

GOVERNOR’S TASK FORCE ON MENTAL HEALTH

DRAFT FINAL REPORT

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GOVERNOR'S TASK FORCE ON MENTAL HEALTH

EXECUTIVE SUMMARY

1. Introduction

Governor Mark Dayton established the Governor's Task Force on Mental Health to develop comprehensive recommendations for improving Minnesota's mental health system. The Task Force included representatives of individuals and families with lived experience of mental illness, mental health advocates, mental health service providers, counties, courts, law enforcement, corrections, public health, education, housing, and legislators. They met seven times between July and November 2016 and also worked in smaller formulation teams to develop the recommendations summarized below.

The Task Force concluded that Minnesota's mental health system provides a variety of effective services that can assist people in their recovery from mental illnesses. However, it is not yet a comprehensive continuum of care that promotes wellness, prevents mental illnesses where possible, and supports all Minnesotans with mental illnesses to pursue recovery in their home communities. The availability of services varies from region to region and there are critical shortages across the state for some services. The publicly-funded system is focused on the needs of people with severe mental illnesses and spends relatively little on supporting wellness, preventing illness, and responding effectively when symptoms first arise. The system has become a complex set of public and private programs and services that is overseen by fragmented and overlapping federal, state, local, and tribal agencies. Funding is similarly fragmented and inadequate to support a robust set of programs and services.

These system inadequacies create significant problems for people with mental illnesses and their families. Not only must they fight the stigma and discrimination that comes at people with mental illnesses, but they must also fight through a confusing maze of insurance benefits, eligibility requirements, financial arrangements, service providers, treatment plans, and logistical challenges to get the services they need. Even if they are able to find local providers, the services are sometimes a poor fit with their sense of what they need and they are sometimes difficult to access due to physical, language, or cultural barriers. Moreover, they often struggle to integrate their care across a range of public and private providers and across institutional sectors that have conflicting expectations and incentives.

The Task Force developed a vision and identified a set of principles that should drive improvements to the mental health system to create a comprehensive continuum of care. They believe that the mental health system should be person- and family-centered, and that it should provide integrated, culturally – responsive, community-based services and activities. The following recommendations provide a basic roadmap for fulfilling their vision.

2. Recommendations

Recommendation #1: Create a comprehensive mental health continuum of care: The state should adopt a wide definition of the mental health continuum of care to include mental health promotion and

prevention, early intervention, basic clinical treatment, inpatient and residential treatment, community supports, and crisis response services. The state should collaborate with partners and stakeholders to undertake systematic planning to improve availability and access to mental health services and mental health promotion activities in the continuum. Responsibility for ongoing system assessment, service development, and quality management should be assigned, along with the funding and staffing to fulfill those functions.

Recommendation #2: Redesign governance of Minnesota’s mental health system. A Minnesota Mental Health Governance Workgroup should be convened to make recommendations to the Governor and Legislature about redesign of governance structures for mental health activities and services in Minnesota. This should include possible changes to the current “state directed, county administered” model; clarification of roles, responsibilities, and accountability; development of mechanisms to support innovation and adoption of promising models; and design of funding structures to align with the new governance structure.

Recommendation #3: Use a cultural lens to reduce mental health disparities. State agencies should convene a workgroup of people from American Indian tribes, communities of color, and other cultural backgrounds to detail strategies for improving mental health services and activities for communities experiencing mental health disparities. These should include ways to support and grow culturally-specific providers; make the entire system more trauma-informed; and supplement the existing medical model with culturally-informed practices.

Recommendation #4: Develop Minnesota’s mental health workforce. The Governor and Legislature should continue to support development of Minnesota’s mental health workforce, including implementation of the recommendations in “Gearing Up for Action: Mental Health Workforce Plan for Minnesota.” DHS and MDH should work with the Mental Health Steering Committee (responsible for the Mental Health Workforce Plan) to ensure progress on those recommendations.

Recommendation #5: Achieve parity. In general terms, “parity” is the concept that people should have access to mental health services under the same conditions that they have access to other healthcare services. The capacity of the Departments of Commerce and Health to review health plans’ alignment with parity laws and enforce those laws should be expanded. Data should be systematically reported and tracked to identify when insurers are not following parity laws, consequences should be significant and swift, and solutions should be implemented in a timely way. In addition, the state should require that private insurers cover the same mental health benefits that are funded through Minnesota’s Medical Assistance and MinnesotaCare programs. This will improve access to mental health services and make it easier to achieve parity by promoting more standardized benefits across the coverage spectrum.

Recommendation #6: Promote mental health and prevent mental illnesses. The Governor and Legislature should support efforts to build robust mental health promotion and prevention capacity within the state. Infrastructure and programs should be developed to build public understanding of mental health; strengthen community capacity to address system needs and gaps, especially for vulnerable populations; and address adverse childhood experiences and trauma throughout the lifespan.

Recommendation #7: Achieve housing stability. Because housing stability is a critical factor in mental health, the Governor and Legislature should ensure that affordable housing—including housing with supports where needed—is available to all individuals and families to ensure both the access to and the effectiveness of mental health care. This should include funding for additional affordable housing development for low-income Minnesotans, and supports and protections targeted to people with mental illnesses.

Recommendation #8: Implement short-term improvements to acute care capacity and level-of-care transitions. There should be an expectation that access to mental health and substance use disorder care is as accessible as physical health care. The Governor and Legislature should fund and assign responsibility for several short-term solutions to the patient flow problems implicit in the shortage of inpatient psychiatric beds. These can help ameliorate the situation and build collaborative capacity while longer-term solutions and more extensive solutions are developed. The strategies include expansion of community-based competency restoration; strengthening community infrastructure; making changes to the civil commitment process; expanding options for parents and children; supporting efforts to reform addiction treatment, and assessing the impact of increases in the counties' share of payments for stays at state-operated hospitals. DHS should convene a workgroup to facilitate ongoing collaboration around these solutions.

Recommendation #9: Implement short-term improvements to crisis response. The Governor and Legislature should fund and assign responsibility for several short-term improvements to Minnesota's system for responding to mental health crises. These extend ongoing work in the crisis response system and build further capacity and collaboration across the state. They include expansion of Crisis Intervention Team training; providing additional resources where people already seek help; improving collaboration between mental health and criminal justice; improving data sharing and collaboration; telehealth solutions; and further improvements to community services.

The Task Force recommends that the work laid out in these recommendations be assigned to existing agencies and organizations where possible, and urges the Governor and Legislature to fund these bodies to take on the additional work. They recommend that Recommendation #2, on redesigning the governance structure, be implemented through creation of a new workgroup that would be facilitated by a contracted organization that is not aligned with any particular agency or stakeholder group. They envision that the longer-term implementation of the Task Force's recommendations would occur within the structures recommended by that workgroup and implemented by the Governor and Legislature. In the meantime, they recommend that the Commissioners of DHS and MDH, a county representative, and a tribal representative meet periodically to discuss the progress on the Task Force's recommendations and address barriers to implementation. The Commissioner of DHS should assign responsibility for calling and facilitating those meetings.

A. Introduction

1. Task Force's Charge

Governor Mark Dayton established the Governor's Task Force on Mental Health in order to:¹

1. Advise the Governor and Legislature on mental health system improvements within the State of Minnesota.
2. Develop comprehensive recommendations to design, implement, and sustain a full continuum of mental health services throughout Minnesota.
3. Make recommendations on:
 - a. Developing and sustaining a comprehensive and sustainable continuum of care for children and adults with mental illnesses in Minnesota, including policies, legislative changes, and funding;
 - b. Clear definition for the roles and responsibilities for the state, counties, hospitals, community mental health service providers, and other responsible entities in designing, developing, delivering, and sustaining Minnesota's continuum of mental health care;
 - c. Reforms needed to support timely and successful transition between levels of care, including early intervention services and substance abuse services; and
 - d. Expanding the capacity of Minnesota's mental health system to responsively serve people of diverse cultures and backgrounds.

The Task Force included representatives from various sectors within and related to mental health services, including individuals and families with lived experience of mental illness, mental health advocates, mental health service providers, counties, courts, law enforcement, corrections, public health, education, housing, and legislators.² The Task Force agreed that while Minnesota's mental health system provides a variety of effective services, it is not yet a comprehensive continuum of care that promotes wellness, prevents mental illnesses where possible, and supports people with mental illnesses to pursue recovery in their home communities.

2. Role of the Task Force

The Governor's Task Force on Mental Health is one activity in a very complex system of subsystems that include mental health care, substance use disorder treatment, primary care, social services, law enforcement, criminal justice, education, and housing. These subsystems operate in the geographic and cultural communities that Minnesotans live in and that ground their wellness. Individuals and organizations in these systems are collaborating with communities on dozens of projects to improve the services they provide and the coordination of those services. The Task Force wanted to support that

¹ See Appendix I for the complete text of the Governor's Executive Order.

² See Appendix II for a list of Task Force members.

work while also identifying opportunities for transforming the existing array of services into an integrated and comprehensive continuum of care. They also recognized that there are several critical issues in the current mental health system and that many stakeholders were relying on them to make recommendations to address those problems.

The Task Force decided to address two immediate challenges facing Minnesota’s mental health system as well as three longer-term transformational opportunities. Together these allowed the Task Force to respond to the Governor’s charge and to yield both short-term solutions to pressing problems and a roadmap for more visionary transformation. The Task Force thus offers recommendations on two immediate challenges:

- Crisis response: Improving response to people experiencing a mental health crisis and diverting people with mental illnesses from the criminal justice system.
- Acute care capacity: Addressing the shortage of inpatient psychiatric beds and the barriers that impede patients’ transitions between levels of care.

The Task Force also offers recommendations on three transformational opportunities:

- Defining and creating a continuum of care: Defining the dimensions of a “continuum of care” and laying out a road map for transforming the existing array of services into a true continuum.
- Transforming the governance structure: Identifying the challenges with the current governance structure and suggesting a process for transforming that structure to support a continuum of care.
- Using a cultural lens to reduce mental health disparities: Explicating the importance of culture in understanding mental health and mental illness and identifying opportunities to improve mental health services and activities by infusing cultural awareness throughout the continuum of care.

3. Task Force Process

After identifying Task Force members, the Governor appointed Department of Human Services Commissioner Emily Piper to chair the Task Force and gave DHS primary responsibility for supporting the Task Force’s work. Commissioner Piper assigned a fulltime staff person to support the Task Force and also arranged for a consultant from the state Bureau of Mediation Services to facilitate the Task Force meetings. Contacts were established with the various state agencies, other government entities, and stakeholder groups relevant to mental health, and a contact list of about 350 people was developed. The staff set up a Task Force website to communicate with the public about Task Force activities and share Task Force documents.

People on the contact list were informed about upcoming meetings and invited to attend meetings and provide comment on Task Force work. A public comment period was included in each meeting, and comments gathered by staff were collected and sent to the Task Force before each meeting. All comments were also posted on the website.

The Task Force met seven times between July and November of 2016. The first three meetings included overviews of the current mental health system and presentations by people with lived experience of mental illness, their families, and providers of mental health services (including culturally-specific

providers). The Task Force identified a long list of challenges and opportunities in the current mental health system and prioritized those challenges to focus on the five topics introduced above. They established five Formulation Teams made up of Task Force members and their designees, each supported by DHS staff. The Formulation Teams gathered and reviewed background information, formulated issues, and planned the Task Force discussions to help Task Force members move efficiently toward recommendations on each of the five topics. Each Formulation Team met about six times during September and October and prepared documents that were reviewed at Task Force meetings.

Before the October 17th meeting, the staff incorporated the work of the Formulation Teams into an integrated draft of recommendations. These were discussed and refined at the October 17th meeting, and additional drafts were circulated and revised such that a final draft was ready for consideration by the Task Force at their last meeting on November 7. At that meeting, the Task Force reviewed each recommendation and attempted to reach consensus ...

[Finish this after last meeting].

B. Starting Points

The Task Force felt strongly that the mental health system should be designed around the circumstances and needs of the people it serves. This required them to hold two perspectives simultaneously. At a micro level, they needed to understand the experience of individuals and families who make their way through the mental health system. At a macro level, they needed to envision the system as a whole and how it could be designed to improve the experience of individuals while also meeting system goals like accountability and sustainability.

1. The Ideal System from the View of People with Lived Experience of Mental Illness and Their Families

In early meetings, the Task Force heard from people with lived experience of mental illnesses and their families about their expectations for the mental health system:

1. That the general public has an understanding of mental health and mental illness so that reactions and decisions aren't made based on stigma. People should know what they can do to maintain their mental health and wellbeing, and they should know what to do or where to go if they want to engage in wellness/prevention activities. They should also be able to recognize when their experiences might go outside the norms of sadness or worry or creativity and might be the emerging symptoms of a mental illness.
2. That people know enough about the mental health system that they know where to go to learn more when they need to, and where to turn for help with symptoms of mental illness.
3. That there's a place to go and people to help when people first need help, rather than waiting until people are really sick.
4. That those helping places should be responsive to people's individual and cultural backgrounds so the help that is available makes sense to them and is responsive to their needs.

5. That the person has choices—in services, treatments, and providers. The system should be flexible in how it helps, when it's available, where it's provided, who it's provided by, etc. People want options.
6. That the relationship between providers of services and those receiving them will be considered paramount to the success of the services and that both parties need to support strong, trusting relationships. This requires that providers understand people's personal and historical backgrounds.
7. That the person is engaged in their treatment planning and it is related to their personal goals.
8. That the services should be person- and family-centered—i.e., that the person and the family can articulate what they want, the system offers options, and then the person and family decide how to move forward.
9. That the services and provider options reflect an understanding of how trauma and other social factors can influence mental health.
10. That the person or family seeking help can be assured that any services or treatments being offered are supported by the best evidence available and that the individual, family, and care team support collaborative decision-making about choices among the options.
11. That the services needed are available no matter what form of insurance the person has (including uninsured).
12. That the care should be as local as possible. Common treatments should be available close to home, and only very specialized treatments should require significant travel.
13. That the help that is received has to be integrated into one understandable package of support—it shouldn't be offered by a variety of different providers in different settings with different rules and different access points that need to be figured out by the individual or family. If it's too hard to negotiate, they won't use it or they will try to use it but it will fail them.
14. That mental health services are integrated with community supports, including affordable and stable housing, to increase effectiveness of services and a more sustainable recovery.
15. That the system should be built on the fundamental assumption that recovery is possible and that the person involved can have a rewarding, satisfying life and make contributions to the community.

2. Task Force Vision and Principles

With the expectations of people served by the mental health system in mind, the Task Force then shifted perspectives to a macro view to lay out the characteristics of a system that could meet those expectations while also meeting the needs of other stakeholders. They summarized this system in a vision statement and a set of principles that describe the ideal mental health continuum of care.

Task Force Vision:

Minnesota will have a comprehensive, sustainable mental health continuum of care that includes mental health promotion and prevention, early intervention, basic clinical treatment, inpatient and residential treatment, community supports, and crisis response services to promote resilience and recovery. These services and activities will be person- and family-centered, integrated, culturally-responsive, and community-based. It will rely on public/private partnerships to meet the mental health needs of all

Minnesotans in order for them to live, work, learn, participate in community life and reach their full potential.

The Task Force identified the following principles to guide their decision-making:

1. **Prevention and early intervention:** It is better to help someone avoid illness or address symptoms early than to wait until their condition has become more acute to provide services. Promoting wellbeing for the entire population; primary prevention (preventing a mental illness from occurring); secondary prevention (identification and screening of people with high risk factors or low protective factors for mental illness); and tertiary prevention (halting or slowing the progress of an illness that has already been diagnosed) are all essential strategies. The system should employ a full range of effective mental health promotion and prevention strategies, including education of the general public about mental health and their role in supporting people with mental illnesses.
2. **Resilience and recovery:** Mental health and wellbeing are the result of many societal and individual factors. Improving Minnesotans' mental health will require both addressing social and economic conditions that can contribute to mental illnesses as well as helping individuals heal from mental illnesses when they occur. For children, the goal of mental health services is help them heal from hurts so that they can adapt to challenges and achieve their full potential (resilience). For adults, the goal of mental health services is recovery, defined by the Substance Abuse and Mental Health Services Administration (SAMSHA) as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."³ For some people resilience and recovery involve freedom from the symptoms of mental illness; for others, they involve effective management of symptoms in order to live a satisfying life. Resilience and recovery are about individuals striving toward maximum participation and performance in appropriate life activities including school, work, family life, civic engagement, spiritual practice, recreation, and socializing. They are mirrored by the need for *systemic* recovery and resilience—the ability of the society to heal its social inequities and adapt to the changing needs of community members.
3. **Person-centered and family-centered:** Recovery is best achieved by person-centered, person-driven, and family-centered strategies and care, which means that each person and their family directs their own recovery to the greatest extent possible. The approach is summed up in the "Nothing about us, without us" motto. Family and friends can play a crucial role in helping ensure that decision-making and care are driven by the preferences of the person as much as possible.
4. **Autonomy:** There is a fundamental tension between involuntary civil commitment as a means to ensure safety and treatment and the curtailing of civil liberties. The mental health system should be designed to prevent or reduce the use of civil commitment whenever possible, and to ensure that individual autonomy is only constrained when absolutely necessary.
5. **Anti-stigma:** The stigma surrounding mental illnesses is very powerful discrimination that isolates people, prevents them from seeking treatment, dramatically complicates recovery, and undercuts public support for mental health services. It also misleadingly links mental illness with violence. It is important to fight stereotypes and misleading information about mental illnesses and to educate society about the reality of these illnesses. Education should also prepare people to respond

³ "SAMHSA Announces a Working Definition of 'Recover' From Mental Disorders and Substance Abuse Disorders," SAMHSA News Release accessed on December 22, 2013 at <http://www.samhsa.gov/newsroom/advisories/1112223420.aspx>

appropriately when encountering someone with a mental illness or experiencing a mental health crisis.

6. **Community-based:** As much as possible, mental health services should be accessible in local communities so that people can pursue recovery while remaining integrated in their communities. The system of services in each community should reflect the community context and the strengths of that community.
7. **Commitment:** Policy makers and regulators should commit to following through and implementing the recommendations of the Task Force. This could require additional financial or human resources.
8. **Access to the right services, in the right place, at the right time:** People experiencing mental illnesses should be able to find the right services in the right place at the right time. Just like what we expect when we break our arm or experience a heart attack, people with mental illnesses should have timely access to services that meet their needs in a convenient location. They should also receive services in the least restrictive and most integrated community setting of their choice.
9. **Consistency of services regardless of payer:** The healthcare system should provide consistent and appropriate services regardless of whether the person's insurance is publicly or privately paid. There should also be mechanisms to assist people as they move between public and private insurance to ensure smooth transitions.
10. **Public-private partnerships:** The mental health service system relies on effective collaboration among a host of government-operated and private entities. The roles of each organization should be clearly understood and there should be adequate support for the joint planning, collaboration, evaluation, and redesign that is necessary for continuous improvement at a system level.
11. **Public and private insurance:** The mental health service system is funded by both private and public insurance, so any planning for changes to the service system should consider 1) the needs of all people no matter their source of the funding of their services; and 2) the impacts on the services funded by both public and private insurers.
12. **Integration:** Mental health services should be integrated with substance use disorder services as recommended by the federal Substance Abuse and Mental Health Services Administration. Better integration will also aid transitions between service locations and levels of care. Mental health services can be integrated with other health and social services, primary and urgent care, disability services, housing, income supports, law enforcement and corrections, education, etc. New payment models are helping promote such integration.
13. **Coordinated:** Where mental health services are not actually integrated, they should at least be coordinated so that the person and family receiving care do not "fall through the cracks" between providers or levels of care.
14. **Multi-dimensional:** Mental illnesses and substance use disorders are medical conditions that have emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual dimensions. To support recovery, the healthcare, social service, education, and employment systems should help the person—with their family and community—to address all of these dimensions in flexible ways.
15. **Safety net:** The mental health system should ensure that anyone who needs mental health services can access them, regardless of ability to pay, high intensity of illness, symptoms including aggression, history of legal involvement, or other reasons. Even in a community-based system with multiple providers and funders, there should be well-understood responsibility, accountability, and capacity for "no rejections" providers who serve those whom no one else is willing to serve. The safety net function should be clearly spelled out on a local, regional, and statewide basis and funding should be allocated to match responsibility.

