individuals in Minnesota have their medical information stored in a paper record either in the filing cabinets at various medical offices, or in boxes and folders in patients’ homes. When there is a need to access or share medical information, it is shared by mail, fax or the patients themselves. While electronic health information exchange cannot replace provider-patient communication, it can greatly improve the completeness of patient’s records and thereby improve the quality of care. Past history, current medications and other information is readily accessible for the provider during visits. This can better inform decision making at the point of care and prevent readmissions, medication errors while improving diagnoses and decrease duplicity of testing. Using electronic health information exchange to facilitate necessary care coordination could go far in improving both the patient experience and their treatment outcomes.

In addition, there are significant barriers to information sharing between mental health systems, health care, law enforcement and jails. Information isn’t shared across counties, so if a person has been booked in prisons at multiple counties, that information is not carried over. Law

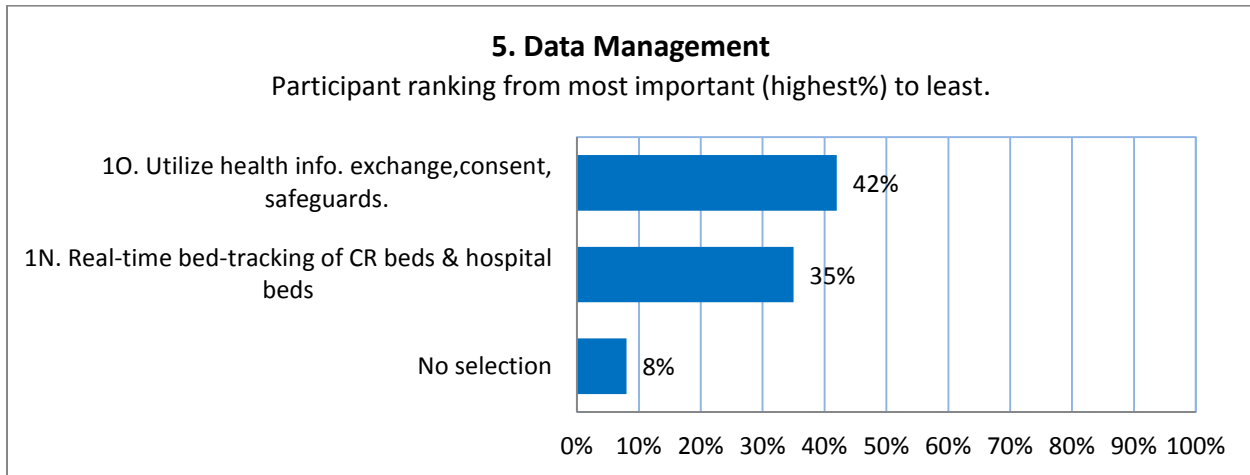
enforcement doesn't know the medical history of people and this can cause harm to both parties. Hospital records do not go to a jail without an inmate's release and jails have limited resources and time to conduct health screens. The medical release signing and health screen occur during the booking process. During this time people are in a stressful situation and are not likely to be forthcoming with any health vulnerabilities they may have. This is especially true for mental health issues.

An added intricacy to the information-sharing problem is the potential impact it may have on a person's ability to find housing. Certain people may not want to release their information for fear that it may impact their eligibility for housing or endanger their relationship with their family, friends or even parole officer. Additionally, while information about a person's mental health state may play a large role in how they are sentenced, often this information is not available to a prosecutor. Prosecutors may find themselves in the position of deciding whether or not a person has a mental illness. As prosecutors are not mental health professions, this practice is both dangerous and an inaccurate way to handle the cases of people who have mental health problems.

Recommendation 10: Utilize health information exchange to better share information, with person's consent and assuring that privacy safeguards are in place.



Workgroup participants then ranked each recommendation from most important to least important:



Jails and Courts

Minnesota jails offer psychiatric services, but these services vary significantly from jail to jail. The vast majority of Minnesota’s county jails offer psychiatric medications, as is required by law, but often that is the extent of their mental health treatment services. In addition, some jails offer access to a psychiatrist to handle prescriptions and assist inmates with medication management. A smaller number of jails offer access to mental health therapy. Not a single jail in Minnesota coordinates care with community providers on a consistent and widespread basis.

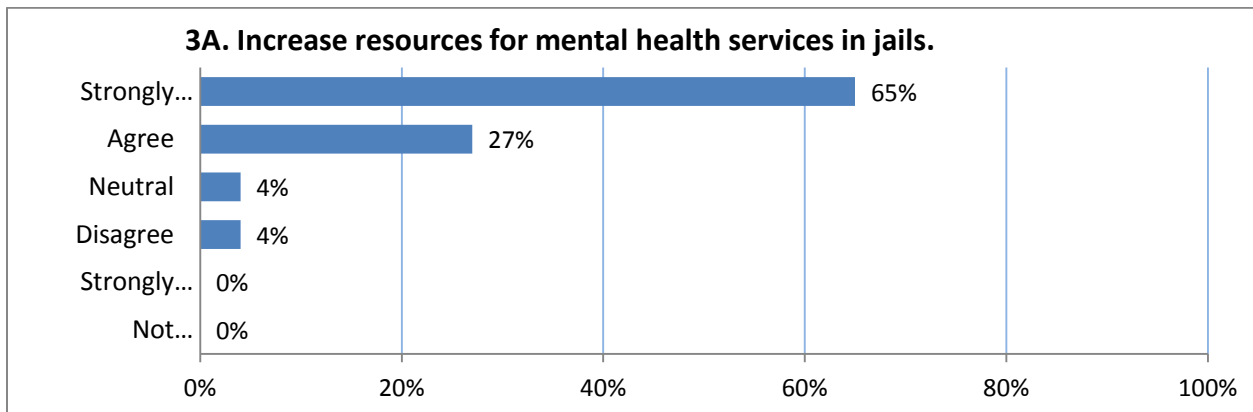
Since 2006, all county jails in Minnesota are required to administer the Brief Jail Mental Health Screen at intake. This tool helps the jail determine if the person is experiencing a mental health issue. While helpful, we know that it takes much more than a screening requirement to ensure that mental health information is accurate and useful for preventing unnecessary criminal justice contact.

While jails do perform a health screen upon entry, there is a strong likelihood for mental health deterioration after time in jail. Currently there are no routine follow-up mental health screens in jail. Part of this issue is that healthcare in jails is often contracted to outside companies, with variable results. Restrictive formularies can require many people to switch their current psychotropic medication to whatever is approved by the formulary. This changing of medications can have extremely variable effects to both the physical and mental health of the person. Changing psychotropic medications is especially concerning in an environment such as jail where the availability of mental health professionals is extremely limited. For example, some Minnesota jails have access to a psychiatrist only once a week. Additionally, there are often problems helping people who actively avoid mental health services. It is difficult to convince some people who are suffering from mental health problems to seek help.

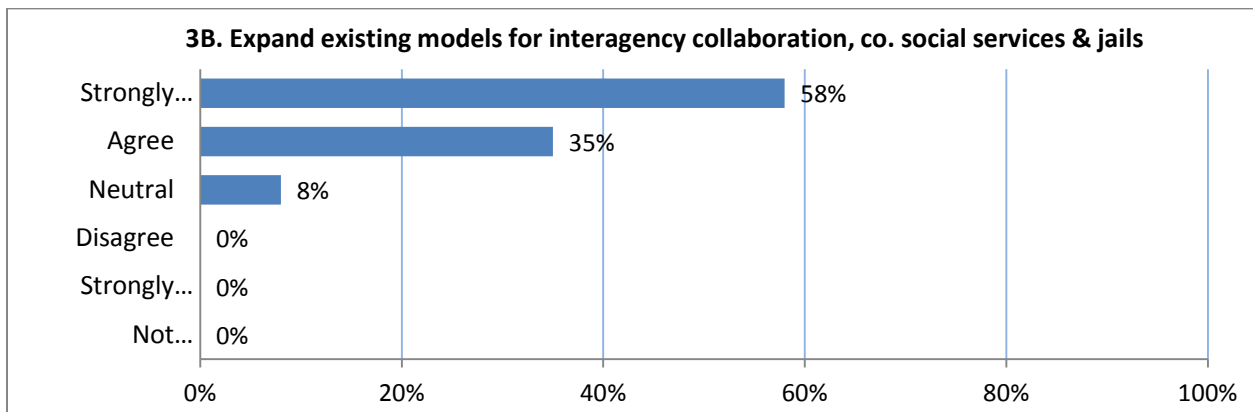
In addition, rarely do law enforcement, judges and others have access to an individual’s mental health information. Furthermore, they may not know the appropriate questions to ask nor the signs to look for to help them determine if the causal factor for the individual’s involvement with the criminal justice system is due to their mental health.

For adult criminal cases, Minnesota has three mental health courts and one veteran’s mental health court. Minnesota also has 35 operational adult drug courts, all of which see a number of individuals with mental illnesses. The Hennepin County Criminal Mental Health Court accepts non-domestic misdemeanor and gross misdemeanor cases from the arraignment, pretrial and trial calendars, as well as felony cases. The Ramsey County Mental Health Court takes only misdemeanor and gross misdemeanor, non-violent crimes. Both metro courts provide intensive case management and specialized probation for cases in the pre-adjudication and post-adjudication stages.

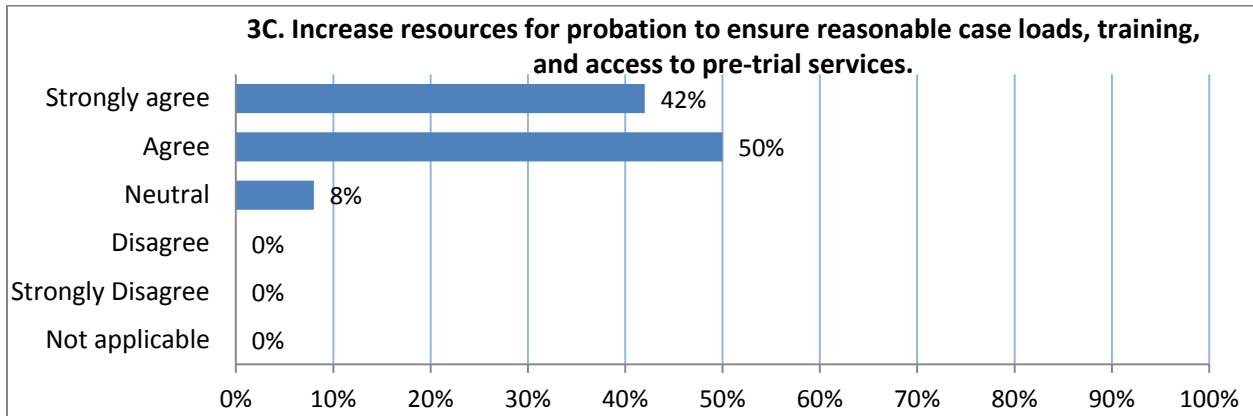
Recommendation 3A: Increase resources for mental health services in jails.



