DEPARTMENT OF HUMAN SERVICES

Community Mental Health Services Block Grant American Rescue Plan Act Funding Plan

Minnesota Department of Human Services

Behavioral Health Division

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Contents

Background

Public Law 117-2, the American Rescue Plan Act of 2021 (ARPA), signed by President Biden on March 11, 2021, directed the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide additional funds to support states through Block Grants to address the effects of the COVID -19 pandemic for Americans with mental illness and substance use disorders.

ARPA allocated $1.5 billion each for the Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block (SABG) grants to the states. The Minnesota Department of Human Services (DHS) received a notice of award for an allocated amount of **$21,622,155** through the MHBG program to assist in the response to the COVID-19 pandemic from Substance Abuse and Mental Health Services Administration (SAMHSA). This one time grant period is **from September 1, 2021 through September 30, 2025 to expend these funds.** Federal block grant monies are provided to support state priorities and SAMHSA asks that states consider the following in developing an ARPA Funding Plan.

States must spend the MHBG funds based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart I: Block Grants for Community Mental Health Services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). () Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the MHBG, as deemed necessary to facilitate a grantee's response to coronavirus.

The MHBG allocation requires states to set aside ten percent (10%) of their total allocation for first-episode psychosis or early SMI programs.

SAMHSA encourages states to consider a focus on support of a behavioral health crisis continuum. An effective statewide crisis system affords equal access to crisis supports that meet needs anytime, anyplace, and for anyone. This includes those living in remote areas and underserved communities as well as youth, older adults, persons of diverse backgrounds, and other marginalized populations; the crisis service continuum will need to be able to equally and adeptly serve everyone.

SAMHSA recommends states consider use of the ARPA MHBG funds to develop, enhance, or improve the following:

- Develop partnerships with the emerging Suicide Lifeline (9-8-8) systems, Law Enforcement, EMS, health care providers, housing authorities, Housing and Urban Development (HUD) Continuum of Care, hospital systems, peer-based recovery organizations, and substance use specific treatment providers, all of whom have a critical role in the crisis continuum.
- Utilize five percent of funds for crisis services, as described in the FY 2021 appropriations language.
- A comprehensive 24/7 crisis continuum for children including screening and assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination.
- Provide increased outpatient access, including same-day or next-day appointments, for those in crisis.
- Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and frontier areas; use of GPS, to expedite response times, and to remotely meet with the individual in crisis.
- The adoption and use of health information technology, such as electronic health records, to improve access to and coordination of behavioral health services and care delivery.

- Consider digital platforms, such as Network of Care, which facilitate access to behavioral health services for persons with SMI-SED.
- Advance telehealth opportunities to expand crisis services for hard to reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States cannot use the funds to purchase any items for consumers/clients.
- Implement an electronic bed registry that coordinates with existing HHS provider directory efforts and treatment locator system that will help people access information on crisis bed facilities, including their locations, available services, and contact information.
- Support for crisis and school-based services that promote access to care for children with SED.
- Develop medication-assisted treatment (MAT) protocols to assist children and adults who are in crisis, which may leverage telehealth when possible.
- Expand Assisted Outpatient Treatment (AOT) services.
- Develop outpatient intensive Crisis Stabilization Teams to avert and address crisis.
- Technical Assistance for the development of enhanced treatment and recovery support services including planning for Certified Community Behavioral Health Clinics (CCBHC).

SAMHSA requests that the following information is included when submitting the proposals:

1. Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.
2. Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.
3. Describe your state's spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.
4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the Guidebook on crisis services.
5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.
6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.
7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.
8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the, the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.

Mental Health Services System Gaps and Needs

The Minnesota Department of Human Services, Behavioral Health Division, has identified the following needs and gaps in its Mental Health Services system.

- Enhancing the Mental Health Crisis services Continuum
- Expanding training and infrastructure for First Episode Psychosis and Mood Disorder Program
- Increasing Trauma Informed Mental Health services for American Indian Communities
- Integrating and Increasing School Linked Behavioral Health Grant Program
- Increasing Mental Health and Recovery Supports Services and Programs

Mental Health Crisis Services

The Minnesota Department of Human Services, Behavioral Health Division, has identified the following needs and gaps in its Mental Health Crisis Services. We are proposing on spending a total of **$1,081,108** for Mental Health Crisis Services.