16. **Sustainability and cost-effectiveness:** The system should be based on a sustainable and affordable financial framework with rational incentives.
17. **Suicide prevention:** Suicide can result from inadequately-treated mental illness. Suicide is preventable and the mental health system should invest in proven suicide-prevention programs.
18. **Stewardship:** The mental health system should reflect responsible stewardship of public and private funds, ensuring that funds are used efficiently to have maximum positive impact on health outcomes.
19. **Understandability:** The system should be easily navigated by people with mental illnesses and providers because it operates in efficient, understandable pathways.
20. **Cultural responsiveness, competence, and specificity:** The system should respect cultural and social norms of people who might have alternative conceptualizations of mental health and mental illness. As much as possible, services should be responsive to the needs of people from the range of cultural and ethnic groups in Minnesota (culturally responsive and culturally competent) and/or specifically targeted to the needs of a particular cultural or ethnic group (culturally specific). Education about various cultural perspectives should be delivered to create better understanding and awareness.
21. **Accessibility:** Mental health services and information need to be available in multiple formats and languages to meet the needs of the range of people living in Minnesota. Printing documents in multiple languages and formats is a good start, but assuring that follow-up resources are also available in multiple languages or responsive to the needs of linguistic/cultural subpopulations will also be necessary.
22. **Housing:** Stable, safe, affordable housing is key to pursuing recovery in the community. The mental health services system should collaborate and coordinate with housing services to prevent homelessness where possible and to quickly address the need for housing—with appropriate services—to avoid or ameliorate mental illness or mental health crises. The system should also identify housing gaps and request resources to fill those gaps, as well as providing up-to-date, useful information about the availability of safe housing and the processes and funds for accessing housing.
23. **Transportation:** Transportation is a key dimension of access to services: if a person has no way to get to appointments, the treatment may be available but it's not accessible. Humane and safe transportation is also especially important during a mental health crisis. The mental health system should include, or coordinate with, transportation services to ensure that people with mental illnesses can access services with safety and dignity.
24. **Employment:** Employment is one key to maintaining independence and self-identity, which makes is an important factor in recovery. The mental health service system should coordinate with employers and vocational services providers to ensure that people receive the support they need to prepare for and maintain stable employment. It should also work with employers to increase understanding about mental health and mental illnesses.
25. **Prevent, reduce or eliminate criminal justice involvement:** The mental health service system should be set up to prevent, reduce or eliminate criminal justice involvement by people with mental illnesses whenever possible.
26. **Evidence-based:** The system should support evidence-based interventions and treatment to produce the desired outcomes. Where evidence has not yet been developed for a particular treatment or sub-population, research should be initiated to test the intervention and cultural leaders should be consulted about the most appropriate way to proceed. Some people prefer the

term “evidence-informed” to acknowledge the importance of cultural differences and the fact that evidence gained about one cultural group may not generalize to other cultural groups.

27. **Capacity:** The system should have ample capacity of staff and programs to meet the needs of all Minnesotans with mental illnesses and emotional disturbances.
28. **Accountability:** The rules and incentives governing the service system should clearly define accountability among all parties.
29. **Data-driven and continuous improvement:** The mental health system should have a transparent system for setting quality goals and measures, gathering data, assessing outcomes against measures, and implementing improvements. Changes to the system should be driven by this data and analysis.

3. Mental Health Primer

This section presents basic definitions and concepts that are used in the rest of the report.

a. Mental Illness is Biological, Psychological, and Social

Conceptions of normal behavior and optimum health grow out of people’s cultural backgrounds, personal experiences, and the myriad messages they receive from family, friends, communities, education, employers and the media. These conceptions change historically, shaped by scientific discoveries, commercial interests, and political and cultural relationships. The current scientific understanding of mental illness in the United States is based on a medical model that interprets some thoughts, feelings, and behaviors, such as hearing voices or feeling prolonged periods of despair, as symptoms of illness that can be treated by medical professionals with medications and therapies. Historically, this model emphasized the biological and chemical dimensions of mental illness as a brain disease and developed interventions within the medical system to address mental illness.

The medical model has expanded its understanding of mental illness to the current biopsychosocial model, recognizing the role of biological, social, and environmental dimensions and origins.⁴ Robust research on adverse childhood experiences shows that children who experience traumatic events or protracted dangerous or chaotic living situations are significantly more likely to develop mental illnesses as children or adults if they do not have the individual or community resources to heal from those experiences. There is also evidence that other social determinants of mental health, such as experiencing poverty, income inequality, racism, historical trauma, and reduced social capital or collective efficacy, contribute to the onset and development of mental illness.⁵ For example, children from ethnic and cultural minorities experience the ongoing trauma of racism, which can lead to internalization of devaluing messages, negative self-perceptions, feelings of voicelessness, and rage.⁶ The behaviors that result from racism can be confused with symptoms of a mental illness instead of

⁴ Timothy Melchert, *Biopsychosocial Practice: A Science-Based Framework for Behavioral Health Care* (Washington, D.C.: American Psychological Association), 2014; Compton, M, & Shim, R., *The Social Determinants of Mental Health* (Washington, D.C.: American Psychiatric Publishing/ American Psychiatric Association), 2015, p. 3.

⁵ Compton, M, & Shim, R. (2015). *The Social Determinants of Mental Health*. American Psychiatric Publishing/ American Psychiatric Association, Washington D.C.

⁶ Kenneth V. Hardy, “Healing the Hidden Wounds of Racial Trauma,” *Reclaiming Children and Youth*, Vol. 22, No. 1, 2013, pp. 24-28.

being recognized as natural responses to adverse social circumstances. If left unaddressed, the chronic stressors may lead to mental illnesses.

The mechanism through which trauma and many social determinants of health impact the development and course of mental illness has been illuminated through research on brain development. “Toxic stress”, defined as chronic or acute stress that activates the physiological stress response system, can create chemical and structural changes in the brain and body and maladaptive patterns of behavior that can contribute to the development of both mental and physical illnesses. Because children from ethnic and cultural minorities are more likely to live in poverty, and children in poverty are more likely to experience adverse events, this research helps explain some of the origin of mental and physical health disparities in Minnesota. Historical trauma and current institutional racism also contribute to the buildup of toxic stress, further exacerbating health disparities.

As more research is done on brain function and development and the genetic factors involved in mental illness, it is becoming clearer that epigenetics, the process by which genes are turned on or off or by exposure to environmental and social factors, sheds more light on what causes mental illnesses and what we can do about it.⁷ These studies provide new explanations of how mental illness—like other illnesses—involve the intertwined impacts of chemical/biological processes in the brain and social experiences. The research on epigenetics, in particular, helps explain how mental illnesses is both biologically and socially “inheritable,” as seen in the impacts of intergenerational trauma on members of groups that have suffered historical oppression and its negative consequences across generations.

b. Definitions of Mental Health, Mental Illness and Emotional Disturbance in Minnesota

Mental health is defined by the World Health Organization as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”⁸

Minnesota statute defines mental illness as follows:

“Mental illness” means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person’s capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.⁹

⁷ “Disorders Share Risk Gene Pathways for Immune, Epigenetic Regulation,” (Washington, DC: National Institute for Mental Health Science Update, January 29, 2015). Accessed on 6/10/16 at <http://www.nimh.nih.gov/news/science-news/2015/disorders-share-risk-gene-pathways-for-immune-epigeneticregulation.shtml>.

⁸ “Mental health: a state of well-being,” World Health Organization Website, accessed on 6/3/16 at: http://www.who.int/features/factfiles/mental_health/en/.

⁹ Minnesota Statutes, section 245.462, Subd. 20 (a).

For children, mental illness is referred to as “emotional disturbance” with a similar definition in Minnesota statute.¹⁰ Both “mental illness” and “emotional disturbance” are generic terms that refer to a range of medical disorders and the symptoms that define them. Some diagnoses include depression, anxiety disorder, schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), and eating disorders. Clinicians diagnose the conditions based on physical, psychological, and behavioral symptoms, and the American Psychiatric Association maintains a manual of classifications of mental illnesses called the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or “DSM-5.”

Mental illnesses and emotional disturbances affect every Minnesotan directly or indirectly. Close to half of adults will experience at least one mental illness during their lifetime, and almost everyone has a family member or close friend who has experienced mental illness.¹¹ Mental illness is associated with other chronic illnesses and can lead to disability. It can compromise a person’s ability to go to school or work and it contributes to absenteeism. It creates financial and personal burdens for the person with the mental illness as well as family members, other earners, and/or taxpayers who help provide or pay for services. Improving the mental health system is a goal that almost everyone supports.

c. Risk and Protective Factors

Risk and protective factors have been identified to help understand and predict who might develop mental illnesses. Protective factors are characteristics or circumstances that can help a person avoid mental illnesses, while risk factors are social, psychological, and biological characteristics or circumstances that can promote the development of mental illnesses. Figure 1 identifies risk and protective factors for mental illness.¹²

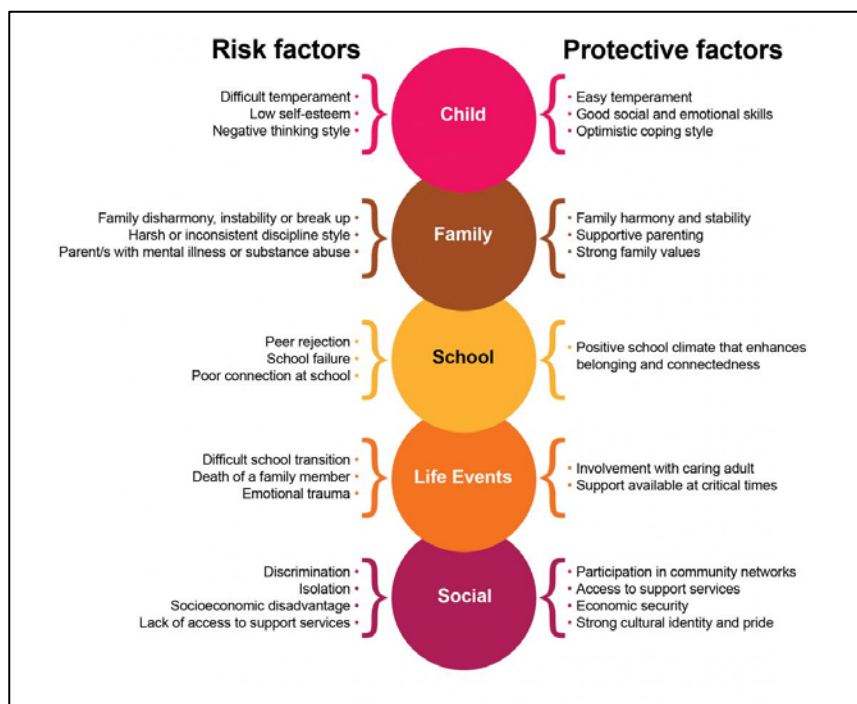


FIGURE 1: RISK AND PROTECTIVE FACTORS FOR MENTAL ILLNESSES

¹⁰ Minnesota Statutes, section 245.4871, Subd. 15.

¹¹ “Mental Illness Surveillance Among Adults in the United States,” Center for Disease Control and Prevention website, accessed on 7/12/16 at http://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html.

¹² “How Mental Health Difficulties Affect Children,” Kids Matter website accessed on 6/7/16 at <https://www.kidsmatter.edu.au/families/about-mental-health/should-i-be-concerned/how-mental-healthdifficulties-affect-children-0>.

d. The Social Determinants of Health

Figure 1 shows that risk and protective factors are not just personal psychological traits: they also include social determinants of health like whether one lives in a safe neighborhood or has access to nutritious food. In explaining the social determinants of health, the World Health Organization's Commission on the Social Determinants of Health identified three conceptual relationships that help determine health and health inequities:¹³

1. The social, economic and political context into which someone is born plays an important role in that person's socioeconomic position.
2. A person's socioeconomic position (as evidenced by class background, gender identity, race, ethnicity, etc.) shapes the social determinants of health, including: a person's living and working environment; their access to food, transportation, and healthcare; their personal behaviors; their biological predisposition to health and disease; and their psychosocial perspectives.
3. These social determinants of health, mediated by the healthcare system and other sectors (for example, education and social services) affect the health of individuals and help create the unequal health outcomes of populations.

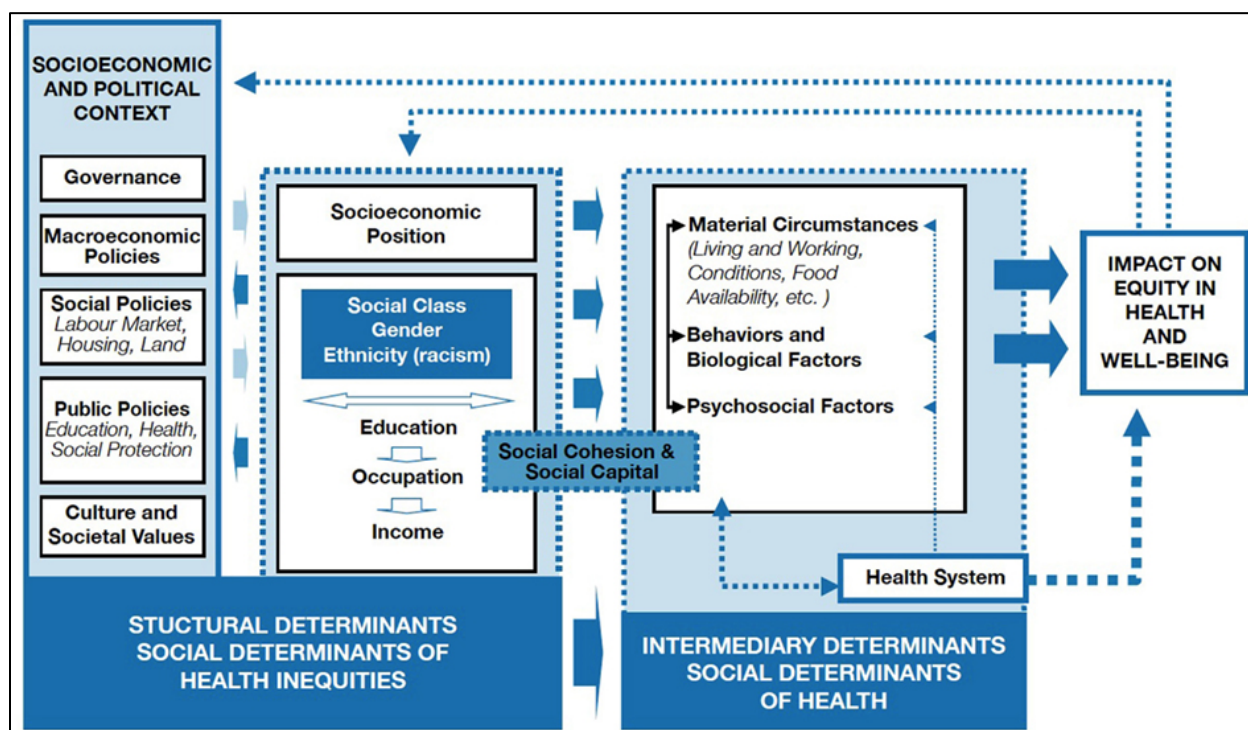


FIGURE 2: SOCIAL DETERMINANTS OF HEALTH¹⁴

Figure 3 illustrates those relationships. One benefit of this conceptual model is that it provides a very general map of extremely complex interactions among factors that produce mental health and mental

¹³ Orielle Solar and Alec Irwin, "A Conceptual Framework for Action on the Social Determinants of Health." Social Determinants of Health Discussion Paper 2, Policy and Practice. (Geneva: World Health Organization, 2010), p. 6.

¹⁴ Orielle Solar and Alec Irwin, op. cit.

illnesses in individuals. The model draws attention to the larger social and economic forces that affect health and health inequities and helps contextualize the investments in healthcare as just one set of investments that will be needed to improve the mental health of Minnesotans.

e. Continuum of Intensity of Mental Illnesses and Mental Health Services

Mental health and mental illnesses are often arrayed on a continuum of intensity, from no mental illness to severe emotional disturbance (children) and serious and persistent mental illness (adults). Because mental illness is often episodic and many people recover fully from mental health symptoms, individuals' intensity of mental illness can fluctuate over time, but it is useful to have estimates of the populations of people with different levels of mental illness intensity in a given year. The DHS Community Supports Administration estimates that about 20 percent of children experience an emotional disturbance, and about 20 percent of the adult population experiences a mental illness in a given year. This translates to more than 300,000 children and 800,000 adults in Minnesota each year.¹⁵ Many of these people do not seek or receive professional help for their illnesses, and most who do are served in public and private outpatient settings and recover fully within a relatively short period of time.

SAMHSA estimates that 5.4 percent, or 221,000 of adults in Minnesota, have a serious mental illness (SMI), defined as having a diagnosable mental illness that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.¹⁶ Unlike many other states and SAMHSA, Minnesota statute has defined a subcategory of adults with serious mental illnesses: adults with serious and persistent mental illnesses (SPMI). Minnesota has also established a subcategory of emotional disturbances called severe emotional disturbance. These categories were created in order to establish eligibility for certain case management services and they are based on repeated use of mental health services. The Community Supports Administration estimates that about 2.6 percent of Minnesota adults have serious and persistent mental illnesses in a given year, and that 9 percent of Minnesota's school-age children and 5 percent of preschool children have a severe emotional disturbance, which is a mental health problem that has become longer-lasting and interferes significantly with the child's functioning at home and school. This totals about 109,000 children from birth to age 21 with serious emotional disturbances.

¹⁵ "Children's Mental Health: Transforming Services and Supports to Better Meet Children's Needs," (Saint Paul: Minnesota Department of Human Services, DHS-5051-ENG, October 2015). Accessed on 6/28/16 at: <https://edocs.dhs.state.mn.us/lfsrver/Public/DHS-5051-ENG>.

¹⁶ Joan Epstein, Peggy Barker, Michael Vorburger, and Christine Murtha, *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders* (Washington, D.C.: Department of Health and Human Services, SAMHSA Office of Applied Statistics, 2002). Accessed on 10/3/13 at <http://www.oas.samhsa.gov/CoD/CoD.htm - ch3>.

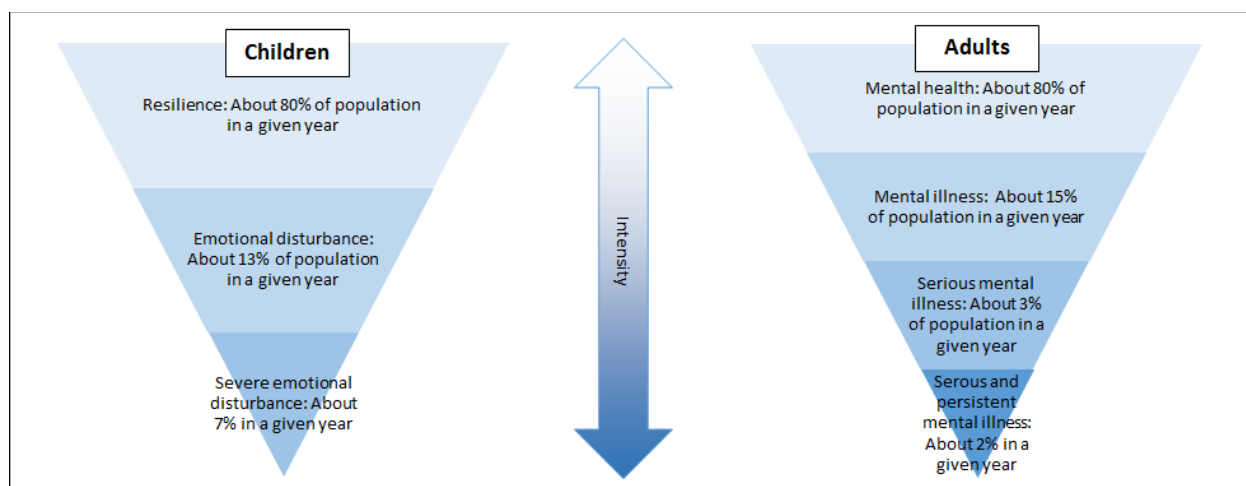


FIGURE 3: INTENSITY CONTINUUM OF EMOTIONAL DISTURBANCE (CHILDREN) AND MENTAL ILLNESS (ADULTS)

Within the categories of adults with serious and persistent mental illness is a much smaller subpopulation of adults with co-occurring conditions that complicate their recovery and pose a risk to personal and/or public safety. Co-occurring conditions include: substance use disorders, traumatic brain injuries, developmental disabilities, chronic physical illnesses, aging-related dementias, and symptoms that include aggression, violence, or self-harm. When these conditions cause someone to present a danger to themselves or others, it is sometimes necessary to pursue a temporary restriction of their rights under the Civil Commitment Statute (Chapter 253B of the Minnesota Statutes). This statute lays out the legal process and conditions under which civil commitment might be pursued. Once a person is committed (usually to the Commissioner of Human Services or to a community provider), there are strict rules for treating the person, assessing their progress, and discharging the commitment.

f. Co-Occurring Conditions

Many people who have a mental illness also have other health challenges including substance use disorders; developmental, intellectual, perceptual or motor disabilities; or chronic physical illnesses. This is called having a “co-occurring” condition, and these conditions contribute to the fact that people with schizophrenia, schizoaffective disorder, and bipolar affective disorder in Minnesota die younger than their peers who do not have serious mental illnesses by an average of 24 years.¹⁷ The cause of death that reflects the widest disparity is heart disease (27 years difference), followed by accident (18 years), COPD (15 years), and cancer (15 years). Intermediate causes of the disparate death rates include higher rates of smoking, poor weight management, poor nutrition, low physical activity, poor access or utilization of preventive healthcare, poverty, social isolation, effects of anti-psychotic medications, higher rates of substance use disorders, unsafe sexual behavior, and residing in group care facilities and homeless shelters where there is increased exposure to infectious diseases.

¹⁷ Michael Trangle, Gary Mager, Paul Goering, and R. Christensen, “Minnesota 10 by 10: Reducing Morbidity and Mortality in People with Serious Mental Illnesses,” *Minnesota Medicine*, Vol. 93, No. 6, 2010, p. 38-41. 10 “Treatment for Co-occurring Mental and Substance Use Disorders,” SAMHSA website accessed on 7/12/16 at <http://www.samhsa.gov/treatment#co-occurring>.

People with mental illnesses are more likely than people without mental illnesses to experience substance use disorders and chronic physical illnesses, and about 45 percent of people seeking substance use disorder treatments have been diagnosed with mental illness as well.¹⁰ According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), the best treatment for people with co-occurring conditions addresses the multiple conditions simultaneously.¹⁸ This requires integrated treatment and collaboration across disciplines.