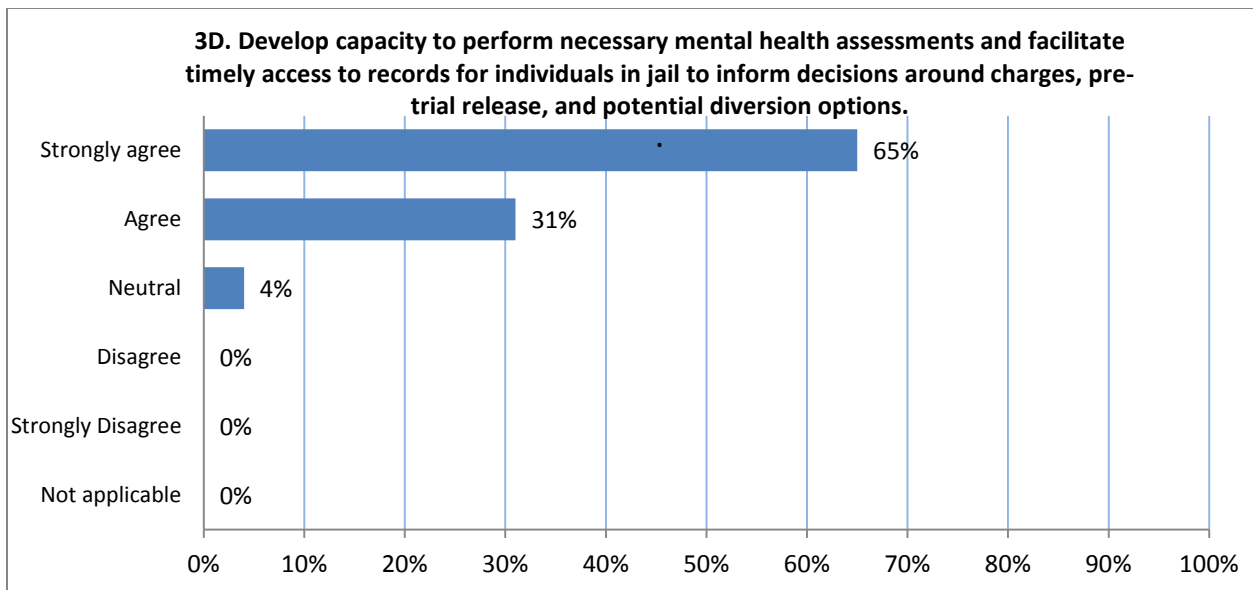
Recommendation 3B: Expand existing models for interagency collaboration between county social services and jails to other communities.



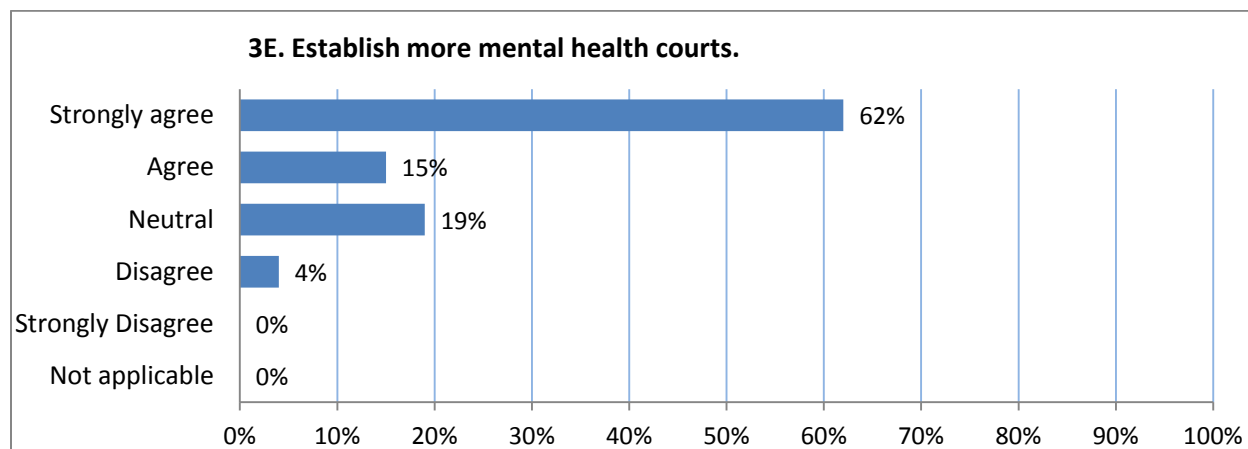
Recommendation 3C: Increase resources for probation to ensure reasonable caseloads, training, and access to pre-trial services.



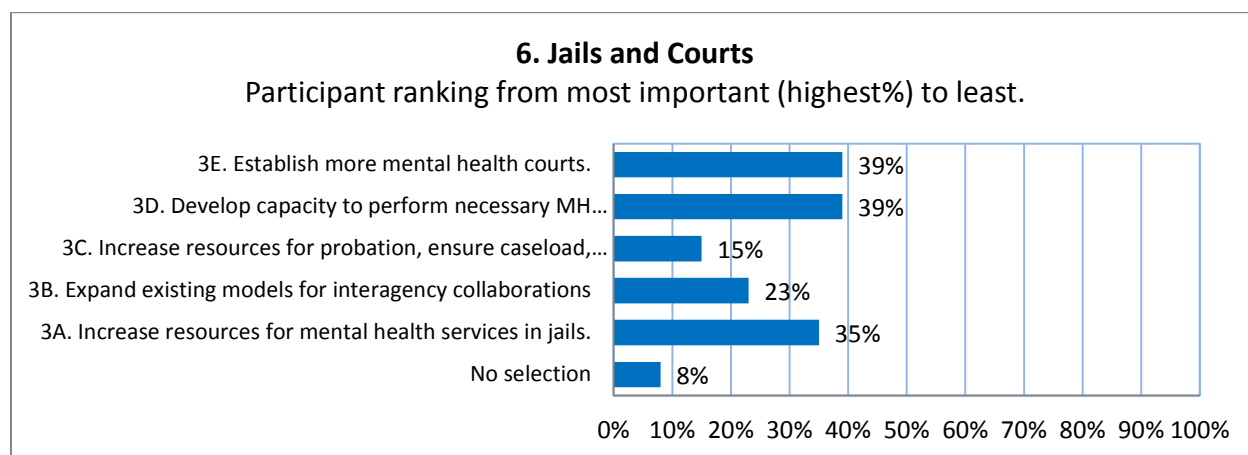
Recommendation 3D: Develop capacity to perform necessary mental health assessments and facilitate timely access to records for individuals in jail to inform decisions around charges, pre-trial release, and potential diversion options.



Recommendation 3E: Establish more mental health courts.



Workgroup participants then ranked each recommendation from most important to least important:



Discharge

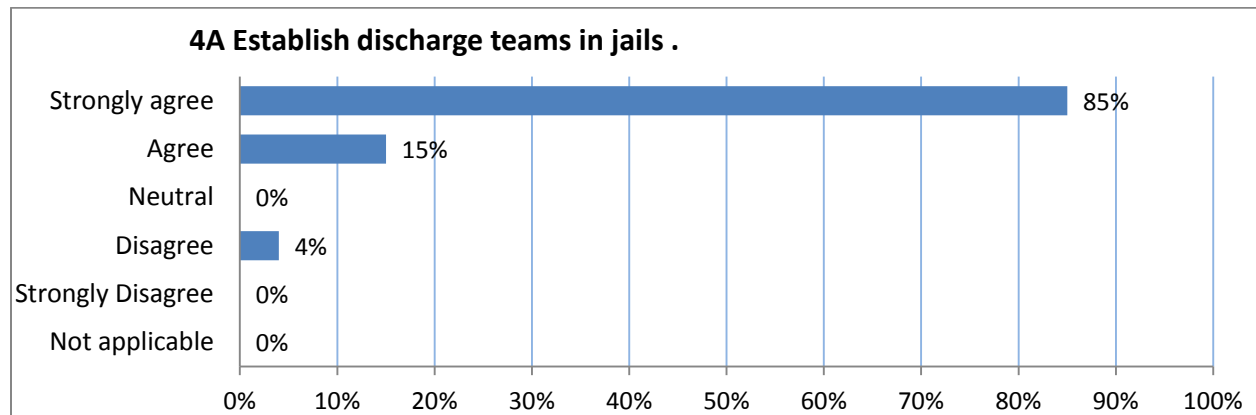
While some counties in Minnesota have begun to provide discharge planning services for many of its jail inmates, more could be done. Many jails have difficulty in coordinating discharge services within the time frame of a typical jail stay. There is not enough time to effectively implement discharge planning and to ensure that every inmate receives discharge planning. In addition, there is a lack of community resources to direct inmates to following discharge. There needs to be a coordinated hand off from discharge directly to community resources. For example, jails have had difficulty finding out whether a person booked into jail already has a caseworker. This can lead to delays in service.

In addition, discharge plans are often meaningless and recidivism rates remain high when there is inadequate supportive housing. Currently people are being discharged from jail but often have nowhere to go, drastically increasing the chances that a person will end up returning to jail. Even if a jail provides discharge assistance, a person's first priority after being released is often finding a place to stay. As a result, getting additional help, diversion plans and attempts to obtain benefits are often neglected. This is especially true for people with offenses that may result in an increased difficulty getting into a shelter or even exclude them from getting into a shelter all together.