The current crisis system in Minnesota consists of the following: Mobile crisis response services, Residential Crisis Stabilization Services, **CRISIS single point of entry to crisis lines, Crisis Text Line text messaging service and regional coordination. There are 34 Mobile Crisis teams that cover all 87 counties in the state of Minnesota, including 4 that are tribal specific crisis teams. There are 22 Crisis Residential Stabilization Programs spread across 9 Counties in the state with a total of 110 beds. These programs offer residential stabilization for up to 10 days. These are adult beds only. As MN currently does not have a benefit for crisis stabilization beds for children. **CRISIS was developed and piloted in 2018 to provide a single point of entry to accessing 24/7 crisis lines throughout the state. Intelligent call forwarding is used to route individuals to their local mobile crisis team based on the location at the time of the crisis call. This is still in the developing stages. Mobile crisis services in MN consist of the following components: Phone screening, face to face assessment, therapeutic intervention, short term crisis planning, and connecting an individual to ongoing services.

The phone screening portion of the crisis services are non-billable. Since 2016 the number of crisis calls for Minnesota has increased by approximately 20,000 calls. With this component of mobile crisis not being billable, and the rapid growth and need for this service, it leaves teams in a desperate situation having to staff the lines, as well as use grant funds, and other county or tribal funds to maintain the 24/7 coverage.

The ARPA MHBG funds would support the crisis best practice of someone to talk to by increasing access to availability of staff on the 24/7 crisis lines. There are so many partners within the crisis continuum but there is a disconnect between those partners and a significant need to develop partnerships with them so we can have a more cohesive and effective crisis system that is coordinated at all touch points. This funding would support our ability to build those partnerships. Especially as we work to implement 988 in Minnesota.

Minnesota does not currently have a MA benefit for children crisis residential stabilization and our children's continuum, while growing, is not yet as robust as the adult continuum. So it is critical that we follow up with warm hand offs and psychological consults for children to provide support when they stay in the community.

In many rural areas the response time to get to individuals can be longer and in times when a more immediate response might be needed to prevent further escalation of the crisis and result to a higher level of care, technology could support telemedicine crisis response. It would provide crisis responders with technology to support MN reaching sustainability in the area of individuals having someone to respond with regard to crisis best practices.

For many children receiving crisis services in MN, referrals come from the school. Additional crisis support for schools to promote access to care for children with SED would provide more immediate response at the school and promote the child remaining in school.

While most of the teams provide community stabilization there are some who do not and for those that do, it can be limited as they are prioritizing mobile response with the limited staffing available. Funding to support more community stabilization would increase capacity for teams to provide this and support clients following a crisis while they are waiting to get connected to other services.

Minnesota is further along in the areas of someone to call and someone to respond; however, we are in the exploration stage for somewhere to go**.** There is a need to explore stabilization receiving centers, obtain more information and determine how this would look in MN. Crisis teams also have limited expertise in serving individuals with SUD experiencing a mental health crisis.

The State of Minnesota plans to advance the development of crisis and other needed prevention, intervention, treatment and recovery support services by working with Crisis teams to begin to gather data on how frequently crisis teams are serving individuals with SMI and SED and develop a better understanding of how they coordinate with case managers.

Summary of Proposed Spending Plan

The State of Minnesota plans to spend the five percent set aside in the total amount of **$1,081,108** for mental health crisis services in the following ways.

- Develop partnerships with the emerging Suicide Lifeline (9-8-8) systems, Law Enforcement, EMS, health care providers, housing authorities, Housing and Urban Development (HUD) Continuum of Care, hospital systems, peer-based recovery organizations, and substance use specific treatment providers, all of whom have a critical role in the crisis continuum.
- Utilize funding to allow for additional phone response to work toward sustainability of someone to call.
- Increase capacity for crisis response staff to work toward sustainability of someone to respond.
- Utilize funds for the purchase of IPADS and telemedicine platforms/technology to allow for telemedicine delivery of service in rural areas when appropriate to provide immediate response when needed. Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and frontier areas; use of GPS, to expedite response times, and to remotely meet with the individual in crisis.
- Increase capacity for response for children in need of crisis response.
- Increase capacity for community stabilization response.
- Provide increased outpatient access, including same-day or next-day appointments, for those in crisis.