Some chronic care models have been developed specifically to support people with co-occurring conditions, including the Behavioral Health Home model now being implemented in Minnesota. This model involves certifying providers who can provide integrated and coordinated treatment of mental health, substance use disorders, and chronic physical illnesses. Treatment is also coordinated with long-term services and supports. These certified providers are then able to bill through Medicaid for this enhanced level of service and coordination.

g. Minnesota's Mental Health System

The definitions and concepts presented above make it clear that the Minnesota mental health system cannot be narrowly focused on clinical services, but must comprise a much wider set of formal and informal services and activities that support individuals, families, and communities. The mental health system includes the following:

- **Individuals and Communities:** All Minnesotans are a part of the mental health system as a sources of resilience for people in their communities, as senders and receivers of messages about mental health and wellbeing, as a family member or friend of someone with mental illness, or as a recipient of mental health services. Communities and community organizations can promote health and prevent illness among their residents through community engagement, population health planning, and public education campaigns.
- **Mental health services providers:** Psychiatrists, psychiatric nurse practitioners, psychologists, and social workers in public and private practice; community mental health centers and outpatient clinics; residential treatment and rehabilitation centers; psychiatric hospitals; psychiatric units of general hospitals; and mental health services in schools, jails, and other settings. The vast majority of Minnesotans are served by community-based providers, but a small portion are also served by Direct Care and Treatment, the state-operated mental health services providers. Most people served by Direct Care and Treatment have been civilly committed to the Commissioner of DHS (although community providers also serve people who have been civilly committed).
- **General medical and primary care providers:** Primary care doctors, nurse practitioners, and nurses often provide mental health services as part of their physical medicine practices in private clinics, community health centers, and hospitals.

¹⁸ "Behavioral health" is a term that commonly refers to both mental illness and substance use disorder treatments. Because the Task Force's focus is on mental health and because some advocates object to the term "behavioral health," the terms "mental health" and "mental illness" will be used in this document. This is not to downplay the fact that many people experience both mental illnesses and substance use disorders, and that treatments for the two are most effective when integrated.

- Human and social services providers: Minnesota has a huge network of social service providers who assist people with direct mental health services as well as support services including income supports, housing, education, employment, food supports, family counseling, etc. Mental health and substance use disorder services are also sometimes provided in schools, community centers, spiritual centers, jails, and prisons.
- Suppliers: Providers of mental health services rely on commercial suppliers of clinical and treatment protocols, pharmaceuticals, medical equipment, and supplies, including the extensive research and evaluation networks that underlie those products.
- Voluntary and community networks: Minnesota has an especially vibrant network of volunteer- and peer-run organizations that support people with mental illnesses and substance use disorders.
- Policy makers: Federal and state agencies and professional boards, counties, and tribes all play a strong role in developing and shaping the mental health provision system by helping to determine what services are provided and/or funded, by setting the standards under which those services will be provided, by determining the eligibility of individuals for various services, and by overseeing the licensing, certification, and quality management of the various players in the system. They also facilitate community planning and engagement around mental health promotion, illness prevention, service development and delivery, and ongoing system assessment.
- Insurers/health plans: Mental health services are provided under a number of different insurance and provision arrangements. Insurers and health plans play a significant role in determining members' access to mental health services.

Another way to illustrate the reach and complexity of the mental health system is to show all the related service systems it touches. These include primary care, education, law enforcement, courts, housing, transportation, social services, income supports, and employment. Not only are mental health services occasionally provided in these settings (for example, in schools or jails), but these sectors collaborate with the mental health system to prevent mental illnesses and support people who are experiencing mental illnesses.

h. Community-based Mental Health Services Model

Minnesota's mental health system follows a community-based model of care that provides mental health services in local communities instead of in large centralized institutions. De-institutionalization has shifted the vast majority of mental health services from state-operated institutions to community-based organizations including community mental health centers, independent mental health professionals, primary care clinics, and community hospitals. The community-based model allows people to access mental health services close to their homes and to remain integrated in their families and communities while receiving care.

While almost everyone agrees that de-institutionalization has brought significant improvements in person-centered, recovery-oriented mental health care, the community-based model has introduced a great deal of complexity into service-provision. Services are available at multiple locations and at multiple levels of care, each with their own payment arrangements, eligibility requirements, and criteria for intake and discharge. A person seeking services travels to the provider or providers and is often

faced with coordinating among providers to get the treatment and supports needed. Transitions among levels of care (say, from an inpatient hospital stay to one's home with outpatient services) can be difficult to plan because multiple providers—each with their own requirements and timetables—must be coordinated. Some of the gaps identified in the existing mental health system result not from a lack of available services themselves but from inadequate coordination among the many organizations and individuals involved in a person's care.

C. Recommendations

The Task Force offers nine recommendations for transforming Minnesota's mental health system into a comprehensive continuum of care. In general, the Task Force kept recommendations at a high level, acknowledging the complexity of the issues and calling for continued collaborative work to follow the road maps provided by the Task Force. For Recommendations #8 and #9 (crisis response services and inpatient psychiatric bed capacity), the Task Force recommends more short-term solutions that could be implemented within the next year. These can help ameliorate existing problems while more systemic solutions are devised and pursued. The Task Force recognizes that their recommendations will require significant staffing and resources to implement, and urges the Legislature and Governor to allocate the resources necessary.

The Task Force reviewed dozens of past reports that contain recommendations about Minnesota's mental health system and Task Force members are committed to ensuring that their recommendations gain traction and get implemented in the coming years.¹⁹ They considered various options for "ownership" of the recommendations going forward, including the establishment of a new oversight body to track progress on their recommendations and a set of new workgroups to organize the work. However, the Task Force was also cognizant of the need for redesign of Minnesota's governance structure for mental health services more generally, and they did not want to add another formal layer of decision-making across the already existing (and overlapping) layers. Moreover, they were sensitive to the demands that new planning structures make on the stakeholder groups involved, many of whom are already stretched thin by the existing planning and advisory bodies. Finally, they respect the existing planning and oversight roles laid out in statute and they want to integrate their recommendations within the ongoing policy-making, funding, and implementation structures as much as possible.

The Task Force recommends the following approach for tracking the implementation of their recommendations:

1. Where possible, recommended work should be assigned to existing agencies or organizations whose missions match the work, often in collaboration with other agencies and organizations. If additional funding or staffing is needed, the Task Force recommends that the Governor and Legislature allocate those additional resources.
2. For Recommendation #2 on re-designing the governance structure, the Task Force feels that the existing agencies and organizations' overlapping or conflicting perspectives would make it difficult for any particular agency to lead. The Task Force thus recommends the creation of a

¹⁹ For a list of background reports, see the Task Force website at <https://mn.gov/dhs/mental-health-tf/resources/>.

new workgroup that would be facilitated by a contracted organization that is not aligned with any particular agency or stakeholder group.

3. The Task Force envisions that the Mental Health Governance Redesign Workgroup (see Recommendation #2) will recommend a governance structure for the ongoing oversight of the mental health continuum of care. The longer-term implementation of the Task Force's recommendations will occur within the structures recommended by that Workgroup and implemented by the Governor and Legislature.
4. Until the governance re-design is developed and implemented, the Task Force recommends that the Commissioners of DHS and MDH, a county representative, and a tribal representative meet periodically to discuss the progress on the Task Force's recommendations and address barriers to implementation. The Commissioner of DHS should assign responsibility for calling and facilitating these meetings.

Recommendation #1: Creating a Comprehensive Mental Health Continuum of Care

Summary: The state should adopt a wide definition of the mental health continuum of care (as illustrated on page 24) and undertake systematic planning to improve availability and access to mental health services and mental health promotion activities in the continuum. Responsibility for ongoing system assessment, service development, and quality management should be assigned, along with the funding and staffing to fulfill those functions.

a. Introduction

The Task Force embraced the Governor's charge to recommend changes that would transform Minnesota's existing mental health system into a true continuum of care. This section describes a conceptual framework and recommendations for achieving that transformation. "Continuum" suggests at least these four types of continuity and completeness:

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

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

A continuum of care that would meet the principles listed on Page 8 would need to comprise six categories of activities and services.²⁰ These align with SAMHSA’s Recovery Oriented Systems of Care model for substance use disorder services.²¹

- Mental health promotion and illness prevention: Activities to prevent trauma and build resilience across the lifespan; build community capacity to improve the social determinants of health; and help systems better support children, adults, and families to fully develop.
- Early intervention: Activities and services to identify mental health concerns at the earliest signs and respond to them in a timely, effective way.
- Basic clinical services: Mental health treatment services are provided by a range of credentialed mental health practitioners and mental health professionals and by primary care providers. These services include diagnostic assessment, treatment planning, and treatment. They are provided by public and private providers in a variety of settings that include community mental health centers, clinics, hospitals, private offices, schools, jails and prisons.
- Inpatient and residential services: Residential and inpatient services provide an intensive level of treatment and rehabilitation, and acute care is provided in specialized psychiatric hospitals, the psychiatric units of community hospitals, and sometimes in general medical units of community hospitals.
- Community services and supports: Minnesota has developed an extensive array of services to support people with mental illnesses in their local communities, including case management and care coordination at several levels of intensity, supportive housing, employment supports, personal care assistance, and peer supports.
- Crisis services: Services for people experiencing an acute mental health crisis include crisis phone lines, mobile crisis teams, short-term residential crisis services, and mental health urgent care services. Crisis services involve coordination across several sectors, often including health care, emergency response, law enforcement, social services, and others.

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

- Collaboration among providers, payers, people with lived experience of mental illness, and others to support operations and improve service delivery: case management, care

²⁰ These six functions are not intended to prescribe an individual’s treatment and recovery path; people will access the services and activities in whatever functional category or categories meet their current needs. This document refers to “services and activities” in the continuum to acknowledge that the continuum includes not just direct services to individuals, but also population-based mental health promotion and prevention activities as well as all the collaborative activities that ensure a robust and responsive service system.

²¹ Melanie Whitter, Donna Hillman, and Peggie Powers, “Recovery-Oriented Systems of Care (ROSC) Resource Guide,” September, 2010, p. 2, available at: http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf

coordination, discharge planning, care management, shared record-keeping, transition protocols, etc.

- System-wide collaboration and oversight functions: Governance and funding structures; centralized assessment, forecasting, and planning; quality assurance and metrics; workforce development; etc.
- Collaboration with other sectors: Mechanisms to collaborate or integrate with substance use disorder treatment, public health, primary care, housing, employment, education, transportation, criminal justice, and social services at multiple levels. For example, developing processes and infrastructure for better data-sharing (while protecting individual privacy) would improve integration of services.

These components of a comprehensive continuum of care are illustrated in Figure 4. The individual, family, and community are at the center, surrounded by the sectors of social services and support systems available to them. In addition to the mental health system, these include substance use disorder treatment, public health, primary care, housing, employment, education, transportation, criminal justice, and other social services. The mental health continuum of care includes services and activities in the six functional categories (tan rectangles), with the lines connecting them representing the operational collaboration that enables smooth access and integrated service delivery. System-wide collaboration and oversight functions (gray oval) help ensure that the system as a whole meets the needs of all Minnesotans, has adequate resources (funding, workforce, technology infrastructure, etc.), is sustainable, and engages in ongoing data-driven assessment, planning, innovation, and service and activity development. Lines connect the mental health continuum of care with all of the other sectors to emphasize the importance of collaboration among sectors to meet the needs of individuals and families.

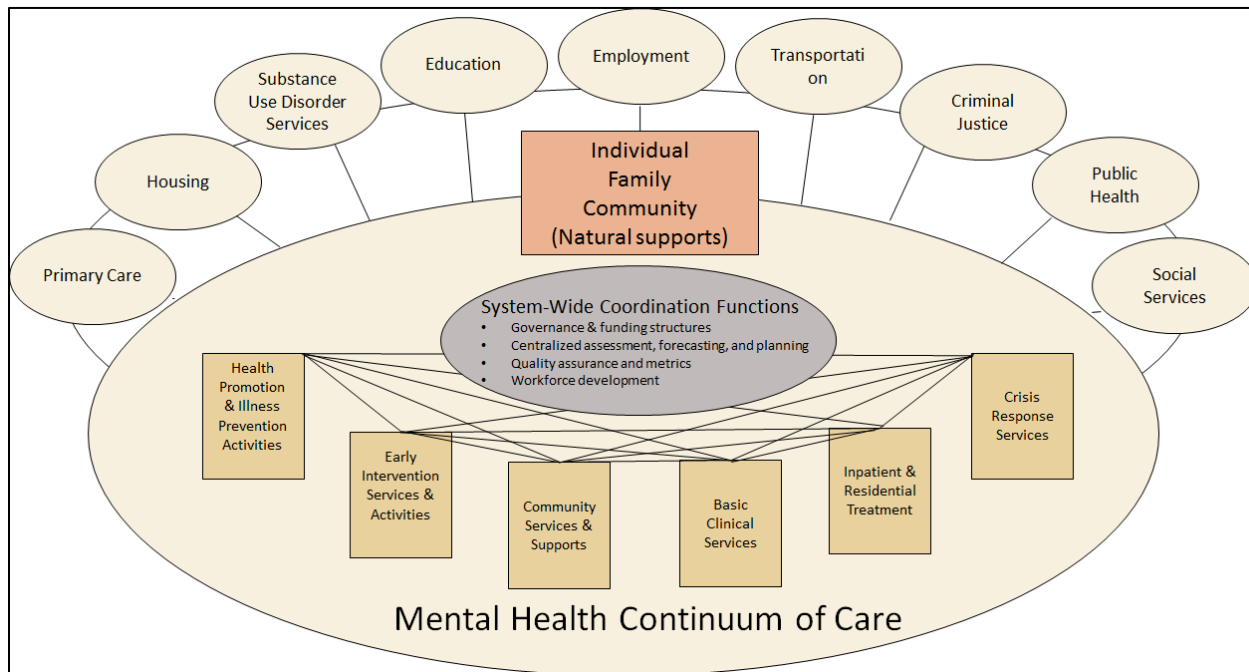


FIGURE 4: ELEMENTS OF A COMPREHENSIVE CONTINUUM OF CARE

c. Systematic Development of the Continuum

Minnesota’s mental health service system has grown over time in response to a variety of historical conditions, new federal funding opportunities, and shifting state and local priorities. The services and supports available to an individual vary widely from place to place, and the process for adding new services is not systematic and depends on scores of factors unique to each location. The Task Force recommends that the state adopt a more disciplined and systematic approach that would allow the state to transition from the current mental health system into a comprehensive mental health continuum of care. A basic “road map” for that process is laid out below.

1. Develop a service/need matrix that systematically identifies the services and activities needed in all six parts of the continuum. The Task Force recommends the services and activities listed on the following page as a starting point. While all of these services and activities are all available somewhere in Minnesota or under current development, they are not universally available.

Mental Health Promotion and Illness Prevention	Early Intervention	Basic Clinical Services	Community Services and Supports	Hospitalization and Residential Treatment	Crisis Response Services
<p>Individual/Family Level</p> <ul style="list-style-type: none"> Follow Along Program Child and Teen Check-Ups Birth Defects New Born Follow-Up Family Home visiting (eligible families) Early Childhood Family Education Parent supports Integrated Adult/Children’s Mental Health Education and Classroom Based Initiatives Positive Behavioral Interventions and Supports Bullying Prevention Diversion and Restorative Justice Youth Development and Prevention Mentoring Economic and Nutrition Supports (e.g. WIC) Skills Development Initiatives (e.g. Army Soldier and Family Fitness) Culture and Language Preservation programs Support and Resource Groups Senior Initiatives <p>Community and Systems Level</p> <ul style="list-style-type: none"> Community Capacity (Including Community Resiliency Planning and Implementation) Social Connectedness Initiatives Education and Outreach (e.g. Adverse Childhood Experience) Suicide Prevention Community Planning Integrated Mental Health and Primary Care Systems improvements & policy changes Mental health consultation (e.g., child care) Trauma Informed Systems Development Workplace wellness initiatives 	<ul style="list-style-type: none"> Home visiting (M) Early childhood mental health (MG) First Episode programs (PMG) ACES work (Adverse Childhood Experiences) (G) Mental Health First Aid (G) 	<ul style="list-style-type: none"> Physician/Primary Care (PM) Psychiatrist (PM) Mental Health Professional (PM) Community Mental Health Center (PMG) Community Health Center (PMG) School-linked Mental Health (PMG) Clinical Care Consultation (with mental health professionals) (M) Dialectic Behavior Therapy (DBT) (PM) Telemedicine (PM) 	<ul style="list-style-type: none"> Case Management (M) Targeted Case Management (M) Community Support Programs/Club Houses (G) Children’s Therapeutic Services and Supports (M) Adult Rehab Mental Health Services (M) Assertive Community Treatment (M) Youth Assertive Community Treatment (M) Respite Care (child) (G) Personal Care Assistance (PCA) Community First Services and Supports (M) Community Alternatives for People with Disabilities (CADI)Waiver Independent Living Services (ILS) (M) Behavioral Health Homes (M) Health Care Homes (M) Therapeutic Foster Care (M) Family Foster Care (G IVE) Corporate Foster Care (G) Supportive Housing (G) Warm Lines WRAP Training Special Ed/504 Plans and Intermediates and Coops (Ed funding and M) Community Paramedics (M) Bridges Housing (G) Crisis Housing Fund (G) Peer-led Support Groups Illness Management and Recovery (M) 	<ul style="list-style-type: none"> Day Treatment (PM) Mother/Baby Partial (PMG) Partial Hospitalization (PM) In-reach Services (M) Inpatient (PM) Community Behavioral Health Hospital (CBHH) (PM) Children’s Residential Treatment (PM & IVE) Psychiatric Residential Treatment Facilities (child) (PM) Intensive Residential Treatment (adults) (MG) State Operated Secure (Anoka Metro Regional Treatment Center (AMRTC), Minnesota Security Hospital (MSH), Child & Adolescent Behavioral Health Services (CABHS) (G) Subacute for Children (MA) 	<ul style="list-style-type: none"> Crisis numbers (G) Crisis teams (PM) Crisis stabilization (MG) Crisis homes (adults) (G) Psych Emergency Departments (PM) Psych Urgent Care (MG)

Mental Health Promotion and Illness Prevention	Early Intervention	Basic Clinical Services	Community Services and Supports	Hospitalization and Residential Treatment	Crisis Response Services
			Intensive Community Rehabilitative Services (M) Integrated Dual Disorder Treatment (M) Preferred Integrated Network Program (MG) Independent Placement and Support (G) Care Coordination (M) Group Residential Housing (G) Nonemergency Medical Transportation /Protected Transport (MA) Family Psychoeducation Children (MA) Dialectical Behavior Therapy- Intensive Outpatient (M)		

2. For each service or activity, identify the following:
 - a. The appropriate service levels for the service (e.g., every person should be within 90 minutes of a mobile crisis team, or there should be one psychiatrist for every 10,000 people in a geographic area). For mental health promotion and prevention activities, define the community engagement expectations.
 - b. The categories of population that are most relevant for population-based mental healthcare planning, including categories of age, cultural background, gender identity, ability/disability, etc.
 - c. Across all services and activities, define the regions of the state around which service availability and access to services and community planning will be organized. This could be in conjunction with the re-design of the Adult Mental Health Initiatives, or coordinated with that work. Recommendation #2 on page 29 includes more discussion of regional and state planning functions.
3. With all of the above dimensions laid out, coordinate with regional planning bodies to prepare “continuum maps” that outline what activities and services are available in each region, where, and for whom, and identify what activities and services are still needed in each area for particular populations. Identify where services can be co-located (schools, colleges, clinics, etc.) to enhance access. The regional planning bodies should include people with lived experience of mental illness and their families.
4. Policy planning and funding decisions—including state and county agency strategic plans—should be made with consideration of the continuum maps. The Governor and Legislature are urged to build stable funding for the activities and services outlined in the continuum maps. Investments should be considered in three categories: short term priorities, investments in innovation, and sustained infrastructural investments for proven services and activities. More details about system-wide collaborative functions are included Recommendation #2 on page 29.
5. Implement care and funding models that promote integration and person-centered care. Care management models, including Certified Community Behavioral Health Clinics, Behavioral Health Homes, and Health Care Homes, should be expanded. Substance use disorder services and mental health services should be integrated. Programs to build trauma-informed systems and learning communities across systems (clinics, education, law enforcement, etc.) should be expanded.
6. Throughout the mental health system, collaborate with existing data-sharing organizations and projects to develop mechanisms for better data sharing (while protecting privacy).
7. While the Continuum Maps are being created and implemented, the state should continue to expand access to care for core services/activities and key populations. Because mental health promotion and prevention are often overlooked, the Task Force has highlighted them in Recommendation #6 on page 37. Other key services and populations include:
 - a. Expand children’s services, especially for very young children. Build capacity of children’s residential mental health services to serve specific populations and different levels of care such as crisis homes and psychiatric residential treatment facilities (PRTFs). Continue to expand school-linked mental health grants and mental health promotion, prevention, and early intervention activities in schools.
 - b. For adults, the state should increase access to core mental health services such as crisis, community supports, residential services, and to early intervention efforts such as first-episode programs. Mother/baby programs and child care support for mothers needing

- to access mental health and/or substance use disorder treatment should also be funded.
- c. The state should improve and expand services for populations who experience significant mental health disparities: people with low incomes, people of color and American Indians, LGBTQ youth and adults, new immigrants, veterans, and people with complex co-occurring conditions in addition to their mental illness. This will require addressing accessibility barriers that can keep non-English speakers, people who are deaf or deaf blind, new immigrants, and others from knowing about and accessing mental health services. See Recommendation #3 for related recommendations.
 - d. The state should improve and expand mental health services for elderly Minnesotans, including residential services with capacity to serve people with mental illnesses and dementia, especially those whose symptoms can include aggression or sexually inappropriate behavior.
 - e. Support ongoing efforts to expand access to employment opportunities for people with mental illnesses.
8. The state should continue to pursue promising collaborations between the mental health service system and other sectors, including substance use disorder treatment, public health, primary care, education, housing, corrections, etc. For example, collaboration should continue to improve students' access to mental health services in schools; the Departments of Health and Corrections should work together to improve state prisons' visiting environments and policies to encourage and foster parent/child relationships.
 9. The Governor and Legislature should take a strong stand condemning discrimination against people with mental illnesses and the "not in my back yard" attitudes that can limit the development of community-based mental health services.
 10. DHS and MDH should establish a coordinated planning process to implement the comprehensive continuum described, using existing mechanisms and advisory bodies to collaborate with other agencies, stakeholders, and partners. Designing the continuum must balance unique local and regional circumstances with the need to establish statewide expectations for a comprehensive continuum of care. It must also be driven by the needs and perspectives of the people being served, so local communities and individuals with lived experience of mental illness and their families should be included in the decision-making process. Responsibility for the process should be accompanied by adequate funding, staffing, and time to complete it, across the continuum.