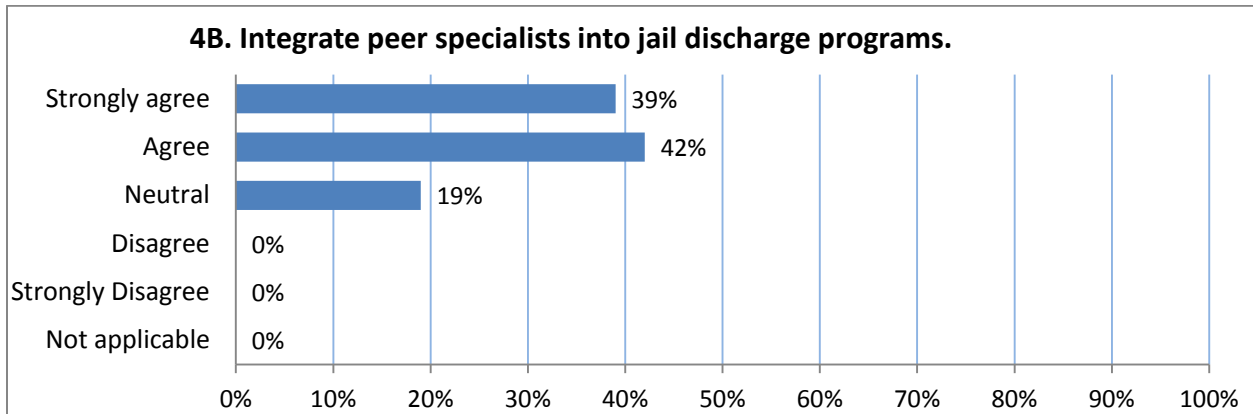
In order to effectively implement discharge plans, discharge teams should be placed directly within jails to work with inmates. Furthermore, it is imperative that discharge teams follow up with released persons. In order for a discharge plan to work, discharge teams need to follow people from jail through obtaining community resources. An effective option may be to have immediate continuing care.

Once a person is discharged, they go straight from jail to a discharge follow up meeting where they receive assistance in finding benefits, housing, employment, and other services. Increased funding and resources in order to maintain a sufficient number of discharge teams can help individuals. In order to increase inmate engagement with discharge teams, peer specialists working in jails would be of value. Housing assistance and medical assistance should be a focus of the discharge process as well.

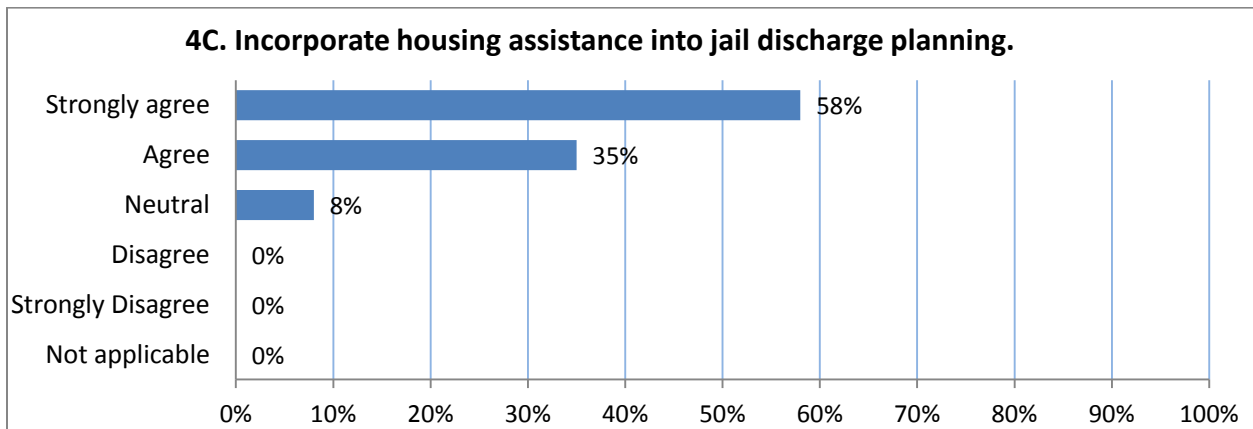
Recommendation 4A: Establish discharge teams in jails to connect persons with community resources.



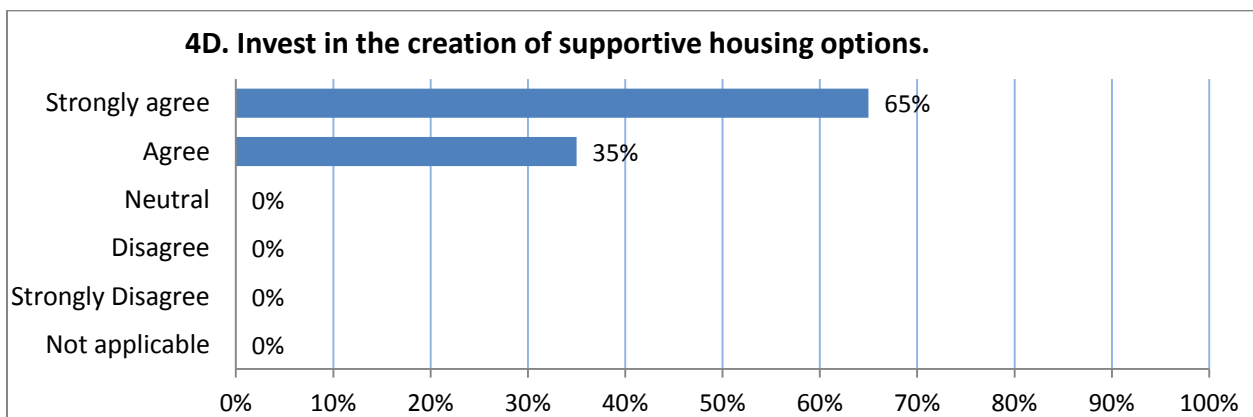
Recommendation 4B: Integrate peer specialists into jail discharge programs.



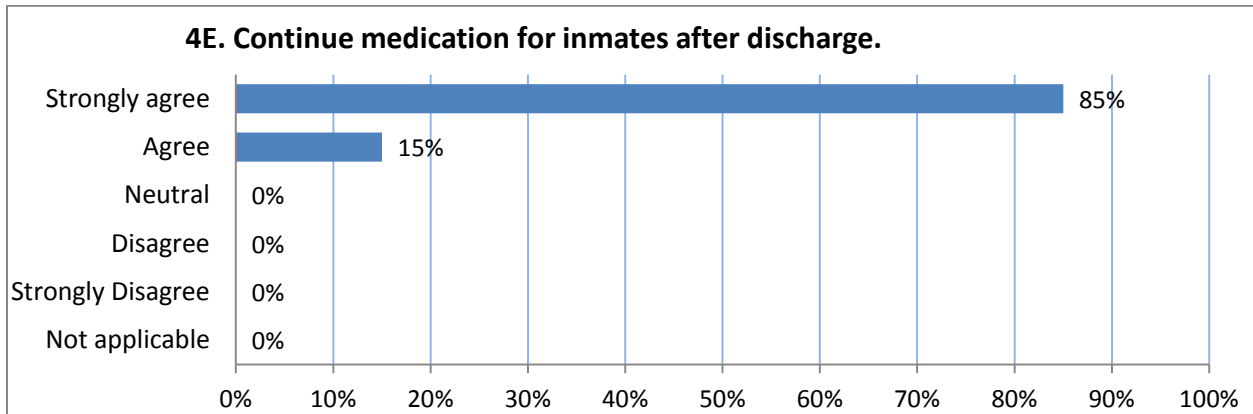
Recommendation 4C: Incorporate housing assistance into jail discharge planning.



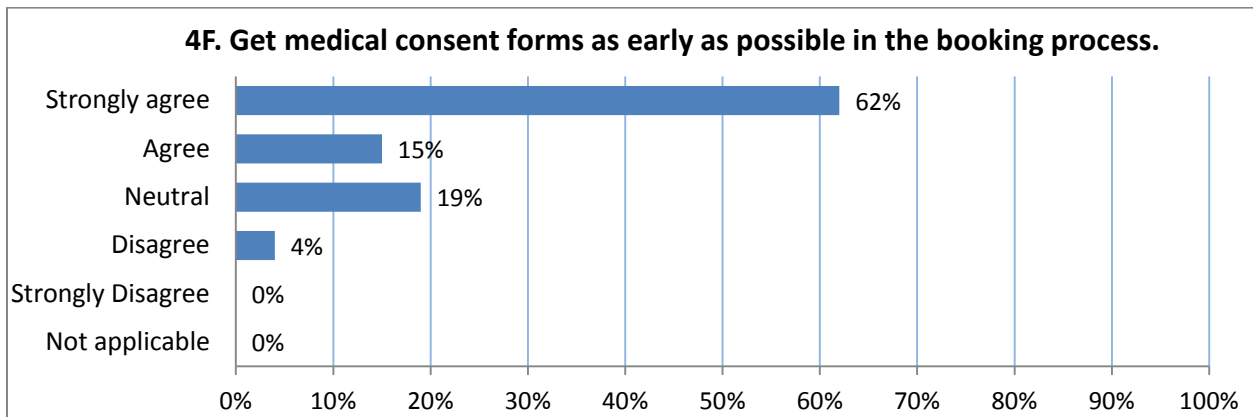
Recommendation 4D: Invest in the creation of supportive housing options.



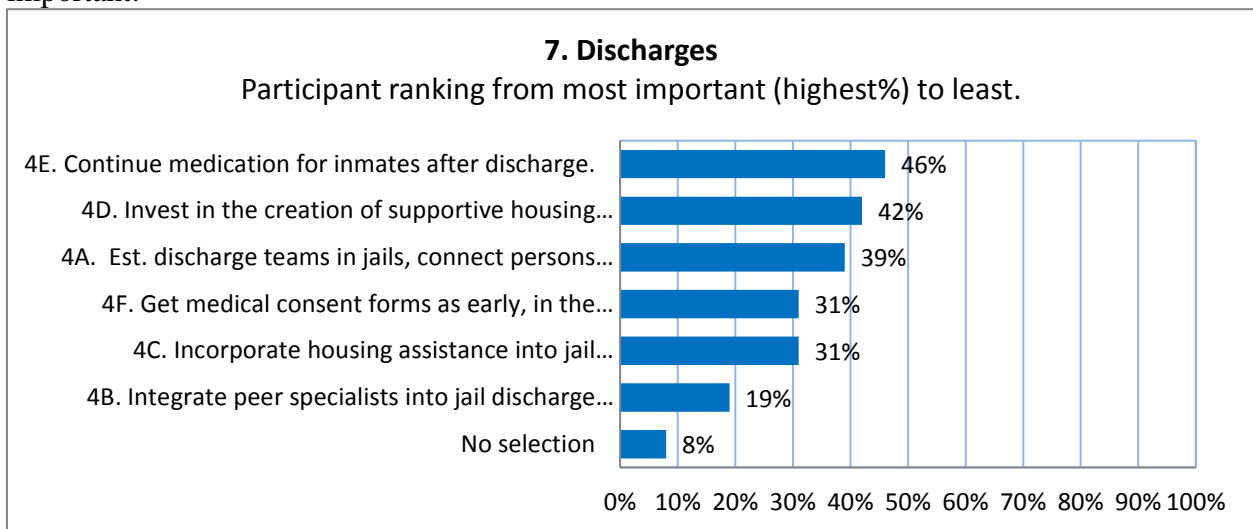
Recommendation 4E: Ensure Continue Access to Medication for inmates after discharge.



Recommendation 4F: Get medical consent forms as early as possible in the booking process.