First Episode Psychosis

The Minnesota Department of Human Services, Behavioral Health Division, has identified the following needs and gaps in its First Episode Psychosis (FEP) Services. We are proposing on spending a total of **$2,162,216** for First Episode Psychosis Service, an evidenced based programs for people with early serious mental illnesses.

Minnesota's FEP programs are based on research studies and evidence based practices. First, the 2008 RAISE study which showed the Coordinated Specialty Care model is effective. Minnesota's FEP programs use the Coordinated Specialty Care model. Second, Minnesota uses the Navigate curriculum which was created as a result of the 2008 RAISE study.

Prior to COVID-19 pandemic, FEP providers provided face to face services. Currently, Minnesota FEP providers focus on FEP, not early Mood Disorders and we have found that there is a need to provide services for first episode mood disorders in our state. We have also found that there is a need and gap within our state's FEP providers to be trained in CLAS standards, Cultural Formulation Interview, signs and symptoms of substance induced psychosis, correctional system and how to provide resources to inmates on psychotic episodes, access to an integrated community of practice, and access to a telehealth support center.

Since FEP and early Mood Disorders affect adolescents and young adults, we plan to collaborate with the Minnesota Department of Health, Minnesota Department of Education. Additionally, other behavioral health providers, Minnesota Department of Corrections, and Minnesota Department of Human Service's Health Care Administration.

Summary of Proposed Spending Plan

The State of Minnesota plans to spend the ten percent set aside in the total amount of **$2,162,216** as outlined below for First Episode Psychosis.

- Provide training and consultation to FEP and First Episode Mood Disorder providers across the State on clinical signs and symptoms of psychosis within the context of COVID-19.
- In addition train the providers on CLAS standards and Cultural Formulation Interview to enhance cultural responsiveness in their delivery models.
- Establish an integrated community of practice to ensure bi-directional referral system between primary care and behavioral health providers.
- Develop a tool for bi-directional referrals and test it for fidelity. Build a manual to train providers on signs and symptoms of substance induced psychosis.
- Collaborate with Department of Corrections to train providers across correctional system and provide resources to inmates on psychotic episodes.
- Develop a telehealth support center to provide support to providers across the State serving clients in two programs to deliver services via telemedicine to meet safety precautions around social distancing during COVID-19.

American Indian Mental Health Services

The Minnesota Department of Human Services, Behavioral Health Division, has identified the following needs and gaps in its American Indian Mental Health Services. We are proposing on spending a total of **$5,405,539** for American Indian Mental Health Services.

The COVID-19 pandemic has significantly impacted individuals in our tribal and urban American Indian communities, especially those experiencing mental illness and mental health issues. While social distancing is necessary to reduce the spread of COVID-19, at the same time, contributed to disproportionately negatively impacts those in our communities with SMI and/or SED. Because our American Indian communities are largely culturally communal, social distancing has been especially isolating culturally, where healing often occurs through our cultural practices and traditional healing practices. Our partners have reported clients have increased stress, anxiety, feelings of isolation and loneliness, the use of alcohol or illicit substances, and other symptoms of underlying mental illness. There were challenges with access to the treatment and support needed prior to the pandemic. Now these challenges have been amplified by the pandemic. Each of our tribal communities are distinctly unique, and have unique needs.

Summary of Proposed Spending Plan

The State of Minnesota plans to spend the **$5,405,539** for American Indian Mental Health Services in following ways.

- Develop and implement trauma-informed training programs for mental health providers working with tribal nations to develop a culturally competent and responsive workforce. Focus will be to address inter-generational trauma and develop culturally-responsive strategies to address suicidal behaviors, and promote mental well-being among tribal citizens.
- Using the Treatment Improvement Protocol (TIP 61) titled Behavioral Health Services for American Indians and Alaska Natives, from SAMHSA, we will develop training programs for State of MN on following aspects:
    - Importance of historical trauma
    - Acceptance of a holistic view of behavioral health
    - Significance of Community
    - Value of Cultural Awareness
    - Role of Culture and Cultural Identity

School Linked Behavioral Health Grant Program (MHBG)

The Minnesota Department of Human Services, Behavioral Health Division, has identified the following needs and gaps in its School Linked Behavioral Health Grant Program. We are proposing on spending a total of **$10,000,000** for School Linked Behavioral Health Grant Program.