Recommendation #2: Redesigning Governance of Minnesota's Mental Health System

Summary: A Minnesota Mental Health Governance Workgroup should be convened to make recommendations to the Governor and Legislature about redesign of governance structures for mental health activities and services in Minnesota.

a. Introduction

The governance of the mental health continuum of care (which includes governmental and collaborative stakeholder planning bodies, policy making, funding decisions, service and program development and

oversight, and accountability and quality assurance functions) is complex, fractured, and overlapping. Multiple federal, state, county, local, and tribal agencies set policies that affect mental health care services and activities, and policies made in one jurisdiction often complicate or even undercut goals and policies set in other jurisdictions. Policies are implemented through complex funding mechanisms that are similarly overlapping and sometimes at cross-purposes. Quality standards and outcomes tracking is often tied to particular policies or funding mechanisms, making it very difficult (and inefficient) to assess the performance of the system as a whole. Transforming Minnesota's array of mental health services into a comprehensive continuum of care will require collaboration across multiple layers government and across the entire stakeholder community: state, county, local, and tribal agencies, provider organizations, people who provide direct care, professional organizations, payers, people with lived experience of mental illness, advocates, community leaders, and others. Clear authority, responsibility and accountability are very difficult to achieve in the current complex system.

One important issue that has been raised repeatedly in recent years is the efficacy of Minnesota's "state-directed, county-administered" model of mental health services oversight. This model was implemented in Minnesota Statute in the 1980s, with DHS designated as the "state mental health authority" and counties (and some tribes) designated as "local mental health authorities." This arrangement established a partnership between DHS, counties, and tribes to jointly plan and administer mental health services in the state, and it helped Minnesota make great strides in developing community-based mental health treatment and services. The system has always had strengths and weaknesses, but changes accompanying ongoing de-institutionalization, health care reform, and person-centered care have made some of the weaknesses more pronounced. Responsibility and accountability for services, funding, and quality have blurred, and there is significant variation in service availability across counties and regions of the state. Integrated, person-centered care is difficult to achieve with so many different decision-making bodies and funding sources. Shifts between the grant-based social services model and the insurance-based health care model can also create the need for realignment of governance structures.

b. [Minnesota Mental Health Governance Workgroup](#)

The Department of Human Services should contract with a neutral organization to facilitate a Mental Health Governance Redesign Workgroup. The Workgroup should be tasked with review and re-design of the governance structure for Minnesota's mental health system, including the topics listed below. DHS should assign a staff person with mental health system policy experience to work with the contracting organization to convene, conduct, and coordinate the activities of the Workgroup and any sub-groups needed. The Governor and Legislature should allocate adequate funding to support the contractor, workgroup activities, and the DHS liaison. The work will involve:

1. **Developing a governance planning process** that is inclusive of those who have direct involvement in the mental health continuum of care. The process should enable effective dialogue and consensus among the various partners and stakeholders to reach desired outcomes. These should include people with lived experience and their families, DHS, Department of Health, Department of Education, Department of Commerce, regional Adult Mental Health Initiatives and Children's Collaboratives, public health, counties (with geographic representation and inclusion of social services directors), tribes, managed care organizations

(included state-funded and private market), private insurers, professional associations and licensing boards, community mental health provider organizations, and people who provide direct care. They should also include collaboration with other sectors, including primary care, education, criminal justice, employment, transportation, housing, etc.

2. **Researching other national and/or state models** of governance for consideration. These can inform examination of Minnesota statutes, rules, and advisory bodies as the Workgroup makes recommendations for redesigning governance structures.
3. **Defining the roles and responsibilities in governing the mental health continuum of care**, critically evaluating the existing governance structure's appropriateness to fulfill the roles, and assigning the roles to particular agencies or organizations. Clarify oversight and accountability for ensuring the availability and accessibility of a basic set of mental health services and activities for all Minnesotans. Ensure that there are clear lines of reporting to the applicable entities based on authority, funding and accountability and that reporting is streamlined for efficiency and reduction of duplication.
4. **Defining regional boundaries** (with consideration of Adult Mental Health Initiative boundaries, children's mental health collaborative boundaries, Alcohol and Drug Abuse Division boundaries, Disability Services regional boundaries, public health boundaries, etc.), and align those with accountability for services. This should include developing, implementing, and sustaining the "continuum maps" as described in Recommendation #1.
5. **Establishing a quality improvement structure** that responds authentically to feedback from individuals and families affected by mental illnesses and from providers. This includes streamlining and integrating duplicative quality processes; and setting, tracking, and reporting useful measures; and supporting the data infrastructure necessary to track, share and make decisions based on quality data (while safeguarding individual privacy).
6. **Supporting innovation and a data-driven process for development of new services and activities.** The process should use data to identify, develop, implement, fund, and evaluate services driven by local need.
7. **Define the "safety net" function** and clarify the roles and accountability for safety net service provision. The Task Force believes that funding for these roles should be prioritized.
8. **Assessing the existing funding structures** for mental health services and activities and develop recommendations for changes in funding that align with the proposed governance structure and the goals of health care reform.
9. **Identifying funding and staffing needs for the development and ongoing operation** of the governance structure (apart from the funding of particular mental health services and activities in the continuum).

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

Summary: State agencies should convene a workgroup of people from American Indian tribes, communities of color, and other cultural backgrounds to detail strategies for improving mental health services and activities for communities experiencing mental health disparities.

a. Introduction

Although Minnesotans on average are healthy compared to other states, Minnesota has significant health disparities among populations of color, American Indians, GLBTQ²² people, veterans, and other groups. These populations have shorter life spans, higher incidence of chronic illnesses including mental illnesses, and generally poorer health. These gaps have widened over the past five decades. As the face of Minnesota changes and these groups constitute a larger percentage of the state’s population, it will become only more crucial that these disparities be eliminated. For the purposes of this report, “culture” refers not just to groups defined by ethnic or racial background, but also to groups that are defined by other common experiences and/or beliefs that affect their self-identity and how they are perceived in society.

A recent needs assessment in conjunction with development of certified community behavioral health clinics described disparities in mental health services and outcomes for American Indians, Asian populations, Hispanic/Latino populations, homeless people, older adults, Somali populations, and veterans.²³ Surveys led researchers to conclude that there is a need for more culturally and linguistically appropriate services. Similar conclusions have been drawn for GLBTQ people and veterans: until people feel that mental health providers understand them and their experiences, they are unlikely to access mental health services and the mental health services they do receive are unlikely to be very helpful.

The social determinants of health help explain why diverse cultural communities often experience below average mental health outcomes. Not only do they experience more risk factors, but they also can find it difficult to engage in mental health treatment when the provider does not understand their language, cultural values, or perspectives on mental health. A recent report by the Minnesota Department of Health explains that disparities—population-based differences in health outcomes—are closely linked with social, economic, and environmental conditions.²⁴ Living in poverty has the most measurable effect on the rates of mental illness. People in the lowest strata of income, education, and occupation (known as socioeconomic status) are about two to three times more likely than those in the highest strata to have a mental disorder. Moreover, structural racism, intergenerational trauma, and genocide have lasting effects on people and cultures, leading to disparities that are reproduced generation to generation.²⁵

²² Gay, lesbian, bisexual, transgender, and queer.

²³ Trudy Ohnsorg, “Needs Assessment 2016: Excellence in Mental Health Act in Minnesota.” (Saint Paul: Cincinnatus, Inc., June 13, 2016), pp. 40-55.

²⁴ “Advancing Health Equity in Minnesota,” Minnesota Department of Health, February 2014, accessed on 6/29/16 at http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf.

²⁵ “Types of Trauma and Violence,” SAMHSA website, accessed on 7/7/16 at: <http://www.samhsa.gov/traumaviolence/types>; “Behind the Term: Trauma,” SAMHSA’s National Registry of Evidence-based Programs and Practices, accessed on 7/7/16 at: http://nrepp.samhsa.gov/Docs%5CLiteratures%5CBehind_the_Term_Trauma.pdf, p. 2; “Environmental Scan Summary Report,” Native American Center for Excellence report to SAMHSA, November 2008, accessed on 7/7/16 at: http://www.samhsa.gov/sites/default/files/programs_campaigns/tribal_training/nace-environmental-scansummary.pdf.

These points help explain why “equity” and “equality” are not the same concept. Equity involves creating the conditions so that each person and family can maintain mental wellness and/or recover quickly from mental illnesses. It acknowledges that each person may need somewhat different levels and types of supports, based on their risk and protective factors. Equality assumes that everyone should have access to the same services, which has a veneer of fairness but actually continues to promote disparities.

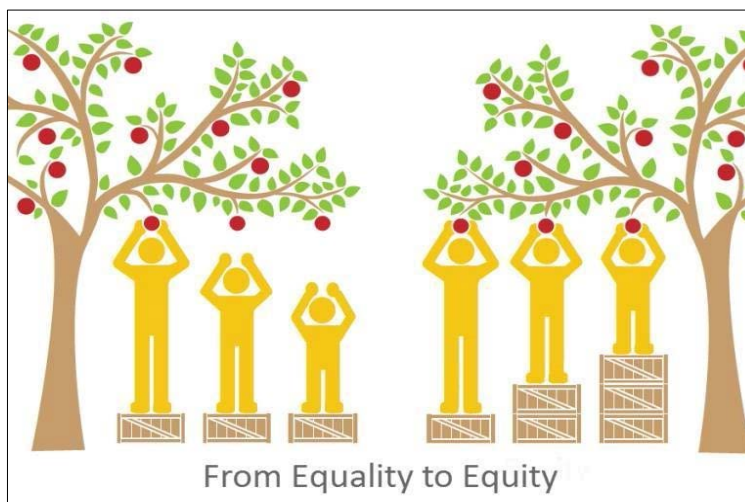


FIGURE 4: EQUALITY TO EQUITY, COPYRIGHT BY SASKATOON HEALTH REGION 2015

b. Using a Cultural Lens to Reduce Mental Health Disparities

DHS should partner with MDH to convene a workgroup of people from American Indian tribes, communities of color, and other cultural backgrounds to further explore how culture could enrich the current understanding of mental wellbeing and mental illness and to make recommendations for improving mental health services and activities for communities experiencing mental health disparities. Agency staff should collaborate with the Cultural and Ethnic Communities Leadership Council and the Healthy Minnesota Partnership in this work. The workgroup would develop expanded definitions of wellbeing, mental health, and mental illnesses that would be more responsive to individuals’ cultural backgrounds and self-understandings and make recommendations for incorporating those expanded definitions into the services, requirements and processes that shape the continuum of care. The group would also develop more detailed strategies on the specific opportunities listed below. These strategies would be pursued by DHS and MDH within their existing policy processes.

1. The Governor and Legislature should support more extensive mental health promotion, prevention, and early childhood mental health services and activities that respond to the disparities in Minnesota’s mental health outcomes. The state should support mental well-being programs that are culturally-responsive, multi-generational, and support individuals and families. Many programs can be offered in the community through trained and culturally representative community leaders.
2. One of SAMHSA’s six strategic initiatives is the integration of trauma-informed approaches into mental health and substance use disorder treatment services throughout the United States.²⁶ To further implement SAMHSA’s directive in Minnesota, the state should support the implementation of trauma-focused treatment models that are culturally specific and

²⁶ For more information about SAMHSA’s initiative, see <http://www.samhsa.gov/trauma-violence>.

responsive.²⁷ The funding should cover training for providers as well as funds to cover trainees' replacements while they are at training and for follow-up costs as the trainees implement the services within their organizations.

3. Mental health providers sometimes lack the cultural knowledge (language, history, norms, social structure, etc.) necessary to provide effective services to people from diverse cultural backgrounds. Language interpretation, already funded in Minnesota, is one example of a service to bridge this gap. Some states also pay for services of "cultural interpreters" who can consult with providers who need more understanding of diverse cultural norms as they diagnose and treat people with mental illnesses. The state should investigate options for funding these cultural consultations, including how consultants could be credentialed and how the service could be funded.²⁸
4. Community health workers, certified peer specialists, peer recovery specialists, and family peer specialists help improve engagement in health care and provide a variety of health education, navigation, and care coordination services. They are effective because they combine the skills learned in training with their deep knowledge of cultures and life experiences of the people being served. To improve engagement of populations experiencing mental health disparities, it's important that partners across the continuum of care adopt strategies that assist more people from diverse backgrounds to take on these roles. One barrier is funding. For example, community health workers are already established in Minnesota statute and some mental health clinics are deploying them successfully, but funding for the full range of their services is not currently covered by Medicaid fee-for-service plans, most pre-paid medical assistance programs, or private insurers. Another barrier is qualification requirements. Many existing cultural healers, cultural brokers, and elders have deep community connections that would make them effective in supporting people receiving mental health services, but some lack specific qualifications currently required to become certified. The state should review and recommend updates to the qualifications for these positions so that the qualifications reflect multiple possible paths to gaining the life experience necessary to provide effective recovery support.
5. New treatment models that emphasize frequent and authentic feedback mechanisms have been shown to improve engagement in treatment and treatment outcomes. The state should support the implementation and expansion of feedback-informed treatment models that incorporate an intentional process of engagement, feedback, and reparation in therapeutic relationships. This is especially important when it is not possible to connect people from diverse communities with culturally-responsive mental health providers.
6. Minnesota currently pays for one session between a mental health provider and a person receiving services before the provider must complete the diagnostic assessment and develop a

²⁷ For example, Trauma Systems Therapy for Refugees, American Indian adapted Trauma Focused- Cognitive Behavioral Therapy, and Parent Child Interactive Therapy.

²⁸ One model to investigate is the use of Qualified Expert Witnesses in the Indian Child Welfare Act court cases. Another is Minnesota's existing practice of paying for children's mental health treatment providers to consult with prescribers as they establish diagnoses and treatment plans for children. Michigan is one state that has already implemented a process for funding cultural consultants.

treatment plan. Especially for culturally specific providers working with people who don't share a medical model of mental illness, one session is not enough to establish the rapport and gather the information necessary to make an accurate diagnosis. The state should propose a way to increase the number of reimbursed sessions before a diagnosis is required.

7. There is strong support for services that are developed and funded based on evidence about their effectiveness. However, there has not been enough research and evaluation to identify a wide range of culturally-specific mental health services that are "evidence-based." The state should create demonstration grants and explore additional federal funding to gather evidence that could lead to more sustainable funding options for culturally specific mental health services.
8. The state should continue to pursue models to improve the integration of primary care, mental health care, and substance use disorder treatment and to ensure that primary care and mental health clinics are equipped to serve and partner with diverse communities in a way that is person and community-centered, culturally appropriate, and trauma-informed.²⁹ The state should support mental health and well-being learning collaboratives and encourage implementation of best practices and emerging culturally-responsive promising practices. It should also explore support for community liaisons who can address social determinants of health at the individual and community levels.
9. The workgroup should review state rules, statutes, and processes to identify opportunities to remove inadvertent barriers to access for people from culturally diverse communities.³⁰

Recommendation #4: Developing the Mental Health Workforce

Summary: The Governor and Legislature should continue to support development of Minnesota's mental health workforce, including implementation of the recommendations in "Gearing Up for Action: Mental Health Workforce Plan for Minnesota." DHS and MDH should work with the Mental Health Steering Committee (responsible for the Mental Health Workforce Plan) to ensure progress on those recommendations.

a. Introduction

Workforce challenges are, and will continue to be, one of the most daunting barriers to development of a robust continuum of care. Providers across the state are already struggling to deliver existing services because of the difficulty of finding qualified staff, and expansion is impossible in many areas and services because of workforce shortages. Moreover, the aging of the workforce threatens to shrink the pool of workers even more. For example, Minnesota is already experiencing a severe shortage of psychiatrists in most parts of the state, and about half of Minnesota's psychiatrists are over age 55 and

²⁹ Examples of integration models include Health Care Homes, Behavioral Health Homes, Certified Community Behavioral Health Clinics, Integrated Health Partnerships, and provision of integrated mental health and substance use disorder services. Health Care Homes have a network of 377 primary care clinics serving people with complex health needs that participate in learning collaboratives.

³⁰ For example, the diagnostic assessments that have been written into Rule 47 (the outpatient mental health rule) have created additional barriers to services that are particularly pronounced in culturally diverse communities.

thus are likely to retire in the next 10 years, further exacerbating the shortage. Similar shortages are felt in most other occupational categories as well.

In 2013, the Legislature directed Minnesota State Colleges and Universities (MnSCU) to hold a mental health summit and prepare a state workforce plan. The plan, “Gearing Up for Action: Mental Health Workforce Plan for Minnesota,” was delivered to the Legislature in 2015, and implementation of the plan has begun.³¹ The Mental Health Steering Committee (a committee of stakeholders who developed the plan with facilitation by HealthForce Minnesota) continues to monitor implementation of the plan. HealthForce Minnesota recently circulated an update on implementation of the plan, indicating which recommendations had been implemented and which still need attention.³²

b. Supporting Development of Minnesota’s Mental Health Workforce

The Governor and Legislature should continue to support implementation of the recommendations in the Mental Health Workforce Plan for Minnesota. DHS and MDH should collaborate with the Mental Health Steering Committee ensure progress on those recommendations. For example, the direct care workforce planning that occurred at the Direct Care/Support Workforce Summit, and the Advisory Committee being established to pursue that work, should collaborate with the Steering Committee overseeing the Mental Health Workforce Plan. In addition, the Task Force recommends the state continue to look for ways to build a culturally-diverse mental health workforce across all occupational categories. See Recommendation #3 on page 32 for more specific recommendations.

Recommendation #5: Achieving Parity

Summary: The capacity of the Departments of Commerce and Health to review health plans’ alignment with parity laws and enforce those laws should be expanded. Data should be systematically reported and tracked to identify when insurers are not following parity laws, consequences should be significant and swift, and solutions should be implemented in a timely way. In addition, the state should require that private insurers cover the same mental health benefits that are funded through Minnesota’s Medical Assistance and MinnesotaCare programs. This will improve access to mental health services and make it easier to achieve parity by promoting more standardized benefits across the coverage spectrum.

a. Introduction

In general terms, “parity” is the concept that people should have access to mental health services under the same conditions that they have access to other healthcare services. For example, if someone experiences symptoms that indicate they may have cancer, they expect to be able to get immediate appointments for the diagnostic and treatment services they need. The system responds differently if someone experiences symptoms of a mental illness, however. In many cases, mental health services aren’t available (or covered by insurance) until someone has severe mental illness symptoms. This is

³¹ The plan, and updates on its implementation, are available at <http://www.healthforceminnesota.org/mental-health/>.

³² For a narrative update, see https://mn.gov/dhs/assets/mh-workforce-progress-report-2015_tcm1053-260860.pdf; for an update presentation, see https://mn.gov/dhs/assets/workforce-progress-update-10-4-16_tcm1053-260861.pdf.

markedly different from the response to other illnesses, which are quickly diagnosed and treated to prevent further illness.

Minnesota was an early proponent of parity, and now both federal and state laws require that insurance benefits for mental health and substance use disorders are equal to coverage for other types of healthcare services. However, studies have concluded that parity laws have not yet had much effect on access to a full range of mental health services in Minnesota and that parity has not been achieved in either Minnesota law or in common practice.³³ There are several ways that mental health services are treated differently: a) the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) for services; b) availability of providers and rules for out-of-network coverage; c) definitions of medical necessity and treatment denials; d) coverage for new treatments; and e) unequal coverage of similar services (for example, if a policy covers residential rehabilitation after heart surgery but does not cover residential rehabilitation after inpatient psychiatric hospital stay).

In October, 2016, the federal Mental Health and Substance Abuse Disorder Parity Task Force announced a series of actions and recommendations at the federal level to address the parity problem.³⁴ These included:

- Addressing network adequacy issue by developing lists of “warning signs” that would suggest parity issues in networks
- Providing education, state agency training academies, tool kits, and funding to states to boost parity enforcement
- Launching a complaint website to assist consumers with parity complaints and appeals
- Releasing a Consumer Guide to disclosure rights
- Reporting publicly on parity investigations and their results
- Issuing guidance on parity for opioid use disorder treatment
- Recommendations to Congress to increase random parity audits of health plans, assess civil penalties against non-compliant plans, extend disclosure requirements to non-ERISA plans, and eliminate state-funded plans’ ability to opt out of the Mental Health Parity and Addiction Equity Act.