Workgroup participants then ranked each recommendation from most important to least important:



Juvenile Justice

The workgroup agreed that the issues of youth are significantly different from the issues of adults with mental illness who have an involvement with the criminal justice system.

At the request of Representative Joe Mullery and several other workgroup members, a subgroup was convened to review recommendations made in the 2014 Juvenile Justice Workgroup Report to the Legislature²⁴ and determine if there were additional or corresponding recommendations.

According to the State Advisory Council on Mental Health:

“The criminal justice system was initially designed to address the needs of adults who had committed criminal offenses. Unfortunately, the needs of juvenile offenders have not always been addressed in a comprehensive and inclusive manner. There is no over-arching entity that directs how services should be delivered or that is evaluating outcomes.”²⁵

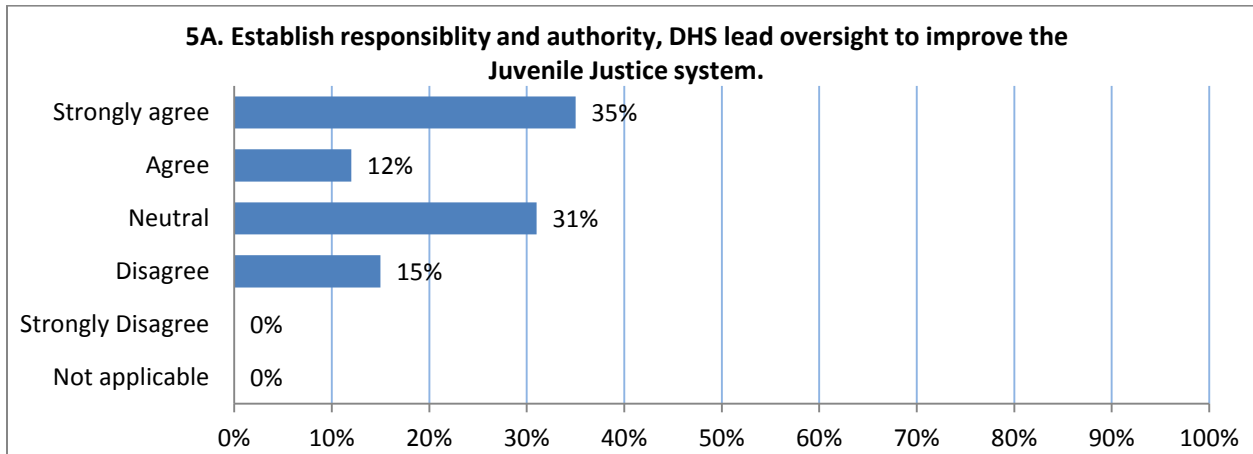
We also know that least 20 percent of youth involved in the juvenile justice system have serious mental illnesses²⁶ and that more needs to be done. As a part of this system, it is imperative that the mental health needs of juvenile offenders are addressed early in their involvement with the criminal justice system. The lack of early identification of mental health needs and the corresponding provision of treatment services to address these needs often results in increased and more costly juvenile justice involvement. Once a youth becomes involved in the juvenile justice system and is detained or incarcerated, access to effective and successful mental health treatment is less likely to occur. This corresponds with a likelihood of further and deeper engagement in the justice system; often up to, and through, adulthood.

²⁴ See: <http://archive.leg.state.mn.us/docs/2014/mandated/140345.pdf>

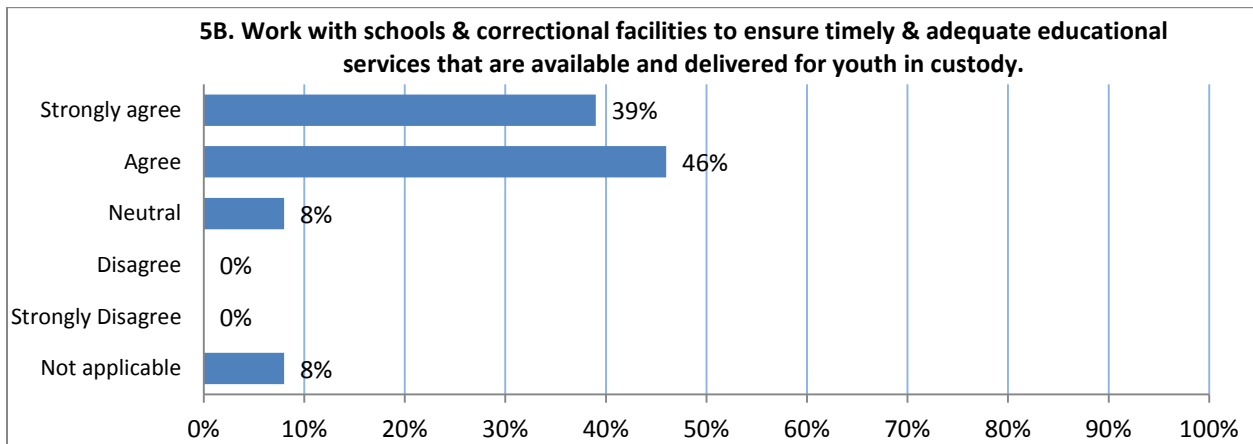
²⁵ State Advisory Council on Mental Health. (2014). 2014 Report to the Governor and Legislature: State Advisory Council on Mental Health, Subcommittee on Children’s Mental Health.

²⁶ NCMHJJ, Blueprint for Change. 2006.

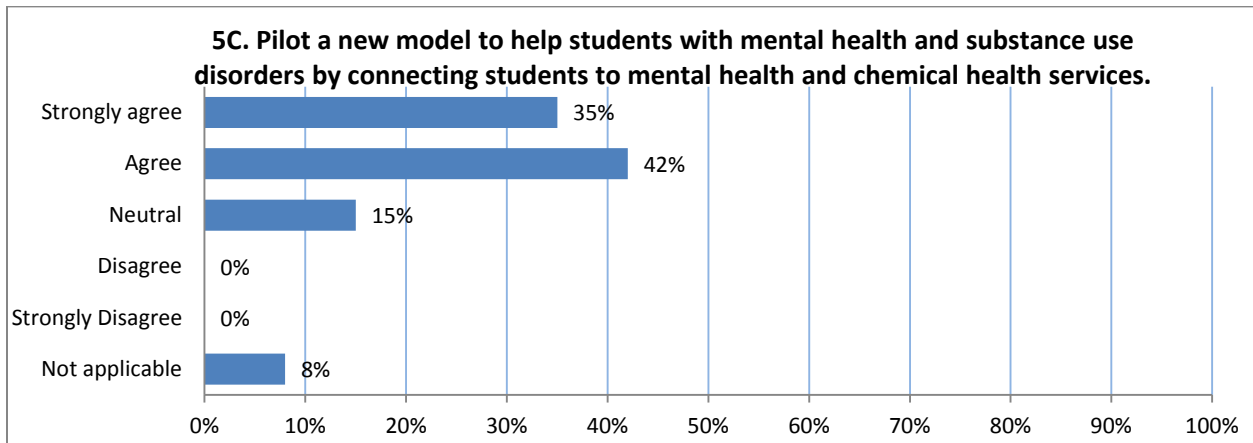
Recommendation 5A: Establish responsibility and authority designating the Department of Human Services as the lead for oversight to improve the juvenile justice system.



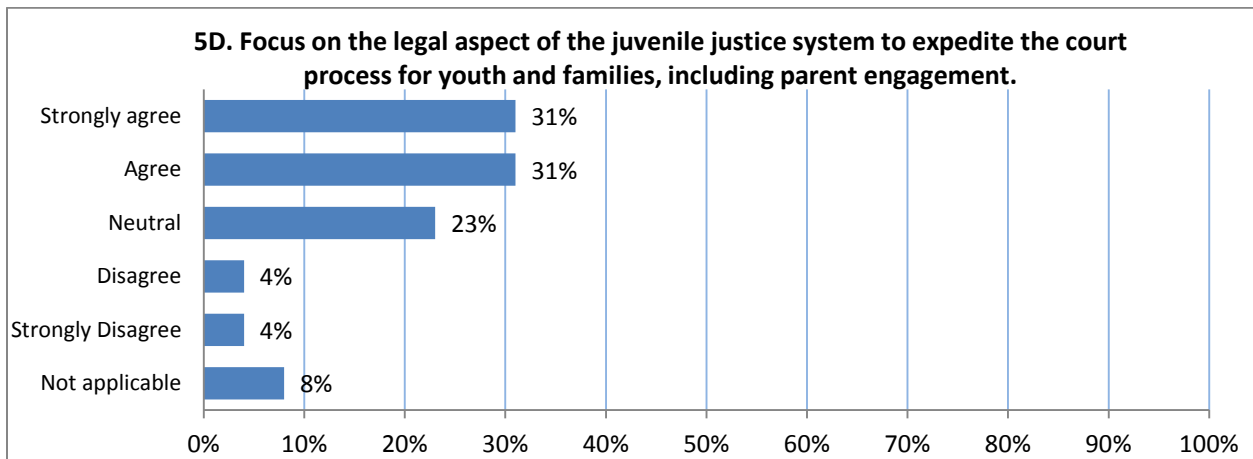
Recommendation 5B: Work with schools and correctional facilities to ensure timely and adequate educational services are available and delivered for youth in custody.



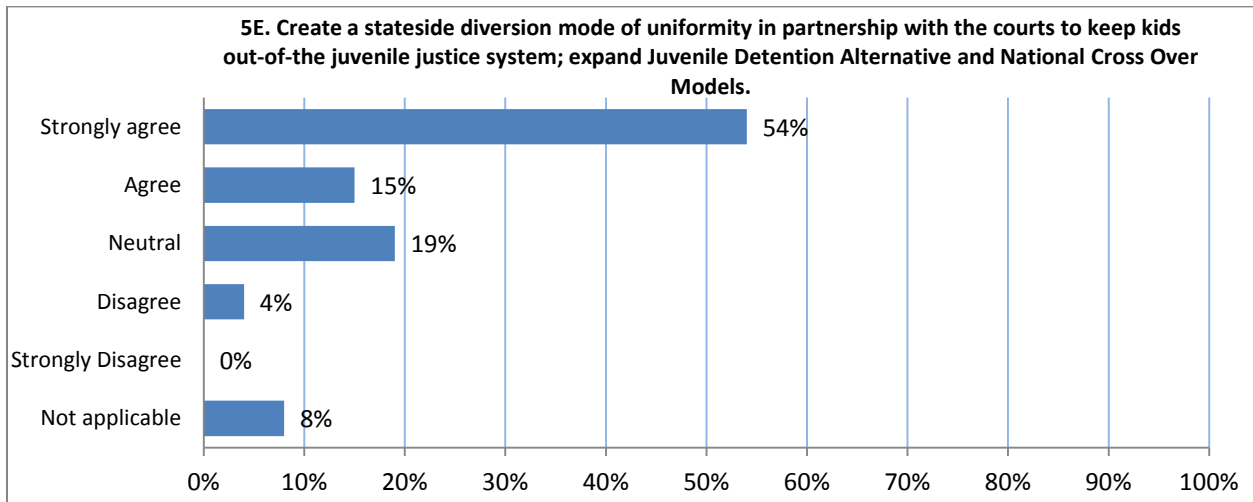
Recommendation 5C: Pilot a new model to help schools support students with mental health and substance use disorders by connecting students to mental health and chemical health services.