As directed under SAMHSA MHBG, the school-linked behavioral health grant program provides early intervention and treatment for students with mental health and substance use disorder needs and builds the

capacity of schools to support students with mental health and substance use disorder needs in the classroom. The grants support school-linked behavioral health services throughout Minnesota. These services include:

- Increase accessibility for children and youth with an emotional disturbance (ED) or a severe emotional disturbance (SED) who are uninsured or underinsured
- Improve clinical and functional outcomes for children and youth with a behavioral health diagnosis

There is a large unmet need for mental health and substance use disorder services among children and young adults. School behavioral health services help meet that need. Research has shown that early identification and treatment improves outcomes. Schools are a natural setting to promote student well-being and address both mental health and substance use concerns. Early interventions conducted by comprehensive school-based mental health and substance treatment systems have been associated with enhanced academic performance, decreased need for special education, fewer disciplinary encounters, increased engagement with school, and elevated rates of graduation.

Untreated behavioral health issues are a significant barrier to learning and educational success. Placing children's behavioral health services in schools provides a great opportunity for mental health and substance use disorder treatment, promotion, prevention, and early intervention. Schools help reduce barriers such as:

- Financial/insurance
- Childcare
- Transportation
- Employment concerns
- Mistrust/stigma
- Past experiences
- Waiting List/intake process
- Stress

School-linked mental services have proven particularly effective in reaching children who have never accessed mental health services and we anticipate similar results for students with substance use disorders. Many children with serious behavioral health needs are first identified through this program. Community mental health agencies provide mental health professionals and practitioners at schools, with most of their time involved in direct child and family services including assessment and treatment, as well as teacher consultation, care coordination and school-wide trainings. Results include:

- Coordination of care, with services delivered to where the kids are
- Increased access and sustained engagement in treatment
- Evidence-based behavioral health services from highly trained behavioral health professionals, regardless of their insurance status.
- Aligned initiatives with school district's multi-tiered systems of support (MTSS)

Summary of Proposed Spending Plan

As directed by the Minnesota Legislature in Minnesota Laws 2021, First Special Session, Chapter 7, Article 11, Section 43, our state has allocating a total $10,000,000 ($2.5 million in FY 2022, $2.5 million in FY 2023, $2.5 million in FY 2024, and $2.5 million in FY 2025) for mental health services provided through the school-linked behavioral health grant program under Minnesota Statutes, section 245.4901.

The newly amended language in Minnesota Statutes, section 245.4901 specifies that allowable grant activities and related expenses may include, but are not limited to:

- Identifying and diagnosing mental health conditions and substance use disorders of students;
- Delivering mental health and substance use disorder treatment and services to students and their families, including via telemedicine;
- Supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;
- Providing transportation for students receiving school-linked mental behavioral health services when school is not in session (Note: the need to providing transportation is to ensure that services continue even when students are not in school, e.g. summer and holiday breaks. Students are typically transported from home/school to home/school for treatment related services);
- Building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and non-licensed staff; and
- Purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telemedicine.

Grantees must provide data to DHS for the purpose of evaluating the effectiveness of the school-linked behavioral health grant program. Grantees must obtain all available third-party reimbursement sources as a condition of receiving a grant and must also serve students regardless of health coverage status or ability to pay.

Eligible mental health providers include mental health clinics, community mental health centers, providers of children's therapeutic services and supports, and mental health and substance use disorder provider agencies that employ either two mental health professionals or two alcohol and drug counselors. Indian health service facilities or facilities owned and operated by a tribe or tribal organization are also eligible grantees. For a successful implementation, we will utilize our existing MTSS framework and engage our school districts and current providers to determine local needs and potential expansion efforts.

Our state department currently collaborates with the Minnesota Department of Education on the school-linked mental health grant program. We plan to continue that partnership and collaboration for school-linked behavioral health grants.

Mental Health and Recovery Supports Services and Programs

The Minnesota Department of Human Services, Behavioral Health Division, has identified the following needs and gaps in its Mental Health Recovery and Support Services. We are proposing on spending a total of **$1,998,292** for additional mental health recovery and support services and programs.

Summary of Proposed Spending Plan

$120,000 for Family Peer Specialist Position to work with First Episode Psychosis Programs

Fund a family peer specialist position to work with the First Episode Psychosis (FEP) programs. This would include leading family support groups at each FEP, teaching a class about FEP to both professionals (teachers, MH professionals, health care, etc.) and to families. Updating FEP booklet on an annual basis.