These federal actions will help Minnesota to ensure that mental health services are not treated differently from other healthcare services, which will improve access and system capacity. Private insurance must cover treatments and supports so that people with private insurance have access to services and so that the cost burdens of not providing services are not shifted to state government or individuals.

³³ “Insurance for Behavioral Health Care,” (Saint Paul: Minnesota Office of the Legislative Auditor, February 12, 2001). Accessed on 6/29/16 at <http://www.auditor.leg.state.mn.us/ped/PEDREP/0104all.pdf>.

³⁴ Mental Health and Substance Use Disorder Parity Task Force Final Report, October, 2016, available at <http://www.hhs.gov/about/agencies/advisory-committees/parity/index.html>.

b. Systems and Accountability for Achieving Parity

The Governor and Legislature should strengthen the capacity of the Departments of Commerce and Health to review health plans to assess alignment with parity laws, improve complaint mechanisms to enforce parity laws, and increase transparency. This should include market conduct exams of insurers and evaluation of plans' network adequacy. There should be a robust method of collecting, public reporting (including insurers' information), and investigating complaints by consumers about coverage of mental health services and treatment. Any consumer complaints about coverage received should include a requirement for insurance providers to respond within an appropriate timeframe, as crisis situations require timely mental health treatment and services.

The Governor and Legislature should also assign responsibility and accountability for planning and tracking progress on implementing parity and ending discrimination based on stigma to the Department of Commerce, collaborating with other agencies where appropriate. The Department of Commerce should establish a plan and funding/policy recommendations to implement parity in Minnesota statute and strengthen state agency accountability for ensuring that health plans provide the coverage required to meet mental health parity. This should include requiring that private insurers cover the same mental health benefits that are funded through Minnesota's Medicaid program as a means of improving access to mental health services and making it easier to achieve parity by promoting more standardized benefits across the coverage spectrum.

Recommendation #6: Promoting Mental Health and Preventing Mental Illnesses

Summary: The Governor and Legislature should support efforts to build robust mental health promotion and prevention capacity within the state. Infrastructure and programs should be developed to build public understanding of mental health; strengthen community capacity to address system needs and gaps, especially for vulnerable populations; and address adverse childhood experiences and trauma throughout the lifespan.

a. Introduction

Minnesota cannot achieve a sustainable mental health continuum of care without a robust mental health promotion and prevention function within the state. Focusing on treatment is important for people who are experiencing mental illness, but "moving upstream" to address the social determinants of health and supporting healthy practices that promote wellbeing is also very important. It is much more person-centered and sustainable to support children's healthy development, promote health and prevent mental illness where possible than it is to wait until a person experiences a mental illness and needs treatment and community supports to pursue recovery.

Mental health promotion and prevention activities occur at two levels: information and support to individuals and families, and support for communities to organize themselves to build protective factors and reduce risk factors at the community level. Given the stigma that surrounds mental illness, an important function of the public health and mental health systems is to work with communities to help individuals, families and communities understand what shapes their health and consider steps they can take together to create mental health and well-being, individually and community-wide. Communities need local resources and ongoing support to engage multidisciplinary, cross-cultural community teams

to share their lived experiences, develop a common understanding about the local health challenges, and develop strategies to address them, particularly the structural inequities associated with trauma, violence and suicide.

Prevention of mental illnesses is a key public health priority because of the high human and financial costs of mental illness.³⁵ The human costs can include damage to family and social connections, loss of livelihood, psychological and physical suffering, and even death. The financial cost is also significant, with the mental disorders costing the United States an estimated \$201 billion in 2013.³⁶ This amount puts treatments for mental illnesses (in both community-based and institutional settings) at the top of the list of national spending on medical conditions (ahead of heart conditions, trauma, and cancer).

Prevention of mental illnesses can begin before children are born. Supporting parents to get good nutrition and prenatal care, abstain from the use of substances, and live in safe, healthy environments gives their babies a good start toward mental health. Once babies are born, all of these factors become even more important so that parents can bond with their infants and provide the responsive interactions that babies need to develop cognitively and socially. As children get older, good nutrition, safety, stable housing, compelling education, and reliable relationships with both peers and adults help them develop resiliency and protective factors to avoid mental illness. All of these efforts exist in balance with our knowledge that poverty, racism, and other factors can make it almost impossible for some parents to provide the safe, nurturing childhoods they want for their children, and that some susceptibility to mental illnesses is genetic and outside our control.

Prevention can support adults who may be at risk for mental illnesses as well. Prevention activities can include supports for the social determinants of health (nutrition, safe housing and neighborhoods, transportation, education, employment, etc.). For people who have experienced chronic mental illnesses, prevention can include any supports or activities that help the person maintain stability in the community (see “Resilience and Recovery,” below). These efforts can prevent relapse and assist the person’s ongoing recovery journey.

There is growing awareness about resilience and the opportunity to improve mental health; some communities have started generating creative solutions. Education alone is insufficient without sustained resources and expertise to capitalize on community interest. Very few of Minnesota’s existing efforts are statewide or state supported. Communities are unable to develop local, community-driven, comprehensive, mental health and well-being initiatives that are evidence-informed, inclusive, culturally relevant, comprehensive and sustainable. This set of recommendation will help develop a more comprehensive public health system to support mental health and well-being and reduce some demands on the mental health treatment system. Promoting mental well-being for the whole population will enhance mental health for those with mental illness, and reduce stressors and intergenerational transmission of trauma, that can exacerbate or trigger mental illness.

³⁵ “Prevention of Mental Disorders: Effective Interventions and Policy Implications,” (Geneva: World Health Organization), 2004, p. 15.

³⁶ Charles Roehrig, “Mental Disorders Top the List of the Most Costly Conditions in the United States: \$201 Billion,” *Health Affairs*, Vol. 35, No. 6, June 2016, p. 1.

b. Promoting Mental Health and Preventing Mental Illnesses

MDH, in collaboration with other agencies and stakeholders, should take the lead in implementing the following activities:

1. Develop a statewide campaign to build understanding about what creates mental health and well-being, including communication and awareness about social determinants of health, trauma, positive psychology practices, resilience, and anti-stigma.³⁷ Target those who work directly with children and families (primary care, child care, schools, and local public health) and communities that experience mental health disparities. Partner with existing efforts to implement and expand anti-stigma campaigns and include evidence based training models where feasible. Partner with cultural groups to develop culturally-responsive messages.
2. Support the development of local community resilience plans aimed at improving mental health and well-being of residents, especially children, adolescents and families. Local initiatives would focus on engaging and mobilizing residents, including cultural healers and leaders; assessing local needs and resources; developing an action plan that includes multiple sectors; customizing models or policies in response to local needs and strengths; and evaluating progress. The plans can address community issues ranging from addressing adolescent risk and protective factors to preventing drug addiction, overdoses, and violence. To support development of the plans, MDH should provide grant funding for local organizing and planning; facilitate a statewide community of practice to support local leaders; and develop materials that can be adapted by local communities and used in their planning.
3. Provide targeted support for communities that experience violence, suicide, and drug overdose at high rates. These are serious and unique sources of stress that contribute to disparities and poor mental health and well-being for the whole community. Institutional responses to these deaths are often reactionary and occur in isolation. Community action teams made up of leaders and residents interested in responding to community challenges should have access to resources, information, and decision-making structures that would help shape their communities in healthy ways. Cross sector teams can provide data and analysis, and promote coordination and shared learning. They can evaluate the specific experiences and partner with institutions to develop real solutions to the trauma, violence, drug overdoses, and suicide.
4. Develop resources and learning communities for organizations to engage in trauma informed organizational development, beginning with health care facilities and including early childhood providers, juvenile justice programs, and schools. Models for supporting organizational change typically involve a multi-year process and require time and resources to fully engage in this effort. This includes activities such as training and assessment of policies, environments, practices, and organization culture.

³⁷ A campaign is a coordinated health promotion effort that can include developing communication materials (videos, toolkits for public service announcements and social media, and presentations); conducting focus groups; developing or purchasing evidence-based or practice-based curricula; offering train-the-trainers classes; coordinating with local leaders to identify key audiences and champions; and other strategies to inform and encourage attention to mental health and well-being.

5. Develop evidence-based and promising mental health promotion programs designed to help individuals and families who are experiencing significant risk factors for developing mental illnesses. These programs can be implemented in community settings and homes or facilitated by health care providers.
6. Ensure that family home visit programs are available to all high risk families, including low-income families, first-time families, homeless families, incarcerated pregnant women, and teenagers with multiple children.³⁸ Home visit programs link pregnant women with quality prenatal care, support parents early in their role as a child's first teacher, help parents develop safe and healthy environments for their children, and share parenting skills and support that decrease the risk of child abuse. Family home visitors also provide critical referrals and follow-up to mental health services for at-risk parents. Current state and federal funding addresses only about 25% of Minnesota's home visiting needs. Without additional funding, the system will miss opportunities to support people with known risk factors for poor mental health.
7. Expand programs to reach all newborns for anticipatory guidance, access to culturally and linguistically appropriate developmental and social emotional screenings and referral. These programs help ensure that babies are developing appropriately and that parents understand how they can support their child's emotional and social development. One example is the Follow-Along program.
8. Develop supports and education for parents of adolescents that are accessible, evidence based, and teach positive parenting skills. Adolescence is a critical window of socio-emotional and cognitive development, and caregivers consistently report the need for more parenting resources for this age group.
9. Integrate mental health promotion strategies into primary care. Develop mental health and well-being learning communities and fund implementation of identified best-practices for healthcare providers and community mental health partners. Integration may include adjustments in clinical practices such as using trauma assessment tools, and in overall approaches to health care, such as developing community partnerships and addressing community-specific needs.
10. Build capacity to collect and analyze population health data regarding current mental health conditions and risk and protective factors associated with mental well-being and illness. Use tools such as the Minnesota Student Survey, Pregnancy Risk Assessment Monitoring System, and Behavior Risk Factor Survey. State and local communities and organizations, especially school districts, need support to analyze the data and apply the information for local planning of mental health promotion and prevention activities.
11. Expand transition supports for new immigrant and their families. Many immigrants and refugees have experienced trauma, poor social conditions, loss of culture and family connections, and social isolation. These experiences increase their risk of poor mental health and well-being. DHS should consider expanding transition supports for new immigrants and their families from 3 months to a minimum of 6 months, or as needed, especially if families have experienced trauma or have young children. The state should also ensure a warm hand-off to local resources after transition supports end. Immigrant communities also need support and

³⁸ Other examples include Living Life to the Full and the Mother and Babies Program.

resources to implement community-based strategies to reduce isolation, such as family mentors and welcome centers.

Recommendation #7: Achieving Housing Stability

Summary: Because housing stability is a critical factor in mental health, the Governor and Legislature should ensure that affordable housing—including housing with supports where needed—is available to all individuals and families to ensure both the access to and the effectiveness of mental health care.

a. Introduction

A growing number of Minnesota families and individuals are struggling to afford a place to call home. Since 2000, the number of Minnesota households spending more than 30 percent of their income on housing increased 69 percent from 350,000 to 590,000. Incomes have decreased by 5.6 percent and monthly housing costs have increased by 8.1 percent since 2000. The rental vacancy rate is about 3 percent around the state (5 percent reflects a balanced market). All of these factors make housing very difficult to both find and afford).³⁹

The importance of housing stability for a strong mental health system has been articulated by Task Force members and the public at every Task Force meeting. It is clear that housing stability is a foundation of mental well-being. Housing stability is also crucial if mental health services are to be effective and for recovery to be possible. Without housing stability, people remain in expensive and restrictive settings far longer than is necessary or, in many cases, do not receive the mental health care they need while living in shelters, on the streets, or in places not meant for human habitation. Many of the Minnesotans least likely to be able to afford housing are also living with mental illness. According to the Wilder Research Center, 55% of all homeless adults in the state are living with a serious mental illness.

The Task Force applauds the Governor and the Legislature for investments made to date in affordable and supportive housing, but a significant gap remains. The lack of adequate affordable housing will continue to impede our progress toward improving Minnesota's mental health system and ensuring equity. The Task Force urges the Governor and the Legislature to take the strongest possible position to close this gap and increase access to affordable and supportive housing.

b. Achieving Housing Stability

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

1. Protect and target existing state investments in housing and support services serving people with mental illnesses.
2. Support the 2017 policy and budget requests for housing and supports that are recommended by the Commissioners on the Interagency Council on Homelessness, including:
 - An increase in bonding for capital to support the preservation and development of affordable and supportive housing;

³⁹“Minnesota Housing 2017 Affordable Housing Plan.” (Saint Paul, MN: Minnesota Housing Finance Agency, 2016), p. 2. Available at: <http://www.mnhousing.gov>.

- Additional rental assistance to increase access to the existing housing market;
 - Targeted prevention resources for families to prevent them from losing their housing and assistance if they lose housing due to a mental health crisis.
 - Individualized community living supports (Group Residential Housing/Minnesota Supplemental Aid reform) for adults with disabilities who have low incomes and housing instability, including access to Medicaid services to help improve housing stability;
 - Increased connections between the juvenile justice, mental health and child protection systems in order to provide a more robust safety net for our most at-risk youth; and
 - Emergency funding for postsecondary students facing food and housing insecurity.
3. Direct that DHS, Minnesota Housing, the State’s Office to Prevent and End Homelessness, and the Olmstead Implementation Office work together to provide an analysis (modeling) of existing resources, identify strategies to leverage additional housing opportunities utilizing existing resources, and document the remaining gap of housing opportunities (by type) needed to ensure all Minnesotans living with mental illnesses have access to affordable and supportive housing.
 4. Provide incentives and support to local communities to prevent and address the loss of naturally-occurring affordable housing (that is, rental housing that is affordable to low-income households without additional public investments or assistance).
 5. Explore the State’s role in preventing overly restrictive tenant screening policies in local communities that make it difficult for people to access housing.
 6. Amend the Minnesota Crime Free Housing Lease Addendum to clarify that calls to law enforcement for mental health emergencies or to report crimes being committed by someone other than the lease holder should not be counted in the “three strikes” policy for eviction.
 7. Consider increased investments in the newly formed landlord risk mitigation fund, based on the outcomes of the initial pilot.
 8. The Minnesota Department of Human Rights should monitor and ensure enforcement of Fair Housing laws and promote adoption of recent Fair Housing guidance that restricts use of blanket policies to screen out potential tenants with criminal histories.

Recommendation #8: Implementing Short-Term Improvements to Acute Care Capacity and Level-of-Care Transitions

Summary: There should be an expectation that access to mental health and substance use disorder care is as accessible as physical health care. The Governor and Legislature should fund and assign responsibility for several short-term solutions to the patient flow problems implicit in the shortage of inpatient psychiatric beds. These can help ameliorate the situation and build collaborative capacity while longer-term solutions and more extensive solutions are developed.

a. Introduction and Overview

The mental health system challenge that generated the most written comments to the Task Force involved the problems related to inpatient psychiatric bed capacity and the attendant difficulties with level of care transitions. Most simply, the problem is that there are long waits for admission to hospitals with inpatient psychiatric beds, particularly those that serve people with mental illnesses and complex co-occurring conditions that include substance use disorders, chronic physical illnesses, intellectual

disabilities, and mental illness symptoms that include aggression and violence. People in mental health crises are forced to wait in inappropriate locations (emergency departments, jails, general hospital wards, at home, and other community settings) for inpatient psychiatric treatment. This creates a host of secondary problems for the patients and families involved and for the people in all of those other settings.

The inpatient psychiatric bed problem can be best understood as a “patient flow” problem. Seen at the system level, when people cannot access the treatment they need in a timely manner, the flow of people through the system is impeded. Like a traffic jam caused by construction, the slow-down reverberates through the system and multiple roads are soon affected. Minnesota’s patient flow problem is actually a complex set of intertwined problems (see the Appendix on page 67 for more information) that include the following:

- Inadequate community-based services and recovery supports such that a person does not receive the support they need when mental health symptoms first arise and they thus get sicker until they are in a mental health crisis.
- Inadequate coordination of services to support individuals toward recovery.
- Inadequate crisis-response services that could help divert some individuals from needing inpatient psychiatric care.
- Problems with discharge planning, which should start at admission, resulting in people being ready for discharge but not having a destination in their home community (with whatever level of supports required) to go to.
- Inefficient administrative processes (especially in the commitment process, funding eligibility determinations, and community placements) that delay both treatment and recovery in community settings.
- The long waiting times for admission to community psychiatric inpatient beds and especially for state-operated psychiatric beds for people who are under commitment.
- Uneven access to inpatient care across the state, leaving many areas with little access to this level of care and individuals receiving treatment far from home.
- The “cycling” of some patients through Emergency Departments, inpatient hospital stays, and discharge back to the community without adequate supports.
- The “trickle down” effects of these psychiatric patient flow problems on other people and services, including friends and families, community hospitals and their other patients, lower intensity psychiatric services, law enforcement, courts, etc. These patient flow problems reverberate throughout the service system, creating backups at community hospitals and preventing people from receiving the “right time, right place” care they need to successfully pursue recovery.
- Questions about what the appropriate number of inpatient psychiatric hospital beds in Minnesota should be and about where policymakers should best invest in order to ensure that people receive “right place, right time” care.

b. Short-term Solutions to Inadequate Acute Care Capacity

The Task Force considered solutions to the inpatient bed capacity problem that it considered to be implementable within one to two years. They do not see these as total solutions, but as strong first steps to take while the state undertakes the more comprehensive planning and coordination needed to solve the larger systemic issues. There should be an expectation that access to mental health and substance use disorder care is as accessible as physical health care. The Governor and Legislature should fund and assign responsibility for several short-term solutions to the patient flow problems implicit in the shortage of inpatient psychiatric beds. These can help ameliorate the situation and build collaborative capacity while longer-term solutions and more extensive solutions are developed.

1. Strengthen Housing and Supports (see Recommendation #7 on page 37 for more information)

Recognizing that housing stability is a critical social determinant of mental health, the Task Force recommends increasing the availability of affordable housing, with supports as needed to ensure access to—and effectiveness of—mental health services. To ensure adequate capacity and appropriate transitions in levels of care, the Task Force also recommends expansion of evidence-based intervention housing models, such as permanent supportive housing. In permanent supportive housing models, affordable housing is paired with or linked to services to assist individuals to remain in their homes. Providing housing with supports has been shown to create a level of stability that serves as a basis for recovery. In addition, bringing services to a person’s home lessens the need for transportation which can help someone who is experiencing a mental health crisis. Supportive housing has been shown to decrease the need for hospitalizations and involvement with law enforcement.⁴⁰

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

2. Improve Local Coordination around Crisis Response (see Recommendation #9 for more information)

The Task Force recommends strengthening crisis response services, as detailed in Recommendation #9 on page 49. Strengthening connections between mobile crisis teams, hospitals and law enforcement will assure individuals experiencing a crisis receive the right care, while relieving the pressure on hospitals and law enforcement to address acute crises with limited resources. There is also an opportunity for strengthening crisis teams to work with families, along with children and youth. Effective mobile and respite crisis services can prevent unnecessary hospitalizations and emergency department visits for both adults and children, thus both supporting recovery and helping to ensure that hospital beds are available for people who truly need them.

⁴⁰ For more information see <https://www.usich.gov/solutions/housing/supportive-housing>.

3. Competency Restoration

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

4. Establish an Ongoing Body to Coordinate and Oversee Work on Inpatient Bed Capacity

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

- Use of data to determine what levels and capacity of adult and children/adolescent inpatient services are needed and where.
- Collaboration with other organizations and workgroups on data collection to better plan and coordinate the continuum of care across the state.
- Discussion of roles and accountability of the Anoka Metro Regional Treatment Center and community hospitals in providing services, particularly for acute care for adults living with serious mental illnesses and complex co-occurring conditions, including symptoms of violence and aggression. (This should coordinate with the “safety net” discussions recommended in the Governance section above).
- Addressing the 48 hour law’s unintended consequences, particularly for community hospitals and Anoka Metro Regional Treatment Center.
- Exploring how to better utilize current resources to ensure access to inpatient mental health care across the state and supporting mental health workforce development, recruitment, and retention to make this possible.
- Inpatient and intensive mental health treatment for families.
- Discussion of financial disincentives to serving people with complex co-occurring conditions.
- Discussion of operational and financial barriers to the development of more transitional community-based services for people leaving inpatient hospital stays, correctional facilities, and jails.
- Examining the adequacy of timing and mental health professional supply related to examinations required by the commitment process.

5. Strengthen Community Infrastructure

a. Increase Intensive Residential Treatment Services and require private insurance coverage for services

The Task Force recommends an increase in Intensive Residential Treatment Services (IRTS), including exploring the development of IRTS that offer different levels of service intensity or are different sizes.⁴¹ This will involve removing impediments to IRTS development, which include requiring providers to have a county contract in place before building or opening a new IRTS program. Increasing IRTS capacity in Minnesota will also depend on support of the neighborhoods and communities where these programs will be located. IRTS programs should be included in the data collection mentioned above to ensure the right capacity is created within Minnesota's system.

In addition, private commercial insurance should be required to cover treatment in IRTS settings. This coverage is a matter of parity with physical rehabilitative services. Implementing this requirement will require work at the state and federal level, as well as with companies that self-insure and determine their own benefits.

b. Increase access to crisis residential treatment

The Task Force also recommends increasing access to crisis residential treatment through the development of additional crisis residential services. These services could be developed as stand-alone programs or included in Intensive Residential Treatment Services settings or other residential programs.

c. Improve discharge planning

Improving discharge planning is a key strategy for ensuring that people can leave hospitals when they no longer meet the criteria for a hospital level of care. The Task Force recommends taking the following steps to improve discharge planning:

- Expand initiatives that assist individuals with unique barriers in transitioning from Anoka Metro Regional Treatment Center (AMRTC) and Minnesota Security Hospital in St. Peter to include individuals in community hospitals who are on the AMRTC waiting list.⁴²
- Improve transitions of care for individuals leaving inpatient mental health treatment, particularly regarding effective medication management and engagement in medication treatment.⁴³
- Develop and expand culturally-sensitive and culturally-relevant discharge planning to ensure successful recovery for all people living with mental illnesses.