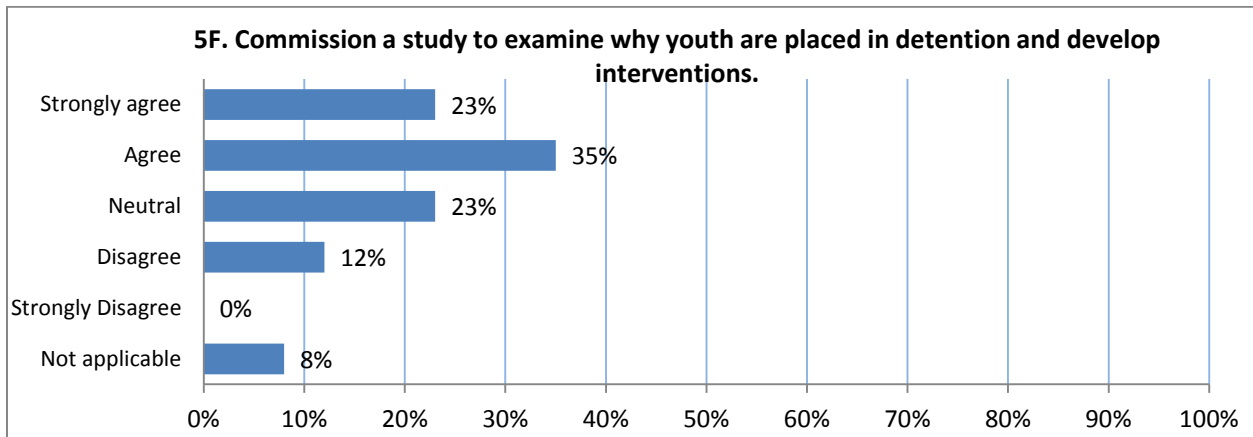
Recommendation 5D: Focus on the legal aspect of the juvenile justice system to expedite the court process for youth and families, including parent engagement.



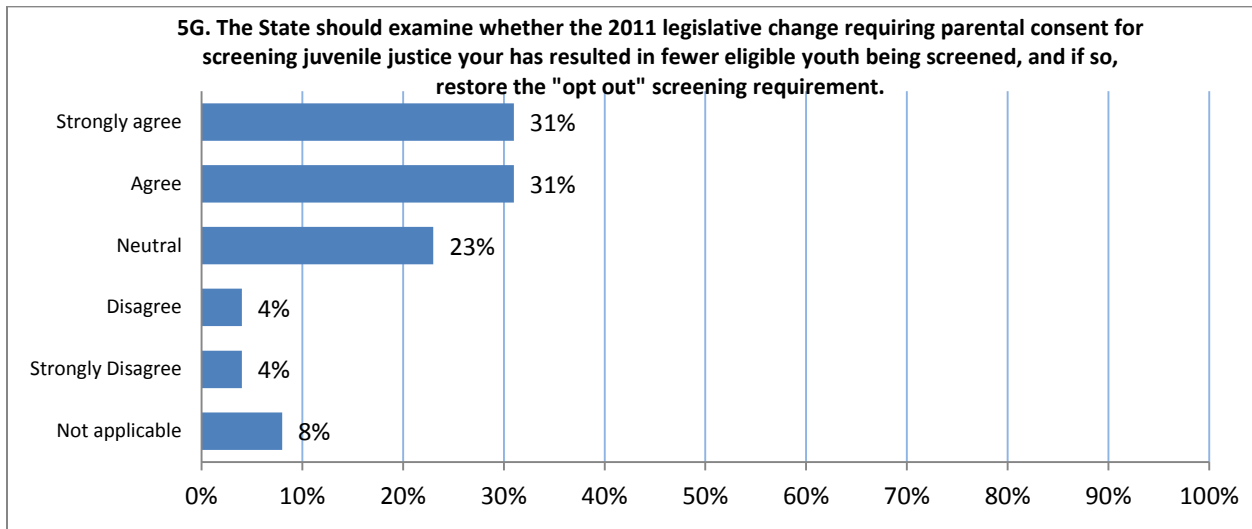
Recommendation 5E: Create a statewide diversion model of uniformity in partnership with the courts to keep kids out-of- the juvenile justice system; expand the use of the Juvenile Detention Alternative Initiative and National Cross Over models.



Recommendation 5F: Commission a study to examine why youth are placed in detention and develop interventions.

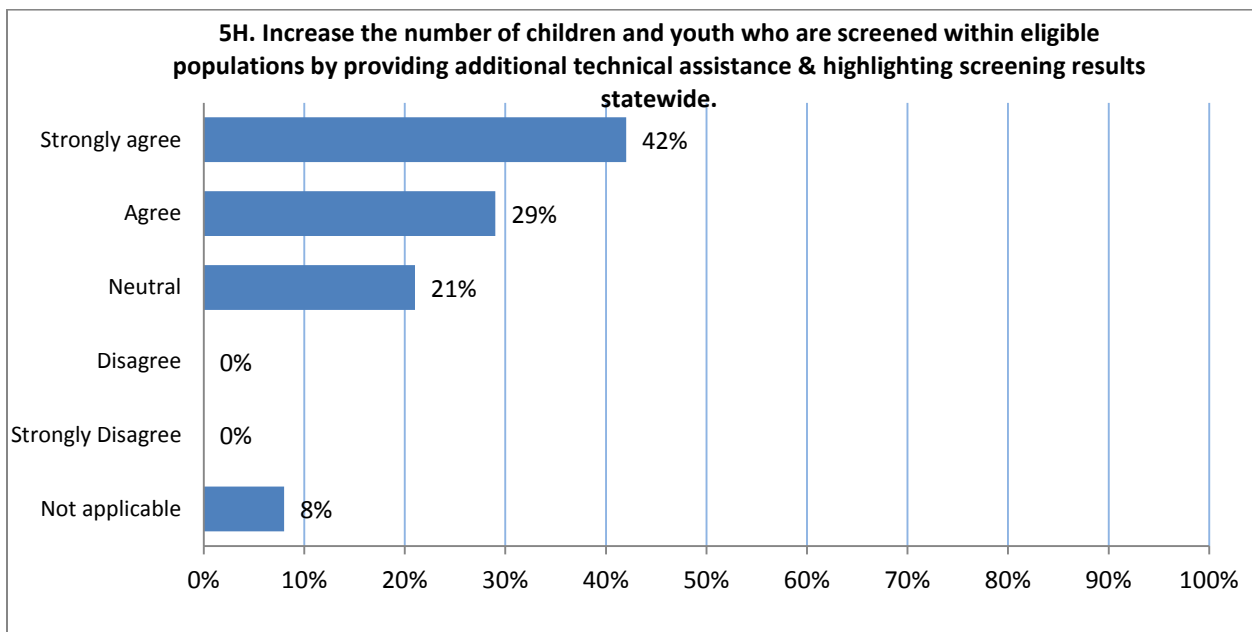


Recommendation 5G: The State should examine whether the 2011 legislative change requiring parental consent for screening juvenile justice youth has resulted in fewer eligible youth being screened, and if so, restore the "opt out" screening requirement.

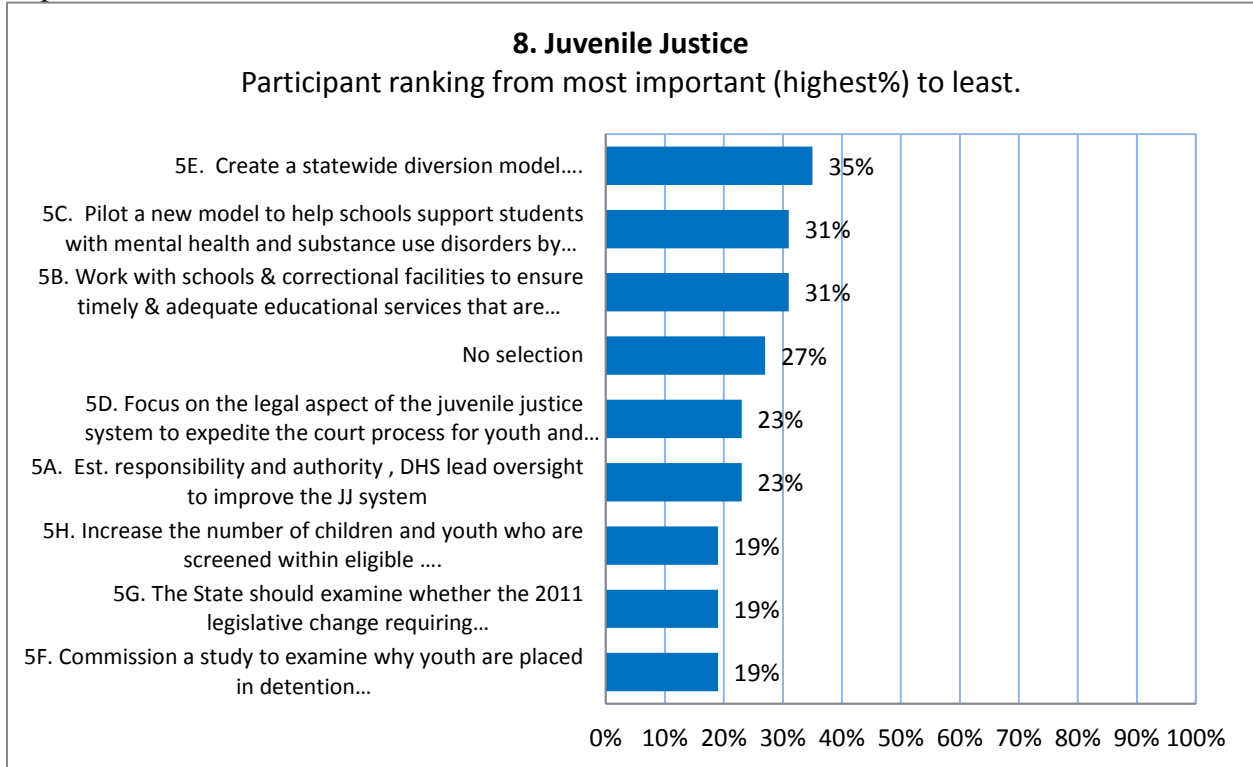


Recommendation 5H:

Increase the number of children and youth who are screened within eligible populations by providing additional technical assistance and highlighting screening results statewide.