$636,236 for Violence Prevention Mental Health Response

Funding to support Local County coordinated community response to violence prevention to detect, interrupt and intervene to prevent violence. Grants to provide outreach and access to communities of color who experience barriers to resources that support healthy connections, economic opportunities, and stable environments. Target populations of diverse communities significantly impacted by the pandemic with serious mental illness and/or serious emotional disorders.

$469,056 for Behavioral Health Family and Community Education Grants

Extend funding for Behavioral Health Family and Community Education grants for 6 current grantees. The purpose of these grants is to engage communities and co-create education for people, families and communities navigating behavioral health systems who are facing cultural, linguistic and/or racial discrimination barriers. All current grantees serve culturally specific communities. The focus of the work is co-creating within the community and with stakeholders. The needs of the communities served have shifted and intensified resulting from health disparities of COVID 19. Given the deliverables and goals of the program and funding, and impact of COVID 19, a two year term/contract was not sufficient for that level of change; for this type of initiative and goal of large-scale community level engagement, a minimum of 3 years would be recommended. Extending 2 more years of funding is recommended.

$50,000 for Enhanced Illness Management and Recovery (E-IMR) Foundations Training for Behavioral Health Providers

Fund 50 registrations for Live Video workshop 14 sessions' series for Behavioral Health Providers and/or purchase a separate training from the Center for Practice Transformation (UMN). This intensive foundation training covers E-IMR principles, modules, and resources. It develops your working familiarity with the E-IMR framework and provides extensive practice for you to develop and hone requisite E-IMR skills. The training process is comprised of two complimentary components: live-video workshops and our Applied Learning Lab (ALL) modules.

$248,000 for 1 Full Time Staff for the Minnesota Department of Human Services, Behavioral Health Division (BHD)

This full time staff will work on managing programs that are expanding in our division due to increased funding from ARPA Mental Health Block Grant funds. This 1 Full Time position will be for a 2 year period of the ARPA grant.

$225,000 for Training Black, Indigenous and People of Color (BIPOC) licensed clinicians in Early Childhood Mental Health to support BIPOC Trainees

Early Childhood staff will collaborate with Cultural and Ethnic Minority Infrastructure Grant (CEMIG) Program to train and support licensed clinicians of color to provide affinity groups to early childhood mental health clinical trainees throughout the State. With this funding, it's estimated that the CEMIG grantees may operate up to 5 on-going affinity groups per year for up to 50 early childhood clinicians and clinical trainees.

$250,000 to Support Culturally Specific Providers in increasing outreach and support services to the BIPOC communities, especially providers focused on providing mental health services to Asian communities.

There is a need in our state to support culturally specific provider in increasing outreach and support services to the BIPOC communities, especially providers focused on providing mental health services to Asian communities. With this funding we proposal the following activities:

- Support community-based and culturally-specific organizations to provide outreach and educational awareness services to the Asian American/Pacific Islander communities, especially focused on creating awareness for mental health services and destigmatizing mental health in Asian communities.
- Support culturally-specific mental health providers and mental health providers specializing in immigrant mental health services to increase outreach and support services to the BIPOC communities, especially for Asian-led providers focused on providing mental health services to Asian communities.
- Organizations that we would partner with to do this work will provide culturally-specific outreach, awareness and education programs.

Summary of Mental Health Block Grant ARPA Funding Spending Plan

Total MHBG ARPA Grant Award = $21,622,155

Service and Program Areas	Budgeted Amounts	Approved Amounts
Mental Health Crisis Services Set Aside	**$1,081,108**	**$1,081,108**
Evidenced Based Practices for Early Serious Mental Illness including First Episode Psychosis (10% of the state's total MHBG award)**	**$2,162,216**	**$2,162,216**
Ambulatory/Community Non-24 Hour Care • **$5,405,539** for American Indian Mental Health Services (25% Set Aside Minnesota State mandate) • **$10,000,000** for School Linked Behavioral Health (Mental Health Block Grant) • **$1,998,292** for Mental Health and Recovery Supports Services and Programs	**$17,297,723**	**$17,403,831**
Administration 5% Max of the state's total MHBG award (Excluding Program and Provider Level)	**$1,081,108**	**$975,000**