⁴¹ Increasing IRTS capacity does not preclude the importance of increasing the capacity of other intensive community-based service such as Assertive Community Treatment (ACT) teams.

⁴² The program is called Transitions to Community Initiative, a state program that as of April, 2016 had successfully assisted 99 individuals move from AMRTC or St. Peter back into the community. See *Transitions to Community* (St. Paul, State of Minnesota, April 2016) for more information.

⁴³ See *Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders* (St. Paul, Institute for Clinical Systems Improvement, Minnesota Hospital Association, and Stratis Health, October 15, 2012), 1, 9-10. These recommendations were developed with many community stakeholders and many hospitals have implemented at least some part of the recommendations.

- Support and increase tribal and county involvement in discharge planning for individuals admitted to an inpatient setting. Tribes and counties should be involved in discharge planning upon an individual's admission, but barriers of distance, high caseloads, and lack of experience can make this difficult. County liaisons to AMRTC and St. Peter have successfully assisted individuals to make timely transitions from AMRTC and St. Peter back to their communities, and some rural counties have collaborated to share liaison case managers to make this approach viable where no single county can sustain a full-time liaison. Tribal liaisons for AMRTC and St. Peter are also recommended, as these liaisons are often knowledgeable about culturally appropriate treatment options and may have extensive clinical knowledge of the individual's situation.

6. Civil Commitment

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

The Task Force recommends including tribes in the commitment process for their members. Currently, an individual tribal member can be committed without tribal input or consultation. Tribes should be involved whenever a tribal member is undergoing the commitment process. Tribes often have important previous clinical information to contribute to treatment planning. Connections to culturally appropriate treatment and clinical history are important components of recovery.

Concerns have also been raised regarding the lack of mental health examiners available for making the required assessments during the civil commitment process and the negative effects this creates in getting people through the commitment process in a timely manner. Straining the commitment process in this manner extends the period of time people are without their individual civil liberties. The Task Force recommends further study of this issue as part of Recommendation #4.

7. Expand Options for Parents and their Children

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

- Intensive mother-baby postpartum mental health treatment that allows mothers to receive mental health treatment while caring for their infants, such as Hennepin County Medical Center's Mother Baby Partial Hospitalization, Intensive Outpatient, and Outpatient treatment programs.
- Inpatient mother-baby postpartum units, such as those in the United Kingdom, Australia, Canada, New Zealand, France, and Belgium.⁴⁴

⁴⁴ Nicole Vlieghe, Sara Casalin, Patrick Luyten, Ria Docx, Marijs Lenaerts, Eileen Tang, Stefan Kempe (2013) Hospitalization-Based Treatment for Postpartum Depressed Mothers and Their Babies: Rationale, Principles, and Preliminary Follow-Up Data, *Psychiatry: Interpersonal and Biological Processes*, 76:2, 150-268. Maeve Kenny,

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

The Task Force also recommends that the Governor and Legislature ensure the implementation of Psychiatric Residential Treatment Facilities (PRTFs) for children and adolescents who need intensive residential treatment. Unlike current residential treatment for children and adolescents, this option does not require families to go through out-of-home placement for their children. Families will be able to get treatment for their children without losing parental rights; however, admission to a PRTF will still be determined by medical criteria. Implementation of PRTFs will be even more important if Minnesota loses federal funding for current children’s residential treatment services.⁴⁵

8. Support Efforts to Reform Addiction Treatment

The Task Force supports efforts to reform Minnesota’s addiction treatment system. A current reform effort will move Minnesota’s substance use disorder (SUD) treatment system from an acute, episodic-based system to a modern, person-centered, and equitable model of care with an emphasis on care for a chronic disease. It will establish a streamlined, person-centered process for accessing SUD services; expand the continuum of care to include withdrawal management, peer recovery support and care coordination services and allow SUD treatment to be delivered outside of a licensed setting. These changes are necessary to advance the integration of SUD services with the rest of the behavioral health care and physical health care system, which should reduce mental health crises and the need for inpatient hospitalization. They will also help remove one barrier to people leaving hospitals when they no longer need a hospital level of care. Waiting for an available addiction treatment setting has been cited as one reason why individuals become stuck in inpatient hospital unit after they no longer need hospital level care. According to the Minnesota Hospital Association/Wilder Research study, 11 percent of potentially avoidable days were due to a lack of availability of addiction treatment settings.⁴⁶

9. Assess Impact of the County Share

The Task Force recommends DHS assess the impact of recent increases in the amounts that counties pay to the state for patients at AMRTC and the CBHHS who no longer meet criteria for a hospital level of care. Counties now pay 100 percent of costs for county residents who are served in a state hospital without meeting criteria for that level of care. All of the funds collected go into the state’s General Fund. Has the increase driven a decrease in non-acute bed days while maintaining or improving stability in the community? Are there ways to further incentivize the development of community-based services? For

Susan Conroy, Carmine M. Pariante, Gertrude Seneviratne (2013) Mother-Infant Interaction in Mother and Baby Unit Patients: Before and After Treatment, *Journal of Psychiatric Research*, 47, 1192-1198. N.M.-C Glangeaud-Freudenthal, A.-L. Sutter, A.-C. Thieulin, V. Dagens-Lafont, M.-A. Zimmerman, A. Debourg, B. Massari, O. Cazas, R. Cammas, C. Rainelli, F. Poinso, M. Maron, S. Nezelof, P.-Y. Ancel, B. Khoshnood (2011) Inpatient Mother and Child Postpartum Psychiatric Care: Factors Associated with Improvement in Maternal Mental Health, *European Psychiatry*, 26, 2215-223.

⁴⁵ The federal Center for Medicare and Medicaid Services has expressed concerns that Minnesota’s children’s residential treatment settings have the characteristics of “Institutes of Mental Disease,” or IMDs, and could therefore be ruled ineligible for federal reimbursement.

⁴⁶ *Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot*, 1.

example, re-investing those dollars into community services is one possible option for strengthening the community-based mental health system that could be considered.

10. For Longer-term Consideration

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

Recommendation #9: Implementing Short-Term Solutions to Improve Crisis Response

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

a. Introduction

A comprehensive mental health continuum of care must include an effective crisis response system to assist people and families experiencing a mental health crisis. To design such an effective response, it is essential to recognize that mental health crises are not the inevitable consequences of having a mental illness.⁴⁷ They usually occur after significant challenging events like loss of housing, employment, or a significant relationship; conflict with a family member or friend; experience of trauma or abuse; a change in treatment without adequate transition planning; or increased substance abuse. The culmination of these stressors can be a highly visible event, but proceeding that crisis event is usually a history of unmet needs. In order to be effective, crisis response must not just address immediate needs for care and safety, but help connect a person to the broader resources they need to pursue recovery.

In Minnesota, people experiencing a mental health crisis usually gains access to professional assistance through one of these doors: they go to the local hospital's Emergency Department; they contact law enforcement or an ambulance by calling 911; or they contact local/regional mental health crisis services through a special phone number or by being directed there by a 911 operator.

If law enforcement responds to a crisis, officers enter the situation with a primary focus of assessing risk, maintaining safety and gaining control of the situation. This can sometimes cause trauma or escalation of symptoms for a person in crisis. A person experiencing high anxiety, paranoia, or other elevated states may react strongly to law enforcement, creating a situation that is potentially dangerous to all involved. With little background information, officers must decide whether the person should remain in their home or be transported to the hospital, crisis center, or to jail if a crime has been committed. If the person is taken to a local emergency department, the officer sometimes must wait with the person

⁴⁷ Bernstein, R. (2009). Practice Guidelines: Core Elements for Responding to Mental Health Crises. Retrieved October 11, 2016, from <http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf>

until an appropriate treatment is located. Law enforcement agencies consistently report that they lack adequate training and resources to respond to mental health crises.

If a person experiencing a mental health crisis goes to the Emergency Department, they are assessed by a physician who determines whether they meet the criteria for needing a hospital level of care. If they do, they are admitted to the hospital's psychiatric ward (if they have one), or to the general ward, or they remain in the Emergency Department while social workers try to find an available psychiatric bed for the person. One significant challenge is that if the person in crisis does not agree to voluntary treatment, the hospital may assess them using the standard for involuntary care, which requires a very high level of medical need that many individuals in crisis will not meet. People in crisis are often refused admission to, or discharged quickly from, the hospital because they do not fit criteria for in-patient hospitalization. If they are admitted, but an appropriate bed is not available, they may stay for long periods in the Emergency Department without appropriate mental health treatment. Hospitals do perform discharge planning, but the short duration of contact often means that individuals leave without a discharge plan that they are ready to implement.

If the person in crisis accesses mental health crisis services, they will either connect with a live person over the phone, engage with a mobile crisis team in their home, or go to a residential crisis provider for a short stay. They complete a screening process to determine what level of care is needed; if hospitalization is needed or residential crisis services are needed, transportation is arranged. The provider may use therapeutic interventions to help de-escalate the crisis. The crisis provider works with the person to develop a short term crisis plan and coordinates with other providers for referrals to the appropriate services. Crisis services capacity varies significantly from community to community. Some regions are still building out their crisis teams and others do not have enough staff to respond in the timeframe required. This can be a significant point of contention when teams try to build collaboration with law enforcement.

There are significant challenges with the response to mental health crises in Minnesota. These include:

- Individuals frequently call 911 or go to an emergency department because it is a known and familiar resource and they don't know about more specialized mental health resources.
- Many mental health emergencies are still responded to by law enforcement following a 911 call. Law enforcement officers often lack the training and experience to recognize and de-escalate mental health crises, which can lead to tragic consequences including the injury or death of the person in crisis, the responding officers, or others involved.
- Staff in Emergency Departments often lack specialized mental health expertise, leaving them ill-prepared to support people experiencing a mental health crisis. Some community hospitals do not have a psychiatrist or psychologist on staff at all, and many do not have them available 24/7.
- There are not enough inpatient psychiatric hospital beds for people who need that level of care, forcing people experiencing a mental health crisis to wait in inappropriate facilities for care.
- Even where mental health crisis services are robust and available, there is often inadequate awareness or collaboration among law enforcement, crisis services, and community health providers.
- People with chronic mental illnesses and substance use disorders who frequently come in contact with law enforcement sometimes end up in cycles of hospitalization, incarceration, and

residential treatment. This is traumatic in and of itself, and may disconnect them from the mental health care and community support services they need. They might not be able to see a specialist during a short stay, or they may be removed from Medical Assistance coverage due to a longer one. These individuals often face significant barriers to housing and services that could support recovery and stability.

- Travel times in rural areas present a significant challenge to timely response to calls (for mobile crisis teams, law enforcement, or ambulance).
- Communities around the state often lack some of the specialized resources that people in crisis may need, especially in rural areas.
- In urban areas, mobile crisis teams and law enforcement can struggle with a call volume that outpaces available staffing.
- Schools often lack the expertise to deal with children’s significant emotional or behavioral crises, and may be forced to call on law enforcement to maintain safety. This can lead to significant trauma and set up further conflicts for children at school. Children whose symptoms include aggression are at significant risk of involvement in the juvenile justice system.
- Physical health urgent care settings, which help reduce unnecessary visits to the Emergency Department, usually do not have behavioral health resources onsite. They may offer an appointment within the next few days, but that is not soon enough to address a mental health crisis.
- People who have experienced a mental health crisis and received services in short-term acute settings like hospitals, often leave without a solid understanding of what will happen next. Without the right supports and engagement in a longer-term plan, the person may quickly experience another crisis.
- A person may have a well-developed plan, including trusted supporters named as health care agents who can authorize treatment. But during a crisis, the person may be unable or unwilling to relay that information to the people trying to help. Timely, appropriate, and electronic access to health care directives could assist individuals with mental illnesses in being able to engage with their own care.

Minnesota has recently pursued several strategies to help address these challenges. They include:

- Several policy reforms and funding allocations were enacted in 2015. Crisis services are now defined as being a part of “emergency services” for the purposes of health insurance. This helps individuals with private insurance, not just Medical Assistance, utilize crisis teams. DHS is also working on a pilot to automatically redirect calls to the appropriate local agency, thus making progress toward having one phone number to access crisis services for all Minnesotans. New crisis residential crisis capacity is being developed with new funding, and should add 12 additional beds by July 2017.
- As Minnesota expands mobile crisis response, significant issues and disparities have emerged. Variations in how people access the service can discourage people from calling in, and create challenges for other responders, including law enforcement. As part of the allocation of funding, the authorizing language also called for the development of strong statewide standards for crisis response. DHS is working with stakeholders to develop language that is clear and comprehensive. Key goals include creating common expectations for when teams will dispatch

a mobile response, promoting collaboration with hospitals in rural areas, ensure that crisis team members are able to authorize transport holds so hospitals have a better understanding of why an individual was brought there, and improving the training that team members receive, so that they can address the unique needs of children, older adults, individuals who speak other languages, or come from different cultural backgrounds.⁴⁸

- Many communities are implementing Crisis Intervention Training, based out of a model developed in Memphis, TN. However, it may not always be possible to pair a CIT officer with a call that might require that skillset. The 40 hour length of the course ensures that officers can develop and hone their ability to respond to individuals in crisis, but creates significant challenges for smaller departments to cover for them while they train.
- While Minnesota has and is expanding access to crisis residential care for adults, this service is not yet available for children. Crisis residential is usually a short term stay of six to ten days, and offers the opportunity to get more intensive care but does not involve a locked/secure unit. DHS has been charged by the Legislature to develop recommendations on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement. In June 2016, the Department of Human Services, Mental health division published a Request for Proposal to contract with a qualifying vendor to conduct a study on funding around this benefit. A vendor has been selected and the project is currently in the contracting phase. Recommendations submitted to the department's mental health division will be used to inform establish children's mental health crisis residential services without requiring county authorization or child welfare as a new benefit with Center for Medicaid Services (CMS) approval.

However, more could be done to improve crisis response. The Task Force feels strongly that the recommendations below would improve crisis response services and collaboration and thus significantly improve the mental health continuum of care. They would help ensure that people in crisis are assessed and treated in the most timely and person-centered way possible, thereby promoting recovery. They would help connect people to the treatment and supports that help prevent further crises. They address issues that arise when individuals in rural areas need high intensity services that might not be available close to where they live. For responders who do not specialize in mental health, these recommendations help connect them to resources and training to help them safely play an assisting role in crisis response. Perhaps most importantly, they would promote the level of community-wide collaboration that is needed to create integrated response to mental health crises.

The Task Force also recognizes that one barrier to better response is the need to clarify roles and responsibilities. At the local level, this can be achieved through local collaboration among the many players involved. At a regional and state level, however, there is a need to consider mental health crises as moments in a person's path to recovery, and responsibility for crisis response should be considered alongside the rest of the mental health continuum of care. There are not just individual mental health crises; there are systemic crises when the system lacks the mechanisms to promote health, prevent

⁴⁸ As of the completion of the taskforce report, this work is on-going. Comments or questions may be directed to Dhs.Mentalhealth@state.mn.us or 651-431-2225. Please specify that you are inquiring about the mental health crisis standards workgroup.

illness, intervene early if symptoms appear, and provide treatment and recovery supports. The Task Force recommends that the Governance Workgroup (see Recommendation #2 on page 29) consider how roles and responsibilities for crisis response are integrated with the rest of the continuum. They envision a day when the response to a mental health crisis is at least as well funded and coordinated as the response to a heart attack or stroke, which will require sorting out issues of parity and clarifying the lines between health care services and social services. Collaboratively and holistically clarifying responsibility is the only way Minnesota can address the root causes of many mental health crises.⁴⁹

b. Strengthening Crisis Response Services and Collaboration

1. **Pre-service Crisis Intervention Team Training as Required Training for Law Enforcement**
Minnesota should implement 40 hours of pre-service Crisis Intervention Team (CIT) training for all officers through the Law Enforcement Academy. This would increase community and officer safety when responding to mental health related calls. In-service officers would get 4-8 hours of refresher training every 3 years. Because of the high cost of taking in-service officers off patrol for 40 hours, pre-service training is the best approach as Minnesota seeks 100% CIT training for law enforcement. Task Force members expressed interest in also integrating training on trauma, including sexual assault.⁵⁰ Other elements of 911 response would also require training: paramedics, fire/EMS, and dispatcher operators.

New officers may be more receptive to training, but each agency will need veteran officers and leaders who are trained and invested in the CIT model and can help younger officers understand how to apply the training. Changes in policy may be needed to realize best outcomes, including clarifying who is the lead officer at a scene involving a mental health crisis.⁵¹ Trainees should also get information about coping skills and resources for themselves, so that they are better equipped to handle the stresses of responding to crisis situations.

Training could be started relatively quickly. However, a focus on pre-service training would mean a lag time before a critical mass of officers would have the training. Current practice has been to restrict the 40 hour course to in-service officers since they have additional context for the training. The Task Force will need to consider this tension. Law enforcement agencies, schools, cities, counties and tribal authorities, Fire/Emergency Medical Services, MnSCU, CIT training organizations, individuals with lived experience, DHS and DPS would all need to collaborate to make this work.

Parallel to this, educators may also need more resources and training to help support positive crisis interventions. Minnesota has about 55,000 teachers licensed, with 2,400 new teachers in a year.⁵² Other

⁴⁹ One recommendation (warmlines) addresses immediate “pre-crisis” needs. Other prevention strategies that build strong services capable of preventing a crisis from occurring and address root causes of trauma are detailed in the Acute Care and Transitions recommendations and the Continuum of Care.

⁵⁰ Sara Suerth recommended “Understanding Trauma” as presented by Central Minnesota Sexual Assault Center.

⁵¹ Dupont, R., Cochran, M. S., & Pillsbury, S. (2007, September). Crisis Intervention Team Core Elements. Retrieved October 2016, from University of Memphis CIT Center, http://www.cit.memphis.edu/information_files/CoreElements.pdf

⁵² Schools, districts and teachers at a glance. Retrieved October 11, 2016, from Minnesota Education Statistics Summary, <http://w20.education.state.mn.us/MDEAnalytics/Summary.jsp>

professional groups may need similar training, such as primary care staff, including nurses) who are more frequently encountering individuals in mental health crisis.

2. Provide Additional Resources Where People Already Seek Help

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

Minnesota should prioritize the co-location of outpatient mental health services delivered by Community Mental Health Centers into Critical Access Hospitals (CAH). CAHs are 25 bed or smaller hospitals and are eligible for cost-based payment for Medicare/Medicaid. They must be a certain distance from the next available hospital, and most provide primary care and outpatient services in attached or satellite clinics. The CAHs maintain a level of access to treatment in less densely populated areas. Residents of these areas are used to going to the hospital for regular outpatient services, as providers see a mix of clinic and hospital patients throughout the day. Sometimes, it may be the only primary care provider located nearby. Both providers and the people being served benefit from ease of accessing multiple kinds of care from a single site. The co-location can support better care and opportunities for joint system engagement. In crisis situations, mental health staff are on site and can offer consultation. In some CAHs, hospital staff also comprise the local Crisis Intervention Team. This model would start with the integration of less intensive services, such as outpatient therapy. But the onsite presences and increased collaboration will allow organic growth of the CAH staff in handling crisis situations. Many CAHs are already serving people experiencing mental health crises, and they need better support and specialized expertise to respond. Minnesota could also consider supporting a statewide community of practice to promote more understanding among primary care providers on how they can support individuals with mental health needs.⁵³

The goal would be to significantly increase access to mental health care access in rural communities through CAHs. As a secondary benefit, those providers would be better able to offer consultation or services on an as-needed basis to patients presenting through the emergency department. Workforce is and will continue to be a significant barrier. Improvements currently being implemented may assist in this process, including development of more rural-focused programs and clinical training through the University and MnSCU systems and additional funds for targeted student loan forgiveness. Co-location can reduce capital/overhead expense for the Community Mental Health Center, and can help drive additional patient volume to the local hospital and clinic.

This proposal would require significant partnership and buy-in between hospitals and health systems and Rule 29 Community Mental Health Centers. DHS and MDH would have roles in supporting this work, resolving questions around regulatory obligations, and monitoring ongoing needs.

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

Minnesota should develop more Urgent Care for Mental Health settings, combining detoxification and/or withdrawal management services, crisis response services, and urgent access to psychiatry and medications. This model offers services at a lower level of intensity than inpatient hospitalization, and it

⁵³ See “Zero Suicide” notes in appendix.

does not use locked or secure units. Data shows promising outcomes for providing crisis stabilization using this model:⁵⁴

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

Additional data suggests a higher diversion rate (did not need to use Emergency Room or in-patient) among people who saw a psychiatric provider who could prescribe medication when appropriate. In addition, the Urgent Care could connect people with medication assistance programs.⁵⁵ As teams reach 24/7 mobile coverage, Minnesota could commit to integrated psychiatry within crisis response as the next benchmark for service.