Workgroup participants then ranked each recommendation from most important to least important:



VI. Additional Opportunities

1. Continue to build upon the collaborations made between the criminal justice, mental health, and substance abuse systems made through the establishment of this workgroup. The ability of this workgroup to work together so closely and deliberately over several years could lead to further understanding of the various system issues as well as create opportunities for further collaboration and enhancements.
2. Study and recommend updates to the Criminal Court Procedures Rules with regard to Rule 20.01, which lays out protocols for the courts to address the needs of people who are “not competent” to stand trial and who need to psychiatric care to restore them to competency. Under current practice, when someone is found not competent, they are then referred for civil commitment proceedings and if found to meet the criteria for commitment they are referred to one of two state-operated programs for care, depending on their level of need. Part of this study may be to consider implementing outpatient pilot projects to restore an individual to competence and to fill the gap in services between persons determined to be incompetent but not able to be committed. Currently, clients in need of competency restoration can only be served at the Minnesota Security Hospital in St. Peter and the Anoka Metro Regional Treatment Center and there are no set protocols for providing care to people who are not competent to stand trial but who do not meet the criteria for civil commitment.
3. Consider necessary reform to civil commitment.
4. Consider improvements and standardization to post-booking treatment diversion programs.
5. Consider methods to improve the sharing of system data from jails to the mental health system.
6. Study this issue as it pertains to persons housed in the Minnesota Department of Corrections.
7. Study and make recommendations on a housing and housing with supports solution for persons with mental illnesses. Consider what additional services are needed for persons who also have a substance use issue. Consider the unique needs of persons who present severe behavioral challenges.
8. Study and make recommendations to support persons who are incarcerated with mental illnesses and/or substance use thrive in the community post release from the Minnesota Department of Corrections.
9. Grant funds to law enforcement agencies to create new or expand existing training programs for officers on mental health.
10. Survey jurisdictions that use a diversion model to take offenders with mental illnesses out of the criminal justice system and place them within a mental health court setting or another treatment setting to compare outcomes based on recidivism.
11. Develop long-term, secure placements for persons in the Criminal Justice system who are difficult to manage.
12. Study this issue more in depth, noting differences based on racial and ethnic groups and ages.
13. Expand the use of Care Coordinators to facilitate access and follow-up with services after release.

VII. Implementation language

The vast majority of recommendations will require funding to implement rather than statutory changes. Further consideration is needed for those items that require a change to state statute.

VIII. Appendices

A. Workgroup members and interested parties

NAME	ORGANIZATION
Mary Jo McGuire	Association of Minnesota Counties
Kay Pitkin	COPE/Emergency Mental Health - Hennepin County
Nicole Robbins	COPE - Hennepin County
Roger Meyer	East Metro Crisis Alliance
Heather Corcoran	League of Minnesota Cities
Anne Finn	League of Minnesota Cities
Ed Edie	Mental Health Association of Minnesota
Ben Ashley-Wurtmann	Mental Health Association of Minnesota
Melissa Hensley	Mental Health Consumer/Survivor Network
Ellen Benavides	Mental Health Consumer/Survivor Network
Terry Schneider	Mental Health Provider Association of Minnesota
Ron Bergee	Minnesota Association of Community Corrections Act Counties
Glenn Anderson	Minnesota Association of Community Mental Health Programs
Mike MacMillan	Minnesota Association of County Probation Officers
Traci Green	Minnesota Association of County Probation Officers
Don Ilse	Minnesota Association of County Social Services Administrators
Mark Sizer	Minnesota Association of County Social Services Administrators

Chief Gordon Ramsay	Minnesota Chiefs of Police Association
Chief Dave Bentrud	Minnesota Chiefs of Police Association
Tom Meier	Minnesota Community Corrections Association
Joshua Esmay	Minnesota Community Corrections Association
Nancy Houlton	Minnesota Council of Health Plans
Darrin Helt	Minnesota Council of Health Plans
Paul Scoggin	Minnesota County Attorney's Association
Carolyn Peterson	Minnesota County Attorney's Association
Stephen Huot	Minnesota Department of Corrections
Glenace Edwall	Minnesota Department of Human Services
Tom Ruter	Minnesota Department of Human Services
Patricia Seibert	Minnesota Disability Law Center
Megen Cullen	Minnesota Hospital Association
Kathy Knight	Minnesota Hospital Association
Representative Melissa Hortman	Minnesota House of Representatives
Dennis J. Flaherty	Minnesota Police and Peace Officers Association
Chinmoy Gulrajan	Minnesota Psychiatric Society
Linda Vukelich	Minnesota Psychiatric Society
Lawrence Panciera	Minnesota Psychological Association
Senator Barb Goodwin	Minnesota Senate
Sheriff Rich Stanek	Minnesota Sheriffs' Association
Sheriff Phil Hodapp	Minnesota Sheriffs' Association
Bill Ward	Minnesota State Board of Public Defense

Rex Tucker	Minnesota State Board of Public Defense
Sue Abderholden	NAMI Minnesota
Matt Burdick	NAMI Minnesota
Rozenia Fuller	State Mental Health Advisory Council
Leann Dorr	State Mental Health Advisory Council
Jeffrey Lind	State Mental Health Advisory Council - Children's Subcommittee
Deborah Fjeld	State Mental Health Advisory Council - Children's Subcommittee
Judge Kerry Meyer	Minnesota Fourth Judicial District
Judge Barb Hanson	Minnesota Seventh Judicial District
Judge Joseph Evans	Minnesota Seventh Judicial District

Interested Parties:

Rochelle Westlund	Joe Pental
Ryan Erdmann	Eric Penniston
Faye Bernstein	Lucas Myers
Jana Nicolaison	Clare Schmidt
Wade Brost	Rachel Stuckey
Alex Migambi	Gina Kunesh
Jerry Webb	Ken Reed
Megan Cullen	Cory Tell
Jennifer DeCubellis	Bruce Weinstock
Claire Wilson	James Jordan
Mike MacMillan	Heather Erikson
Traci Green	Leah Kaiser
Anni Simons	Charles Sutton
Tom Freeman	Samantha Mills
Judge Jay Quam	Anni Simons
Jen McNertney	Kay Slama
Carol Johnson	
Rep Joe Mullery	
Rep. Tony Cornish	
Rep. Paul Rosenthal	
Rep. Tara Mack	
Chelsea Magadance	
Jill Garcia	

B. Meeting Outline and Work Plan

Full Working Group Meeting

Topic: Role of Working Group

Date: July 31, 2014

Time: 2pm to 5pm

Location: DHS Elma

Full Working Group Meeting

Topic: Initial Response/Diversion or Arrest

Date: October 1, 2014

Time: 2pm to 4pm

Location: DHS Lafayette- 444 Lafayette Road, Room 5137, St. Paul

Interim Small Group Meeting: Pre-Arrest/Arrest

Date: Thursday, October 16

Time: 1pm to 3pm

Location: NAMI Minnesota – 800 Transfer Road, Suite 31, St. Paul

Full Working Group Meeting

Topic: Court Process/Jail

Date: Wednesday, October 29, 2014

Time: 1pm to 3pm

Location: DHS Lafayette- 444 Lafayette Road, Room 5137, St. Paul

Interim Small Group Meeting: Court Process/Jail

Date: Monday, November 10, 2014

Time: 1pm to 3pm

Location: NAMI Minnesota – 800 Transfer Road, Suite 31, St. Paul

Full Working Group Meeting

Topic: Release/Discharge Planning

Date: November 26, 2014

Time: 1:30 pm to 3:30 am

Location: DHS Lafayette - 444 Lafayette Road, Room 5137, St. Paul.

Interim Small Group Meeting: Release/Discharge Planning

Date: Friday, December 5

Time: 1pm to 3pm

Location: NAMI Minnesota – 800 Transfer Road, Suite 31, St. Paul

Full Working Group Meeting

Topic: Review Recommendations

Date: December 16, 2014

Time: 12pm to 2pm

Location: DHS Lafayette- 444 Lafayette Road, Room 5134, St. Paul

Interim Small Group Meeting: Hub/ Central Receiving Center

Date: January 7, 2015

Time: 9am to 11am

Location: NAMI Minnesota – 800 Transfer Road, Suite 31, St. Paul

Full Working Group Meeting

Topic: Review HUB/CRC Recommendations, Process for editing report, identify additional recommendations

Date: January 27, 2015:

Time: 9:00 AM-11:00 AM

Location: DHS Lafayette – 444 Lafayette Road, Room 5134, St. Paul

C. Subgroup Recommendations

1. Pre-Arrest/Arrest Subgroup Recommendations :

Improving Mental Health Crisis Response Services

Mental health crisis response services can be crucial to preventing contact with law enforcement and/or avoiding arrest when a person is experiencing a mental health crisis. Issues with sustainability of the current funding model and a lack of consistency persist. These services need to be enhanced and expanded with a goal of statewide, 24/7 access to crisis services which provide a consistent response.

Reform Medical Assistance (MA) payment structure for mobile crisis services

- Establish a sustainable payment rate that covers not only face-to-face contact but other necessary service elements such as telephone/text support, engagement in treatment, service coordination, and travel.

Reform Medical Assistance (MA) payment structure for crisis residential services

- Enact recommendations of the Mental Health Payment Reform Workgroup
- Address issues related to unsustainability for room and board

Ensure access to crisis services regardless of insurance status

- Require insurance plans operating in Minnesota to include crisis response services as a benefit or identify another method to compensate crisis programs for uncompensated services to people with private health insurance coverage.
- Clarify expectation for state grant funds for uncompensated care.
- Define crisis response services as a preventive mental health service with no co-pays.

Improve consistency of mobile crisis services

- Develop uniform service standards and training for mobile crisis teams.
- Include training and protocols for working with law enforcement.

Developing an Integrated Network of Mental Health Crisis Resources

The service delivery system to provide care for people experiencing a mental health crisis is often fragmented. Stronger connections and a more integrated continuum of mental health services are needed to better address the needs of people in a crisis.

Expand mental health urgent care model

- Create sustainable funding methods for mental health urgent care services.
- Establish a mental health urgent care in the west metro and other geographic areas where it could be beneficial and sustainable.
- Connect to other existing resources (e.g. detox, crisis mobile/residential, hospitals) if feasible.
- Educate law enforcement and emergency medical responders about the role/value of mental health urgent care.