Per-area spending for mental health urgent care will likely be in line with what counties and tribes are spending already. However, physical co-location can provide significant operational improvements and efficiencies. Staff can be cross trained between programs and better able to respond to ebbs and flows in the needs of the programs. This can deliver more coordinated and integrated care, and advance Minnesota’s ability to achieve a recovery focused model of care. Prior projects have taken about three years to implement. A new project might proceed somewhat faster based on lessons learned, but construction alone took 20 months.⁵⁶

This model is focused on Medicaid and other publically-funded care. Clinic networks and healthcare systems that focus on individuals with private insurance are more likely to offer reserve appointments in general healthcare clinics during daytime hours than through a psychiatric specialty urgent care clinic.⁵⁷ The Governance Re-design Workgroup (see Recommendation #2 on page 29) could consider what barriers may exist for such models to adapt for greater integration with health plans and clinic networks.

⁵⁴ Bennett, A. L., & Diaz, J. (2013, May). The Impact of Community-Based Mental Health Crisis Stabilization. Retrieved October 3, 2016, from Wilder Research, <http://www.wilder.org/Wilder-Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/The%20Impact%20of%20Community-Based%20Mental%20Health%20Crisis%20Stabilization,%20Brief.pdf>

⁵⁵ M. Trangle. Senior Medical Director for Behavioral Health, HealthPartners. Interview. 9/20/16.

⁵⁶ Conducy, A. Chemical and Adult Mental Health Manager, Ramsey County Community Human Services. Correspondence. 10/7/16.

⁵⁷ M. Trangle, op. cit.

Counties and tribal authorities, health plans, DHS, hospitals, and community mental health centers would need to work together to determine local needs and advance this work. Workforce shortages would remain a key issue.

3. Intersections between Mental Health and Criminal Justice

a. *Mental Health/Law Enforcement Co-responder Models*

Minnesota could pilot models for embedded mental health providers within law enforcement. Some co-responder models involve a stand-alone mental health unit within a police department. The mental health provider is directly hired and is accountable to the law enforcement agency. Others are a collaboration between mental health crisis services and law enforcement. These partnerships have expertise in crisis assessment, intervention and stabilization. They cover distinct geographic regions, and have 24/7 access to a mental health professional, even if the assigned “embedded” clinician is not on duty.⁵⁸ Because Minnesota already has a county-based mental health crisis response infrastructure, this may be a useful approach. This may reduce the likelihood of co-responders becoming another service silo that is not connected with other resources. Minnesota could focus additional grant funding to support co-location of existing crisis teams with law enforcement, or to pay for time spent in ride-alongs or other collaboration.

The co-responder model provides law enforcement officers with assistance as they respond to people experiencing a mental health crisis. Without a professional assessment of a person’s mental health needs, officers tend to err on the side of caution, bringing the person to the ER even if that might not be the best fit with the person’s needs. This can result in lost time, escalation of the person’s mental health symptoms and other bad outcomes, and significant costs. Minnesota should make a careful assessment of how to best provide for collaboration and communication that addresses that gap. The required workforce is in short supply across the state, with most areas being designated as Mental Health Professional Shortage Areas (MHPSA).⁵⁹ The time that the embedded mental health professional spends in ride-alongs and engaged in other non-clinical work can help bridge healthcare and law enforcement cultures. However, many communities already struggle to hire and retain the workforce needed for basic clinical services.

The other major need addressed by different co-responder models is proactive outreach to individuals who come in frequent contact with crisis providers or law enforcement, or who have experienced trauma. Models in Texas and California emphasize this function. In most cases the mental health provider is leading the conversation, and the officer is there to build trust in the event law enforcement does have to respond to that person in the future. Health providers, such as case managers, seek a release of information that covers the mental health team on the law enforcement agency.⁶⁰ Minnesota should carefully consider how closely these roles should be tied to law enforcement. Case management and ACT teams should accept referrals for service from police, but it is not always clear if that service benefits from additional police involvement.

⁵⁸ Abbott, S. *Advocates Jail Diversion Program: A Step by Step Toolkit*. Page 4.

⁵⁹ Health Resources and Services Administration.

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

⁶⁰ Smith-Kea, N., Yarbrough, M., & Myers, S.

While national models are available, some questions will need to be answered as we map those ideas to Minnesota's service spectrum. One major concern will be the availability of a qualified workforce. Nationally, models for co-responders have emphasized having a master's level provider as the embedded person. They have a more significant clinical background, are better equipped to accurately assess risk, and have a licensing board to whom they are accountable.⁶¹ Members of the Task Force affirmed this as an important principle.

With any of these models, communities that have significant levels of mistrust towards police may be less likely to call for crisis services if they believe that they are connected to law enforcement. Another significant factor in long-term outcomes is the strength of the community services to which individuals are being redirected. Despite differences in various co-responder models, a common point is that a mental health provider assists law enforcement in making choices about the options available to assist the person experiencing a mental health crisis. If the community-based services available are insufficient, the co-responder model will struggle.⁶²

The goal of pilot projects should be to test the ability of this model to provide timely, on-scene assessment of an individual's needs and possibilities for diversion to community resources. Pilots should also assess how to best deliver proactive outreach to individuals who come into frequent contact with hospitals, crisis services, and law enforcement. This will require the collaboration of law enforcement, crisis teams, community mental health providers, counties and tribal authorities.

b. Expand Diversion Options for Juveniles in the Criminal Justice System

Minnesota should build on diversion programs to address the needs of children whose primary need is mental health treatment. When a juvenile has mental health needs and is involved in the criminal justice system, the existing tools don't always work to provide best outcomes. Using delinquency proceedings can mean significant collateral consequences for the child: self-identification as a delinquent, restricted access to therapeutic settings, family separation, and additional stress from an uncertain process.⁶³

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

Meanwhile, if a child is directed into Rule 20 proceedings, some parents may be less supportive of treatment because they wish to prevent the consequences of the criminal proceeding for their child. A child with significant needs might not be able to meet the standards for competency, and stay in limbo

⁶¹ Smith-Kea, N., Yarbrough, M., & Myers, S. (2016, September 28). Police-Mental Health Collaboration Programs: A Different Way of Policing. Retrieved October 04, 2016, from <https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/>

⁶² Helfgott, J.B., et al., A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program, *International Journal of Law and Psychiatry* (2015), <http://dx.doi.org/10.1016/j.ijlp.2015.08.038>

⁶³ For example, the model developed in Stearns County could be considered for possible broader replication.

through Rule 20. Some of the best therapeutic settings a child might be placed into are not open to individuals with prior delinquency proceedings.⁶⁴

Minnesota needs more high quality diversion options for youth with mental health needs and criminal justice involvement. The priority should be to identify services and supports needed to maximize safe and therapeutic outcomes for high needs children. This work will require collaboration between law enforcement, child protection, residential programs for children, courts, district attorneys, community mental health providers, schools, counties and tribal authorities.

4. Improved Data Sharing and Collaboration

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

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

Staff turnover or a lack of identified ownership for these projects can undo progress. Minnesota can continue to improve by increasing the quality of resource databases, seeking longer staff retention in care planning roles, and reinforcing recovery and coping skills in discharge plans.⁶⁵

As part of a State Innovation Model (SIM) cooperative agreement, awarded to the Minnesota Departments of Health and of Human Services in 2013 by the Center for Medicare & Medicaid Innovation (CMMI), stakeholders have created the Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services. The Roadmap process was structured, sequential, and integrated the diverse issues of priority settings, including mental health. The steering team, with 25 individuals, and the workgroups, with over 50 subject matter experts from the priority settings, met over 40 times from January 2015 to June 2016.⁶⁶

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

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

Some states have created a centralized registry of advance directives. Individuals complete their plans and store them through a secure online portal.⁶⁷ They may print a wallet card with a bar code or store

⁶⁴ Mahoney, B. Family & Children Services Division Director, Stearns County. Interview. 10/6/16.

⁶⁵ Kemper, J. Health Care Consultant, Institute for Clinical Systems Improvement. Interview. 10/5/16.

⁶⁶ "Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services." Published June 6, 2016. <http://www.health.state.mn.us/e-health/ehealthdocs/roadmap.pdf>

⁶⁷ Models reviewed: Virginia, California, Idaho.

information on their phone that links their name and registry ID. In case of an emergency, a healthcare provider can access their documents with the individual's name and registry ID or date of birth. Minnesota could implement an option for individuals declare that they wish to have information disclosed to law enforcement in a crisis situation. While a registry does not necessarily mean the advance directive is integrated directly into the patient record, it does allow for the person to present at any healthcare provider and still have that information be accessible.

5. Telehealth Solutions

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

a. Build out common network and protocols

Minnesota should expand a single interoperable network standard for telehealth mental health services, and identify sustainable allocation for those infrastructure costs. Parallel to this, DHS should consult with stakeholders as they establish best practices for the workflows used to implement telehealth for crisis situations.

This would include adoption of a common cloud-based platform for connecting providers and individuals, identifying a model for other emergency responders to bring a connection out into the field through tablet or other device, as well as protocols for timelines and responsibilities each partner has in crisis telehealth. This will build on prior work in several areas. Providers in Minnesota have invested significant effort into developing protocols and workflows to support the deployment of telehealth connections between crisis teams and small hospitals.⁶⁸

DHS and AMHI Region 3 (Northeast MN) have partnered to pilot the deployment of a common standard and network for telehealth connections. Hospitals, schools, and clinics all can gain access to the DHS network which allows for fast and easy connections. One of the core principles that the group has affirmed is that telehealth services should adapt to the needs of individuals, not be limited to fixed locations. Some examples of use in this pilot: One member of a crisis team can stay in contact with a child in crisis at a school, while another travels to meet them in person. A psychiatrist from the community mental health center, can provide a diagnostic assessment and start an individual at the county jail on medication without any transportation time or cost.⁶⁹ MN.IT provides helpdesk to support for all users.

For expansion, MN.IT staff who have worked on the pilot have recommended that Minnesota use cloud based services instead of buying/maintaining physical infrastructure. This would be a hybrid approach with all organizations in the mental health ecosystem having ample access to the network and to each other at the outset. Then a pool of subscriptions would be available to be allocated for person-centered access. For example, Individuals who have intensive needs in the community could get far more immediate response in a potential crisis by being able to directly connect via telehealth. Cloud based

⁶⁸ Reitmeier, S. Chief Executive Officer, Northwestern Mental Health. Correspondence. 9/9/16.

⁶⁹ Lee, D. Director of Public Health & Human Services, Carlton County. "Vidyo Telepresence System Live Demonstration- State Advisory Council and Children's Subcommittee." 10/6/16.

services can be deployed quickly, but providers and recipients would need support to understand how best to use the technology.

MDH Office of Rural Health has experience managing grants for capital expenditures rural health systems would otherwise be unable to afford. Further stakeholder work would require broader representation: more hospital systems, crisis teams, other telehealth implementers. Establishing a statewide conference or community of practice could help develop and spread best practices.

b. Reserve Capacity for Crisis Response via Telehealth

Minnesota should establish a common pool of telehealth resources for urgent mental health needs. An RFP process would identify a provider to function as a reserve, available when local resources are not able to respond quickly. The goal would be to significantly reduce the number of times a potential recipient is told that crisis services are unavailable because all staff are already committed to calls. Utilization data from telehealth team would drive further development of the mobile teams.

If a person calls in to a crisis team during a busy time, a shortage of available responders might mean that they are told that the team cannot respond in a timely fashion. Instead, callers could be presented with options: a timeframe for mobile response, or directions to a site where they could access the telehealth team. Potential local sites could be clinics offering physical urgent care, a hospital without dedicated psychiatric resources, or fire station/paramedic base. The local site would need to be able to provide some level of support: paramedic or triage nurse, and the ability to call for further resources when required. A framework for responsibilities, reimbursement to the local site, and other funding considerations would need to be developed. Strong consideration must be given to how this service will help connect individuals to ongoing assistance and develop a relationship with local resources. This model would focus on providing intervention only, and referring back to the local team for crisis stabilization/follow-up services as appropriate.

Drawing from a larger pool of potential callers, a more predictable staffing model could be developed for this reserve. Depending on the needs and staffing models of existing teams, they could potentially chose to cover calls from other areas during times when they have additional capacity. It could take approximately 3-6 months after funding to get staff hired, get the equipment up and running and to train staff in crisis response via telehealth. Host sites may take longer to develop, and host sites will need to train/collaborate with the telehealth crisis providers to work out logistics and team protocols.

Successful collaboration would need to include 911 responding agencies, counties and tribal authorities, existing mobile crisis teams, host site locations, and DHS. Implementing local sites (hospitals, paramedic stations, etc.) would need buy in from internal stakeholders, especially with staff that was primarily trained on physical healthcare.

6. Further Improvements to Community Services

a. Expand Forensic ACT Capacity

Minnesota should invest in specialized Forensic Assertive Community Treatment teams to meet the needs of individuals at risk of future/continued involvement in the justice system due to their mental

health needs. This follows a recommendation in the 2016 Office of the Legislative Auditor report on mental health care in jails.⁷⁰

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

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

Expanded FACT would provide high quality, community based mental health services to individuals at high risk of future involvement in the criminal justice system. The evidence base shows that individuals would have fewer jail and hospital bed days and greater community tenure. Prior expansion has been done at about 1-2 teams per year. The staffing requirements to meet fidelity standards are rigorous, and it may be difficult to find qualified individuals any faster. In order to succeed, counties and tribal authorities, jails, Department of Corrections, DHS, and community mental health providers would need to collaborate.

b. Expand Pre-Crisis Services

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

The Minnesota Warmline is currently available statewide during evening hours (4pm – 10pm) Tuesday-Saturday, and provides support and stability for callers who need to connect with someone urgently. Individuals may call anonymously if they wish, and get the support they need to use their own resources and problem solving skills to address their immediate needs. Approximately half of the callers are experiencing significant stress or anxiety when they call, while the other half are reaching out to break isolation. Nearly 90% of callers report feeling calmer by the end of the call.⁷¹

⁷⁰ Alter, J. (2016, March 3). Mental Health Services in County Jails. 41. Retrieved October 11, 2016, from <http://www.auditor.leg.state.mn.us/ped/2016/mhjails.htm>

⁷¹ Mulvihill, S. Executive Director, Mental Health Minnesota. Grant report to DHS and correspondence. 10/10/16.

Warmline operators are CPS trained. The CPS model gives individuals who have experienced mental illness the framework for supporting others by modeling healthy behaviors, asking the individual to recall previous tools or strategies that have been successful, and offering hope that recovery is possible. Minnesota should support and promote warmline services as an adjunct to crisis services to help individuals avoid more intense needs. This program handles nearly 500 calls/month during its open hours (30 hours/week), with the number of calls increasing every month. Adding hours and clinical supervision would increase the value of this service to Minnesotans who are frequently near crisis.

Appendix I: Governor's Executive Order

STATE OF MINNESOTA

EXECUTIVE DEPARTMENT



MARK DAYTON
GOVERNOR

Executive Order 16-02

Establishing the Governor's Task Force on Mental Health

I, Mark Dayton, Governor of the State of Minnesota, by virtue of the authority vested in me by the Constitution and applicable statutes, do hereby issue this Executive Order:

Whereas, more than 200,000 adults and 75,000 children in Minnesota live with a mental illness;

Whereas, people wait an average of ten years between first experiencing mental health symptoms and accessing treatment;

Whereas, over 50 percent of children and adults in Minnesota who experience homelessness live with a mental illness;

Whereas, Minnesotans who seek mental health services experience gaps in the current mental health system, leading to inappropriate placement in mental health services, or to not receiving care altogether;

Whereas, adults with a serious and persistent mental illness are dying, on average, 25 years earlier than the general public due to heart disease, lung disease, diabetes and cancer;

Whereas, numerous reports have highlighted the cross-sector challenges faced by Minnesotans in need of mental health care, and recommended developing and implementing a more comprehensive continuum of mental health services; and

Whereas, Minnesotans who live with serious mental illnesses can live healthy and productive lives when high-quality and effective mental health services are available to them.

Now, Therefore, I hereby order that:

1. The Governor's Task Force on Mental Health is created to advise the Governor and Legislature on mental health system improvements within the State of Minnesota.
2. The purpose of the Task Force is to develop comprehensive recommendations to design, implement, and sustain a full continuum of mental health services throughout Minnesota.
3. In addition, the Task Force will make recommendations on:
 - a. Developing and sustaining a comprehensive and sustainable continuum of care for children and adults with mental illnesses in Minnesota, including policies, legislative changes, and funding;
 - b. Clear definition for the roles and responsibilities for the state, counties, hospitals, community mental health service providers, and other responsible entities in designing, developing, delivering, and sustaining Minnesota's continuum of mental health care;
 - c. Reforms needed to support timely and successful transition between levels of care, including early intervention services and substance abuse services; and
 - d. Expanding the capacity of Minnesota's mental health system to responsively serve people of diverse cultures and backgrounds.
4. The task force shall consist of members appointed by the Governor, including:
 - a. The Commissioner of the Department of Human Services;
 - b. 4 individuals or family members of individuals with lived experience of mental health issues;
 - c. 2 mental health advocates;
 - d. 2 representatives of community mental health services;
 - e. 2 representatives of hospital systems;
 - f. 2 representatives from law enforcement;
 - g. A representative from the counties; and
 - h. A representative from the judicial branch.
5. The task force shall include four ex-officio leaders from state agencies, who shall be appointed by the Governor:
 - a. The Commissioner of the Department of Health;
 - b. The Commissioner of the Department of Corrections;
 - c. The State Director to Prevent and End Homelessness; and
 - d. The Ombudsperson for Mental Health and Developmental Disabilities.
6. The task force shall include four ex-officio legislative members, who shall be appointed by caucus leadership:
 - a. A Member of the Majority Party in the Senate;
 - b. A Member of the Minority Party in the Senate;
 - c. A Member of the Majority Party in the House of Representatives; and
 - d. A Member of the Minority Party in the House of Representatives.
7. The chair of the Task Force will be the Commissioner of the Department of Human Services.

8. The Task Force will report to the Governor's Office, the Legislature, and the public by November 15, 2016.
9. The Commissioner of the Department of Human Services will provide general administrative and technical support to the Task Force.
10. The Task Force will make its meetings open to the public and provide opportunities for public comment.

This Executive Order is effective fifteen days after publication in the State Register and filing with the Secretary of State, and shall remain in effect until rescinded by proper authority or until it expires in accordance with Minnesota Statutes, section 4.035, subdivision 3.

In Testimony Whereof, I have set my hand on this 27th day of April, 2016.



Mark Dayton
Governor

Filed According to Law:



Steve Simon
Secretary of State



Appendix II: Task Force Members

Emily Johnson Piper

Department of Human Services, Chair

Melissa Balitz – Hastings, MN

Representative with Personal or Family
Experience with Mental Illness

Brantley Johnson – Minneapolis, MN

Representative with Personal or Family
Experience with Mental Illness

Kim Stokes – Britt, MN

Representative with Personal or Family
Experience with Mental Illness

Crystal Weckert – Brainerd, MN

Representative with Personal or Family
Experience with Mental Illness

Sue Abderholden – Minneapolis, MN

NAMI Minnesota

Liliana Torres-Nordahl – Bloomington, MN

Women’s Alliance Minnesota

Shauna Reitmeier – Crookston, MN

Northwest Mental Health Center

Pahoua Yang – St. Paul, MN

Amherst H. Wilder Foundation

Paul Goering – St. Paul, MN

Allina Health

Bruce Sutor – Rochester, MN

Mayo Clinic

Sara Suerth – Brooklyn Park, MN

Brooklyn Park Police Department

Rodney Seurer – Savage, MN

Savage Police Department

Jim McDonough – St. Paul, MN

Ramsey County Commissioner

Jaime Anderson – Minneapolis, MN

Fourth Judicial District

Brenda Cassellius – Saint Paul, MN

Department of Education, Ex-Officio Member

Edward Ehlinger

Department of Health, Ex-Officio Member

Tom Roy

Department of Corrections, Ex-Officio Member

Cathy ten Broeke

State Director to Prevent and End Homelessness,
Ex-Officio Member

Roberta Opheim

Ombudsperson for Mental Health and
Developmental Disabilities, Ex-Officio Member

Clark Johnson

Minnesota House of Representatives, Ex-Officio
Member

Roz Peterson

Minnesota House of Representatives, Ex-Officio
Member

Tony Lourey

Minnesota Senate, Ex-Officio Member

Julie Rosen

Minnesota Senate, Ex-Officio Member

Appendix III: Acronyms Used in this Report

To be completed

Appendix IV: Inpatient Psychiatric Bed Capacity Issue Background

A. Inpatient Psychiatric Hospitalization

When a person is in a mental health crisis, there are several options for how to respond. Some crises can be addressed at home with the help of family and friends or professionals including mobile crisis teams. In some cases, however, a decision is made (by the individual, his or her family, or first responders) that the person in crisis should go to a hospital. In the hospital's Emergency Department, the person is evaluated and is either sent back home, referred to psychiatric treatment elsewhere, admitted to a general inpatient ward of the hospital, or admitted to specialized inpatient psychiatric treatment (at that hospital or another hospital).

People coming to community hospitals in a mental health crisis are sometimes not admitted for inpatient care because hospitals have very strict admittance guidelines. Admittance for a mental health crisis is based on a decision about a person's capacity to harm themselves or others, or neglect themselves to the point of self-harm. People in the most serious crises are placed on an emergency or 72 hour hold and often have legal commitment proceedings begun. Individuals are also brought to hospital Emergency Departments by law enforcement on a hold.

The purpose of inpatient psychiatric care, like other inpatient stays for other medical emergencies, is to stabilize patients so they can be transferred to the appropriate treatment setting to continue recovery. This transfer includes supportive housing options in a person's own home. For psychiatric emergencies, this can take several days or weeks, or longer. For people with complex mental illnesses and co-occurring conditions that include substance use disorders, intellectual disabilities, chronic physical illnesses, and aging-related dementia, stabilization can take even longer.