Leverage technology to improve accessibility and responsiveness of crisis services

- Establish a single statewide phone number for mental health crisis services that links to local crisis resources.
- Explore use of new and available technologies to enable monitoring of location and assure improved dispatching of mobile crisis teams.
- Develop a systemic, real-time bed-tracking of available crisis residential beds and hospital beds.
- Utilize health information exchange to better share information, with person's consent and ensuring that privacy safeguards are in place.

Increase Mental Health Education and Training for Law Enforcement

Training of law enforcement officers on dealing with mental health crises is inconsistent and is not required. Minnesota should ensure law enforcement officers receive education on mental illnesses, scenario-based continuing education and training on responding to a mental health crisis.

Pre-Service Education

- Integrate mental health into the educational coursework for law enforcement that focuses on basic education about mental illnesses and de-escalation skills training.
- Utilize video and scenario-based training where possible.
- Create a financial incentive for CIT trained officers or departments that encourage CIT training

Continuing Education

- Integrate mental health and crisis de-escalation into required annual "use of force" training.
- Develop a POST Model Policy on responding to a mental health crisis.

911 Operators

911 operators have the option of dispatching a mobile crisis team when one is available. In practice this rarely, if ever, happens.

Potential Recommendations

- Clarify statute to indicate that mental health crisis teams can be dispatched in addition to law enforcement and/or other responders.
- Provide training to 911 operators on role of crisis response services.

Further Discussion: Meeting between Law Enforcement and Hospitals to discuss issues and potentially develop recommendations around emergency room use, 72-hour holds, and warm-hand-off/communication/discharge planning.

2. Jails/Courts Subgroup Recommendations :

- Increase resources for mental health services in jails.
- Expand existing models for interagency collaboration between county social services and jails to other communities.
- Increase resources for probation to ensure reasonable case loads, training, and access to pre-trial services.
- Develop capacity to perform necessary mental health assessments and facilitate timely access to records for individuals in jail to inform decisions around charges, pre-trial release, and potential diversion options.

3. Discharge Recommendations

- Discharge teams in place in jails to work with people to create a discharge plan and follow up with them on their plan. Follow person through community resources after leaving jail. Resources for discharge teams.
- Increase peer specialists to encourage people to participate in discharge programs
- Increase housing/stabilization following discharge. Both permanent housing and temporary stabilization. Incorporate housing assistance into discharge team. E.g. have someone to suggest appropriate housing options for that person's specific circumstances.
- Same-day follow-up, person can go straight from jail to discharge planning follow-up meeting.
- More mental health courts
- Continue medication for inmates after discharge
- Get medical consent forms as early as possible in the booking process. Especially important for people who are frequently in the system.

4. Law enforcement /Hospital Subgroup Recommendations :

- Develop integrated acute care services for people experiencing co-occurring mental health crises, acute intoxication and/or medical issues.
- Increased funding for the stabilization component of crisis services.
- Develop a tool for law enforcement to facilitate better communication with health care professionals (see handout). Develop processes for clear communication when law enforcement is handing off an individual to a health care facility.
- Encourage local jurisdictions to have regular meetings between law enforcement and mental health communities to facilitate dialogue and collaboration, identify trends, and address barriers.
- Assure that other "health officers" (including crisis teams) are aware that they may initiate a transport hold when necessary.

5. Juvenile Justice Sub Workgroup Recommendations.

Attendance: Kay Pitkin, Jamie Halpern, Rex Tucker (phone), Representative Joe Mullery and Bill Wyss

The group met to discuss and provide recommendations to improve the juvenile justice system.

Value Statement: Promote shared decision-making, new partnerships, address disparities and develop alternatives to keep youth out of the juvenile justice system.

- **Establish responsibility and authority within the Department of Human Services for oversight to improve the juvenile justice system.**
 - This includes data collection and analysis for decisions regarding evidence-based and promising practices for treatment and other interventions to improve outcomes for youth at risk of or already in the juvenile justice system.
 - Provide guidance and technical assistance to help local jurisdictions implement and improve their juvenile justice prevention and intervention strategies. Clearly define the roles and responsibilities of the various state agencies and their departments that have some responsibility for youth in the juvenile justice system, including a targeted training package.
 - Develop networks of sharing prevention and treatment resources to address the mental health, substance use, and trauma needs of youth at risk of or already in the juvenile justice system.
 - Address the mental health, substance use and trauma needs of youth in locked facilities, i.e., detention, because of Medical Assistance not allowed in locked programs.
- **Strengthen partnerships of the juvenile justice and the education systems to ensure youth educational needs are adequately addressed.**
 - This includes working with schools and correctional facilities to ensure timely and adequate educational services are available and delivered.
 - Promote and implement of The Minnesota Model of School-Based Diversion for Students with Co-Occurring Disorders manual.
- **Develop uniformity and consistency of court jurisdiction statewide**
 - Focus on the legal aspect of the juvenile justice system to expedite the court process for youth and families, including parent engagement.
 - Include a statewide diversion model of uniformity in partnership with the courts to keep kids out-of- the juvenile justice system; expand the use of the Juvenile Detention Alternative Initiative and National Cross Over models.
 - Commission a study to determine why youth are placed in detention and implement solution to keep youth out.

D. Offenders w/Mental Illness: Meeting Minutes

July 29, 2014

Introductions & Background:

- Senator Goodwin opened the meeting by describing the need for reform and innovation in Minnesota when it comes to meeting the needs of offenders with mental illnesses.
- A large percentage of Minnesota's prison and jail population live with mental illnesses and the criminal justice system is often ill-equipped to meet their needs.
- To address the problem Minnesota needs to look at a variety of different solutions.

Reviewing the Charge of the Group & Enacting Legislation

- The workgroup's charge is to develop a report discussing problems associated with the rise in offenders with mental illnesses entering the criminal justice system and to identify potential solutions, including how to divert people out of the criminal justice system and into other services.

Understanding the Systems Issues

- In the course of the discussion, the group identified a number of systemic issues that require attention:
 - o A need for more readily-available community-based mental health services that can serve as an alternative to jail, especially for those who don't meet hospital level of care (e.g. 24/7 mobile crisis response services and crisis residential).
- A need for more community-based treatment programs that can address co-occurring mental illnesses and substance use disorders.
- A lack of intensive residential services that can serve people that have aggressive behaviors.
- A need for more psychiatric-specialty emergency departments and to expand their hours for intake.
- A need for more supportive housing options.
- A need for more comprehensive discharge planning so people leaving jails or prisons can be connected to mental health, housing, and other needed services.
- Barriers to providing training about responding to mental health crisis for law enforcement, including Crisis Intervention Training (CIT).
- Issues with the ability for people to continue or access medications when incarcerated.
- Transportation – Crisis Teams try to be available for transporting people but lack the resources to be available at all times. Law enforcement often becomes the default for transporting people in crisis.

Possible Solutions/Innovative Strategies

- During the discussion, several strategies were identified:
 - o Collaboration between mobile crisis teams and law enforcement to triage situations appropriately and to connect a person to the most appropriate services.
- Coordination between social services and corrections/probation to help people connect with mental health services while in jail and to ensure a smooth transition back into the community following incarceration.
- Protected transportation to provide an alternative to law enforcement when transporting a person experiencing a mental health crisis.

Logistics & Wrap-Up

- NAMI and DHS will serve as co-chairs for the group.
- Future meetings will likely be held at the DHS Lafayette Offices and include the possibility for ITV connections to make it easier for people from outside the Twin Cities to attend.

Next Meeting

- October 1, 2014 from 2:00-4:00 p.m. in room 5137 on the fifth floor of the DHS building located at 444 Lafayette Road in St. Paul.

October 1, 2014

Plans for Proceeding & Future Meetings

- Tom Ruter (DHS) and Matt Burdick (NAMI) outlined the process for the working group going forward.
- Each meeting will focus on a different stage of the criminal justice process (pre-arrest/arrest; jail/court process; and discharge/re-entry).
- The group will look at issues and gaps within each stage and propose potential solutions.
- Between meetings of the full group, small working groups will meet to develop and refine more detailed recommendations and possible legislative language.
- Small group recommendations on the previous meetings' topic will be shared at each subsequent meeting of the full working group for input and discussion.
- Members interested in participating in any of the small groups should contact Matt Burdick at mburdick@namimn.org
- See "OWMI Meeting Plan" for more details.

Site Visits

- Senator Goodwin, Tom Ruter, and Matt Burdick are conducting site visits around the state to learn more about innovative efforts already underway.
- The first visit was to the East Metro Adult Mental Health Urgent Care.
- More information about this model at <http://mentalhealthcrisisalliance.org/>

- Additional site visits are planned for Northern Pines Mental Health Center, Guild Incorporated crisis services, and Carver County.

Discussion of Pre-Arrest/Arrest – Issues and Potential Solutions

The group discussed a number of issues and areas for improvement when a person is experiencing a mental health crisis and may come into contact with law enforcement:

Mental Health Crisis Services

- Mental health crisis services were identified as a key service that can help people experiencing a mental health crisis avoid contact with law enforcement or assist law enforcement in helping the person access mental health care and avoid arrest.
- Potential recommendations for further discussion by small group:
 - Continue expansion of phone/text crisis support, mobile crisis teams, and residential crisis stabilization services with goal of statewide coverage 24/7.
 - Address funding issues to ensure crisis services can become self-sustaining.
 - Improve consistency in crisis response services around the state.
 - Establish a single state-wide phone number for crisis response services.
 - Develop stronger relationship between law enforcement and crisis teams where this doesn't exist – ensure law enforcement is aware of crisis teams and the services they provide.
 - Ensure law enforcement has timely access to mobile crisis teams.
 - Explore applicability of “urgent care” model to other jurisdictions to meet the needs of people who do not meet hospital level of care.

Training/Education for Law Enforcement

- The group identified a need to expand training for law enforcement about recognizing and de-escalating a mental health crisis.
- There is currently no required pre-service training for law enforcement about working with people mental illnesses. Some agencies incorporate this into their training and others do not.
- Training of current officers was also seen as a need. Crisis Intervention Training (CIT) was identified as a very effective program but too costly for many agencies.
- Potential recommendations for further discussion by small group:
 - Require pre-service training on mental health.
 - Identify and promote training programs on mental health for law enforcement.
 - Provide resources for law enforcement agencies to provide training to officers.

Next Meetings

- *Pre-Arrest/Arrest Small Group*: Thursday, October 16 from 1:00-3:00 p.m. at NAMI Minnesota – 800 Transfer Road, Suite 31, St. Paul
- *Full Workgroup*: October 29, 2014 from 2:00-4:00 p.m. LAF 5137

October 29, 2014

Review of Pre-Arrest/Arrest Draft Recommendations

- The group reviewed and offered feedback on the recommendations developed by the pre-arrest/arrest subgroup.
- The group was supportive of many of the recommendations and feedback will be incorporated into future drafts.
- The subgroup will hold a second meeting to discuss interactions between law enforcement and hospitals and areas for improvement.

Site Visits

- Senator Goodwin reported on site visits to Northern Pines Mental Health Center, Guild Incorporated's Crisis Residential program, and the Central Receiving Center in Orange County Florida.

Discussion of Jail/Court Process – Issues and Potential Solutions

- The group discussed issues and areas for improvement when a person is being held in jail and/or going through the legal process.
- A subgroup will convene to discuss this in further depth and develop recommendations.

Next Meetings

- *Release/Discharge Planning Small Group*: Friday, December 5, 2014 from 1:00-3:00 p.m. at NAMI Minnesota – 800 Transfer Road, Suite 31, St. Paul.
- *Full Workgroup*: December 16 from noon to 2:00 p.m. in room 5134 at DHS Lafayette building – 444 Lafayette Road, St. Paul.

November 26, 2014

Beltrami County Tour

- Senator Goodwin met with numerous with community leaders who deal with mental health issues in Beltrami County to discuss issues relevant to this workgroup.
- Issues the community is facing include:
 - An estimated 70 percent of people in jail have a mental illness.
 - A lack of nearby residential crisis services and psychiatric hospital resources.
 - Limited resources for juveniles in crisis and/or involved with juvenile justice system.
 - Law enforcement resources are being strained to transport people.

Review Subgroup Recommendations

- The workgroup reviewed and provided input into recommendations from the Law Enforcement/Hospital Subgroup and the Jails/Courts Subgroup.

Discussion on Discharge Issues

- The workgroup discussed issues and potential solutions related to discharge.
- Ideas raised included:
 - A need to facilitate “warm-handoffs” to mental health, health care, and social services for people leaving jail, including same-day access to services.
 - Housing for people after jail.
 - Using Peer Specialists in the context of treatment engagement.
- A subgroup will meet and discuss these and other recommendations in-depth.

Review Draft Outline

- The group reviewed a draft outline of the report and gave feedback.

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Carver County Tour

- Senator Goodwin, DHS staff, and representatives from the Minnesota Association of Community Mental Health Programs (MACMHP) toured the Carver County jail.
- Thanks to Federal grant funding, the Carver County Mental Health Center is contracting with the jail to provide on-site mental health services.
- This initiative has been very successful but several barriers remain including assisting people who are discharge before mental health staff can connect with them as well as workforce issues which have prevented them from hiring a psychiatry position.

Review Subgroup Recommendations

- The workgroup reviewed and provided input into recommendations from the Discharge subgroup as well as the Juvenile Justice subgroup.
- One final subgroup, tasked with looking in greater depth at the “hub” or “central receiving center” model was established and will report its findings and/or recommendations to the group.

Voting on Recommendations

- Recommendations will be compiled into an electronic survey and distributed for input from the group.

Final Meeting: January 27, 2015

E. Site Visits

East Metro Adult Mental Health Urgent Care | St. Paul, MN
Mental Health Urgent Care | September 2014

Guild, Inc. – Maureen’s House | St. Paul, MN
Crisis Residence | October 2014

Northern Pines Mental Health Center | Brainerd, MN
Mental Health Center | October 2014

Orange County Central Receiving Center | Orlando, FL
Central Receiving Center | November 2014

Beltrami County | Bemidji, MN
County Jail & County Human Services | November 2014

Carver County Jail | Chaska, MN
County Jail | November 2014

Hennepin County Medical Center – Acute Psychiatric Services | Minneapolis, MN
Psychiatric Emergency Department | December 2014

F. Glossary of Service Components

Adult Rehabilitative Mental Health Services (ARMHS) Adult rehabilitative mental health services (ARMHS) is a rehabilitation service designed to bring recovery-oriented interventions directly to individuals in their own homes or elsewhere in the community. The goal is to help individuals acquire, practice, and enhance skills that have been lost or diminished due to symptoms of mental illness. ARMHS has five billable components: Basic Living and Social Skills, Certified Peer Specialist Services, Community Intervention, Medication Education, and Transition to Community Living.

Anoka Metro Regional Treatment Center: (AMRTC)

Assertive Community Treatment (ACT) Assertive community treatment (ACT) is an intensive, comprehensive, non-residential rehabilitative mental health service team model. Services are consistent with Adult Rehabilitative Mental Health Services, except that ACT services are (a) provided by multidisciplinary, qualified staff who have the capacity to provide most mental health services necessary to meet the person's needs, using a total team approach; (b) directed to persons with a serious mental illness who require intensive services; and (c) offered on a time-unlimited basis and available 24 hours per day, 7 days per week, 365 days per year.

AMHSA: Substance Abuse and Mental Health Services Administration

CADI: Community Alternatives for Disabled Individuals

C.A.R.E: Community Addiction and Recovery Enterprise

Case Management: Case management is a service that helps children or adults gain access to needed medical, social, educational, vocational, and other necessary services as they relate to their mental health needs.

CBHH: Community Behavioral Health Hospital

Children's Residential Treatment (CRT): A rehabilitative service designed to meet high levels of treatment need in a safe, contained setting.

Children's Therapeutic Services and Supports (CTSS): A modular package of rehabilitative services for children and adolescents, which can be delivered in homes, schools, or community settings.

CMHSA: Chemical and Mental Health Services Administration

CMS: Center for Medicare and Medicaid Services

CSS/Synergy: Community Support Services/Synergy

Crisis Services: Services currently exist at two levels in Minnesota. Every county must have a published crisis number which residents may access for help. Since 2005, most counties have been developing mobile crisis response teams which can serve all residents in a catchment area with a combination of telephone triage and mobile response, followed by a brief period of stabilization services.

Day Treatment: Comprises a combination of psychotherapy and skills training services in a defined setting – usually school or clinic – for 2 or more hours per day, 3 or more days per week.

DCT: Direct Care and Treatment Division of the Minnesota Department of Human Services.

DHS: Minnesota Department of Human Services.

DRG: Diagnosis-related group

Diagnostic Assessment: A tool utilized to identify the appropriate procedure for addressing a child's mental health difficulties given the severity of the difficulties.

ED: Emergency Department

Family Peer Specialists: Individuals trained to provide nonclinical support and advocacy services to families of children who have an emotional disturbance. This service does not yet exist in Minnesota.

Early Childhood Mental Health Services: Mental health providers offering developmentally and culturally appropriate mental health services across a continuum of care to children, ages birth to five.

HCBS: Home and Community Based Services

HCMC: Hennepin County Medical Center

Integrated Primary Care Practitioner (PCP): A practice of integrating mental health screening, referral and care coordination and, if needed, prescription and medication management through a primary care practitioner.

Inpatient Hospitalization: A secure facility where care is psychiatrically supervised, and is delivered by a multidisciplinary team.

Inpatient Psychiatric Hospitalization : Inpatient Psychiatric Hospitalization is 24-hour care received in a psychiatric hospital or in a psychiatric unit of a general hospital; includes CBHH.

Intensive Residential Treatment (IRTS): Intensive Residential Treatment Services (IRTS) is a time-limited mental health service provided in a residential setting to persons in need of

more restrictive settings (versus community settings) and at risk of significant functional deterioration if they do not receive the service. IRTS is designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting.

IMD: Institute for Mental Disease

MA: Medical Assistance

Medication Management / Psychiatry: Medication Management services are provided by a psychiatrist or other qualified psychiatric care provider. As used here, the term refers to the current description (revised 1/8/13) in the Minnesota Health Care Programs (MHCP) Provider Manual for medication evaluation and management (E/M) codes. MHCP follows the American Medical Association's Current Procedural Terminology guidelines for E/M services.

MHSATS: Mental Health and Substance Abuse Treatment Services

Mobile Crisis Reponses Services: Mobile Crisis Response Services help adults and children in mental health crisis to remain at home or other community locations and avoid more restrictive placement when possible. Services include crisis screening, assessment, intervention, community stabilization, and referral to longer term care when needed. Crisis responders are mental health professionals or practitioners.

MSOCS: Minnesota State Operated Community Services

NABD: Non-acute bed day

OLA: Office of the Legislative Auditor

Outpatient Treatment: Services offered in a mental health setting to individual or groups of children in the community by organized multi-disciplinary clinics (Rule 29).

Partial Hospitalization: Partial hospitalization is a time limited, structured program of multiple and intensive psychotherapy and other therapeutic services provided by a multidisciplinary team, as defined by Medicare, and provided in an outpatient hospital facility or community mental health center that meets Medicare requirements to provide partial hospitalization program services. The goal of the program is to resolve or stabilize an acute episode of mental illness.

Partial Hospitalization: Utilized as step-down from inpatient hospitalization, providing intensive, psychiatrically-supervised services for 5-6 hours per day; with the child spending nighttime hours at home.

Psychiatric Residential Treatment Facilities (PRTF): Combining features of CRT and inpatient hospitalization, medically-supervised treatment designed to meet a high level of acuity. This level of care does not yet exist in Minnesota.

Psychiatry Services: Medical professionals primarily treating children and adolescents with acute, complex, treatment-resistant, and/or co-morbid conditions.

Permanent Supportive Housing Permanent Supportive Housing is an evidence-based practice recognized by SAMHSA, including the following characteristics: (a) tenants may live in their homes as long as they meet the basic obligations of tenancy, such as paying rent; (b) tenants have access to the support services they need and want in order to retain housing; and (c) tenants have a private and secure place to make their home, just like other members of the community, with the same rights and responsibilities.

Residential Crisis Services: Residential Crisis stabilization may follow community crisis assessment and intervention services. It is provided in a short-term, supervised, and licensed residential program. A program of this type is usually licensed as a Rule 36 facility with a crisis stabilization variance or as an adult foster home.

SAMHSA: Substance Abuse and Mental Health Services Administration

School-Linked Mental Health Services: Mental health providers offering outpatient or rehabilitative services (CTSS, above) at, or in conjunction with, a child's school.

SOS: State Operated Services

SPMI: Serious and persistent mental illness

Treatment Foster Care: A therapeutic intervention configured as an intensive service package to help the child stabilize her/his own functioning, prepare foster parents to support the child optimally, and prepare the child and biological family for a permanent family setting.

Youth Assertive Community Treatment (ACT): A team consisting of medical, mental health, and educational professionals that maintains daily contact with youth to prevent psychiatric hospitalization or juvenile justice involvement.

UM: Utilization management