For a small number of patients, their symptoms include aggressive or self-injurious behaviors that pose a risk to personal and public safety. A court can decide that the person needs to be legally committed to psychiatric care, an action that severely limits the person's right to make decisions about the nature and location of their mental health treatment. People under commitment are treated at several large community hospitals and at state-operated psychiatric facilities. Children and adolescents are much less likely to be civilly committed, because this requires parents to relinquish their parental rights.

Providers, law enforcement, and community members have focused particular attention on this sub-population in recent years because our system does not currently have the capacity to meet their complex needs. This is similarly the case for children and youth living with serious emotional disturbance and co-occurring conditions. These conditions include but are not limited to Autism Spectrum Disorders with self-injury or aggression, mental illness with brain trauma, and mental illness and complex medical issues.⁷²

⁷² *Mental Health Acute Care Needs Report* (St. Paul: Children and Adult Mental Health Divisions, Chemical and Mental Health Services Administration, March 2009), 13.

B. Psychiatric Hospital Statistics

Forty-five Minnesota hospitals have non-forensic inpatient mental and behavioral health units for adults and children/adolescents. This includes:

- 34 community hospitals
- 7 Community Behavioral Health Hospitals (CBHHs), state-operated
- Anoka Metro Regional Treatment Center (AMRTC), state-operated
- Children and Adolescent Behavioral Health Services, state-operated
- 2 Veterans Administration hospitals, federally-operated

Including all 45 hospitals and their licensed beds reported for inpatient psychiatric capacity, there are 1,424 licensed beds for inpatient mental health treatment for adults and children/adolescents.⁷³ In reality, there are fewer than this available. AMRTC is licensed for 175 beds, but it operates at 110. At the same time, CBHHs are licensed for 16 beds but currently operate at about 10 beds each. CABHS, also licensed for 16 beds, currently operates at less than 5. In addition, community hospitals report instances of taking beds offline for security or treatment purposes.

The vast majority of hospitals treat adults, not children or youth. Eight hospitals have inpatient children/adolescent beds, while 43 have adult or adult and children/adolescent beds. Hospitals with psychiatric beds are concentrated in the metro area, particularly for children and adolescents, and regional population centers such as Willmar, St. Cloud, Rochester, and Duluth.

The Minnesota Hospital Association released a white paper in 2015 which included statistics showing average inpatient mental health occupancy rates. The Association found average occupancy rates of:

- 80 percent statewide
- 87.4 percent in the Twin Cities
- 76.6 percent in Greater MN⁷⁴

In contrast, the average occupancy rate for all conditions statewide is 40 percent.⁷⁵ The contrast is particularly apparent for children and youth. Mood disorders like depression are the top reason for all inpatient admissions for children and adolescents, including non-psychiatric conditions. The average length of stay for mood disorders is 6 days.⁷⁶

Minnesota hospital emergency department visits for mental health and substance use disorders have increased substantially from 2007-2014. Minnesota hospital emergency departments (EDs) experienced a 49 percent increase in all mental health and substance use disorder visits. For all conditions, the

⁷³ Minnesota does not have a separate license for inpatient psychiatric beds. Community hospitals treating a variety of medical conditions license all of their beds and report how many are designated for use as inpatient psychiatric beds. Stand-alone psychiatric hospitals such as AMRTC do not treat general medical conditions as a primary condition, and therefore all of their licensed beds are for inpatient psychiatric care.

⁷⁴ *Mental and Behavioral Health: Options and Opportunities for Minnesota* (St. Paul: Minnesota Hospital Association, December 2015), 9.

⁷⁵ Ibid.

⁷⁶ Ibid.

increase was 20 percent. During that period, emergency department visits in the metro increased 34 percent and 40 percent in Greater MN.⁷⁷

C. Inpatient Psychiatric Bed Shortage

There has been a great deal of attention paid to the shortage of psychiatric inpatient hospital beds in Minnesota, as evidenced by long waiting lists and other “patient flow” problems that result in people not getting access to the treatment they need at the right time and place. According to the 2009 Acute Care Needs Report, a review of the empirical research literature showed that there are not yet population-based standards for determining the right number of psychiatric inpatient beds needed to serve a certain population size, nor is there an accepted methodology for setting such standards.

“Several reports have identified specific community-based mental health services that can directly impact the utilization of inpatient psychiatric capacity. The 2008 Treatment Advocacy Center report on the shortage of public psychiatric hospital beds recommends 50 public psychiatric beds per 100,000 population. However, the report also states that the use of assertive community treatment teams, club houses and other community supports would directly decrease the number of beds needed (Torrey, et al., 2008). A 2007 National Health Policy Forum issue brief also reported that comprehensive intensive outpatient services such as assertive community treatment, mobile crisis response teams and partial hospitalization produce lower rates of hospitalizations (Salinsky, 2007). A 2006 national focus group convened by the National Association of State Mental Health Program Directors concluded that the need for public and private inpatient psychiatric beds must be evaluated in the context of the full array of care rather than an absolute “per capita” indicator independent of the rest of a state or community mental health system. (Emery, 2006).”⁷⁸

A 2008 Minnesota Medical Association report offers a number of factors contributing to “absolute and functional shortage of psychiatric beds.” These are “staff shortages, high patient acuity levels and a lack of facilities to serve individuals with both mental health and medical needs and discharge barriers such as a lack of housing with supportive services, delays in the commitment process and lack of timely access to outpatient services for medication management.”⁷⁹

Minnesota’s mental health system includes and is expanding the use of assertive community treatment (ACT) teams, mobile crisis, permanent supportive housing, and other community-based services

⁷⁷ Ibid 12, 14.

⁷⁸ *Mental Health Acute Care Needs Report*, 2. See also Torrey, E.F., et.al. (2008). *The Shortage of Public Hospital Beds for Mentally ill Persons*. Treatment Advocacy Center, Arlington, Virginia; Salinsky, E. & Loftis, C. (2007). *Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern?* Issue Brief – No. 82, August 1, 2007. National Health Policy Forum, George Washington University, Washington DC; Emery, B. (2006). *The Crisis in Acute Psychiatric Care: Report of a National Focus Group Meeting*. National Association of State Mental health Program Directors, Washington, D.C.

⁷⁹ *Acute Care Needs Report*, 3. See also Kathol, R., Sterner, S, et.al. (2008). *Psychiatric Bed/ER Diversion Task Force Report*. Commissioned by the Minnesota Medical Association.

intended to help prevent hospitalization. These services, as well as the workforce necessary to deliver them, are important to keep in mind as discussion of inpatient bed capacity progresses.

D. Patient flow – the Front and Back Doors

The concepts of “patient flow” and “front door and back door” are often mentioned when discussing inpatient hospital care for individuals living with mental illnesses, emotional disturbance, and substance use disorders. “Patient flow” refers to how people being treated for mental illnesses and often co-occurring conditions move through treatment, how they are admitted and how they are discharged. “Front door” refers to getting into a treatment setting; “back door” refers to how they are discharged.

The 2014 Plan for the Anoka Metro Regional Treatment Center summarizes the front and back door situation as follows:

“A lack of adequate community support services results in people in the target population too frequently needing a hospital level of psychiatric care. Once admitted and treated, individuals in the target population often occupy inpatient hospital beds (at AMRTC and community hospitals) even after they no longer meet the criteria for a hospital level of care because an appropriate community-based setting for them is not currently available. As a result, they remain in inpatient beds that are needed by others who *do* meet the criteria for a hospital level of care. Those people wait in inappropriate settings (jails, emergency rooms, and community hospital units) for beds to become available, often for days or weeks.

“The factors that force people to wait for access to inpatient psychiatric beds are called *front door* issues, and the factors that prevent a patient from leaving AMRTC or a community hospital at the appropriate time are called *back door* issues. Both front door and back door problems prevent people from making smooth transitions to the right care in the right place at the right time. The lack of community services underlies the failure to prevent people from needing a hospital level of care and too much demand forces people to wait (front door). The (back door) problem of people “stuck” at AMRTC and other hospitals exacerbates the front door problems and forms a serious barrier to recovery. Both problems waste scarce resources that could be better spent on appropriate care and prevention programs. Both problems are further exacerbated by inefficient legal processes, complicated eligibility and funding processes, and inadequate coordination among agencies.”⁸⁰

A recently-released study from Wilder Research on behalf of the Minnesota Hospital Association shows nearly 20 percent of inpatient psychiatric bed days in 20 community hospitals were potentially avoidable. In other words, a person on an inpatient mental or behavioral health unit who reached stability and no longer needed treatment in a hospital was not able to be discharged from the hospital because of a lack of appropriate treatment capacity. According to this pilot study, 14 percent of these potentially avoidable days were due to a patient waiting for transfer to a state-operated Community

⁸⁰ *Plan for the Anoka Metro Regional Treatment Center*, 43.

Behavioral Health Hospital. 11 percent were waiting for substance use disorder treatment. Ten percent awaited Intensive Residential Treatment Services.⁸¹

E. Roles and Responsibilities

Underlying the patient flow problems is confusion between the state, providers, counties, law enforcement, and the judiciary, among others, about the roles each plays. In particular, who is responsible for the “safety net”—the provision of services for a person whom other providers have declined to treat? While the state has historically been the safety net provider, deinstitutionalization, financial incentives, and the Olmstead decision have been driving Minnesota to a community-based care model for decades. As these changes have occurred, roles have not been clarified and confusion continues about who has the ultimate responsibility for treating individuals with the most complex and serious mental illnesses and substance use disorders. What are the expectations of community providers? What are the expectations of the state? What level of involvement should law enforcement play in responding to calls about a person in a mental health crisis? Where does the county fit into the equation? These are difficult questions to answer and they are intertwined with issues of funding and liability.

⁸¹ *Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot* (St. Paul: Wilder Foundation, July 2016), 1.

Appendix V: Crisis Response Additional Recommendations and Models

The Crisis Response Formulation Team examined several models that they felt required more research or development before they could be recommended by the Task Force. They are included here as additional options that communities or regions could consider to improve crisis response.

A. Healthcare System-based Telehealth Pools

Minnesota could support the development of telehealth resources for hospitals and urgent care settings that would be operated by the healthcare system for their affiliates. When a patient presented at a setting without dedicated resources for mental health, telehealth would be used to support the local ED in providing appropriate intervention and stabilization.

CentraCare is in process to establish telehealth for psychiatric consultation to the emergency rooms of the smaller hospitals in its system. Mental health staff would be based at St. Cloud. Hiring the needed workforce has been a challenge, especially to get 24/7 coverage. CentraCare participates in a regional planning effort, including law enforcement, county health and human services, and Central Minnesota Mental Health, the local community mental health center. They are exploring further improvements, including urgent care for mental health that would be co-located with physical urgent care.⁸²

Some key advantages to this model would be greater familiarity between host/remote staff than might be expected in a statewide system. A provider with a set territory can better learn local referral resources and collaborate better with other providers in the same health system. May be more workable in some systems than others based on how many remote sites would need coverage vs. the number of sites that already had psychiatric staff present. Drawbacks include variations in how closely hospital based services connect with county based services in some areas. This might increase regional disparities in the availability of services. Implementing hospitals would need buy in from internal stakeholders, especially at the remote sites: physicians, nurses.

The goal would be to achieve a higher standard of care for patients who present in Emergency Departments where mental health providers are not available on-site. The development timeline would primarily depend on workforce considerations. Discussions between ED staff and mental health providers do take time to build trust, rapport, and clear delineation of responsibilities. Available workforce has been identified as a significant concern. Additional funding to target student loan forgiveness could be offered. Grant support for physical and IT infrastructure might be required.

B. Children's Crisis Residential Service Development

The 2015 Legislature gave instructions for the Department of Human Services (DHS) in consultation with stakeholders to develop recommendations on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement. In June 2016, the Department of Human Services, Mental health division published an RFP to

⁸² Hartford, D. Behavioral Health Section Director, CentraCare. Correspondence. 9/1/16.

contract with a qualifying vendor to conduct a study on funding around this benefit. A vendor has been selected and the project is currently in the contracting phase.

The duties for the contract are to research and interpret best practices including researching other state's coverage for children's crisis residential services. Research will include state laws, literature search and other related research to inform policy and standards around treatment coverage such as funding, staffing, eligibility criteria and overall oversight. Research on funding models would include state Medicaid plan and private insurance, particularly on room and board to inform any research around this level of care, cost effectiveness, quality and outcomes. Conduct surveys and interview key stakeholders and providers to define problem, identify barriers and level of care needed. Facilitate and coordinate stakeholder meetings under the guidance of the children's mental health division. Identify topics for each meeting such as crisis models, target population, licensing and certification, authorization authority, review interviews and research. Submit final report of recommendation to the Department of Human Services by June, 30 2017 with a summary of research findings, meetings, interviews and other sources included.

Recommendations submitted to the department's mental health division will be used to inform establish children's mental health crisis residential services without requiring county authorization or child welfare as a new benefit with Center for Medicaid Services (CMS) approval.

C. Psychiatric Emergency Rooms

Minnesota could support the development of more capacity in psychiatric emergency rooms. This model would support for higher levels of acuity than other centralized models. One key value would be preserving the focus on a mental health response to crisis (services are provided in a dedicated healthcare setting) but still support collaboration with law enforcement (shortened timeframe for transferring a patient to care, able to support individuals with recent assaultive behavior.)

Since 1971, HCMC has operated the Acute Psychiatric Services (APS) unit. Initially designed to handle walk-in appointments and referrals from other parts of the hospital, APS has expanded services and operates a dedicated psychiatric emergency room with 14 rooms. The waiting room is recently remodeled, and is a more calming and de-escalating environment than a general ER. People without appointments present with a variety of needs, particularly medication refills if they have lost access elsewhere or are not yet established with another provider. HCMC has made the deliberate choice to use psychiatrists and other prescribing providers to perform the psychiatric evaluations, another common service. While this has costs, they see a lower rate of in-patient admission because they are able to address more potential concerns in the assessment process. Many individuals present with a "simple" evaluation, but their more complex needs emerge as they talk with the providers.

APS is capable of handling high acuity: individuals with recent assaultive behavior related to a crisis or individuals with medical needs in addition to their mental health. The presence of security personnel on site and that a portion of the APS unit is secured means that law enforcement can expect a 7-9 minute turnaround when bringing an individual to APS. Rooms for people with acute needs are physically designed for safety.

Other collaborations help address related needs. HCMC staff push into the jail, to provide higher levels of treatment than could otherwise be delivered. While APS has a fairly high intake threshold for aggressive behaviors, some individuals are most appropriately housed in a corrections setting. APS also worked with nursing homes and other community settings to readmit individuals discharged to that setting but whose needs escalate. This is helping to build trust and create more discharge options, but significant needs remain. Backups in the in-patient unit tend to push back into APS, and then the Emergency Department, which can lead to patient boarding. Director Megen Coyne identifies increased collaboration as a key priority: HCMC and connected systems have both needs and resources all over. Building trust and communication among departments and programs makes it possible to harness the right resources at the right time to deliver the best outcomes for people being served.⁸³

This model requires a significant patient volume and on-going operational funding, which likely restricts the model to urban areas. HCMC sees about two-thirds of the cost recouped by billing, a shortfall of approximately \$1 million per year. The value the psychiatric ER provides in assisting the ED and other areas of the hospital are significant, but not directly captured. Standalone “receiving centers” present much higher hurdles, including increased reliance on law enforcement if staff from other units are not available during code calls. The Medicaid rule that excludes mental health institutions with more than 16 beds from receiving Medicaid reimbursement is also a strong concern for a patient population with high rates of Medicaid eligibility. The experience of current providers also indicates that a key value of a psychiatric ER is being able to accept transfers from other units of the hospital, including the standard Emergency Department.

The goal would be to replicate and refine a model for people in crisis of moderate to high acuity, including aggressive behaviors, as an expansion of services in high-volume emergency rooms. Physical spaces would need remodeling (or construction) to make them more conducive to recovery. Funding would need to be secured, and staff hired and trained. This program would have some costs that are not directly billable to health insurance (for example, security personnel needed to ensure staff and patient safety). Depending on the people served, some portion of the services could be billed to public health programs. Hospital or healthcare systems would be needed as key partners, along with counties, MDH, DHS. Partnerships with law enforcement could help define plans for addressing security needs.

D. Zero Suicide Model

The Zero-Suicide Model links physical and behavioral health to support young people with mental health challenges. It creates a leadership-driven, safety-oriented culture committed to dramatically reduce suicide among people under care. Survivors of suicide attempts and suicide loss are included in leadership and planning roles.⁸⁴ Zero suicide is a call to relentlessly pursue a reduction in suicide and improve the care for those who seek help. The model comprises:

1. Training to develop a competent, confident and caring workforce

⁸³ Coyne, M. Senior Director, Department of Psychiatry, Hennepin County Medical Center. Correspondence. 9/29

⁸⁴ Covington, D., & Hogan, M. (2015). What is Zero Suicide? Retrieved October 12, 2016, from http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/zero_suicide_final_6.pdf

2. Systematically identifying and assessing suicide risk among people receiving care.
3. Ensuring that every individual has a pathway to care that is both timely and adequate to meet his or her needs. This includes collaborative safety planning and means restriction.
4. Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors.

E. Range Mental Health Wellstone Center⁸⁵

The RMHC Wellstone Center for Recovery is a community-based program designed to assist adults experiencing a mental health crisis or emergency. The program offers individualized services that meet the unique needs of those being served and is staffed around the clock by highly trained mental health practitioners and skilled nursing staff. Each resident has a private room. Most insurance is accepted, including Medicaid.

The program utilizes evidence-based, recovery-oriented services including:

- Individualized Assessment and Treatment
- Psychiatry Medication Management
- Onsite Diagnostic Assessment
- Onsite Alcohol and Drug Assessments (Rule 25)
- Illness Management and Recovery
- Integrated Mental Health and Substance Abuse Program
- Family Psychoeducation
- Holistic Skills Training focusing on Prevention, Wellness and Self-Care
- Discharge Planning and Referrals to ongoing/follow-up services and resources

The criteria for admission are as follows:

- Experiencing a mental health crisis
- Minnesota resident
- Between ages 18 and 65
- Medically stable
- No imminent danger to self or others
- No substantial alcohol/chemical impairment
- Comply with a medical screening
- Bring a two-week supply of prescription medications in bottles

Admissions are taken 24 hours a day, 7 days a week, 365 days a year. The Mobile Crisis Team began in September of 2014 as an additional service out of the Wellstone Crisis Stabilization Center. The mobile crisis team serves adults and children, seven days a week. The mobile crisis team provides an on-site assessment at a common entry point in the community to persons experiencing a mental health crisis.

⁸⁵ Range Mental Health Center Services. (n.d.). Retrieved October 12, 2016, from <http://rangementalhealth.org/services/>

The geographic area served is Northeastern Minnesota. This area includes Northern St. Louis County, Koochiching County, Lake County, Cook County, and within the vicinity of the three tribes including but not limited to Bois Forte and Nett Lake.

F. Beltrami County Jail Diversion Program

Funded with \$2M in one time startup grants in 2015, Beltrami County is designing programs to address the mental health needs of individuals who come into contact with law enforcement. The county is required to show sustainability for the services and provide integrated care. This funding has supported the development of an Assertive Community Treatment (ACT) team, and the hiring of a project coordinator to represent the interests of Tribal Nations in the development of new services. This project may also include the development of Intensive Residential Treatment Services (IRTS).

G. Standards for Crisis Services and Providers

Minnesota made substantial investments in the startup and operation of Mobile Crisis in 2015, and is on track to have 24/7 mobile response throughout the state by January 1, 2018. As the increased allocations are becoming effective and teams are added or expanding, disparities in service models have become more apparent. This need was anticipated in the funding language from 2015, directing the Commissioner to “establish and implement state standards for crisis services” (§245.469 Subd 3.3).

Variations in how people access the service can discourage people from calling in, and create challenges for other responders, including law enforcement. DHS has been working on this area already, and has opened a stakeholder feedback process to take a very detailed look at these issues. Key issues under discussion include:

- Standardizing expectations and criteria for dispatching mobile crisis response
- Promoting better collaboration between rural hospitals and mobile crisis teams
- Realigning standards for who may authorize a transportation hold, so that more of this work is done by mental health providers
- Improving training for crisis teams, including broader offerings from DHS

As of the completion of the taskforce report, this work is on-going. Comments or questions may be directed to Dhs.Mentalhealth@state.mn.us or 651-431-2225. Please specify that you are inquiring about the mental health crisis standards workgroup.

H. Mobile Teams and Residential Stabilization Expansion

In 2015, Minnesota invested \$8.6 million for the next biennium into improved crisis services for children and adults. This includes a charge to revise and strengthen service standards, as detailed above.

Highlights include:

- Funding to establish “one number” access. As above, this will first be done as a pilot in the metro area. Currently available technology limits our ability to accurately reroute calls from both cell phones and landlines.
- Phone based consultation for teams serving individuals in crisis who also have co-occurring intellectual disabilities or traumatic brain injuries.

- Crisis services defined as “emergency service” for the purpose of private insurance coverage. Invokes parity requirements to cover to the same degree as emergency services covered for physical conditions.

Provides start-up funding to expand crisis residential services for adults and requires DHS to develop recommendations for children’s mental health crisis residential services models that don’t require county authorization or a child welfare placement

With this funding, DHS awarded \$500,000 for start-up costs to expand Adult Residential Crisis Stabilization (RCS) statewide. These grants provide funds for start- up costs for a 6 bed RCS program in Itasca County and three new IRTS programs which will include RCS beds in Sherburne, Scott and Hennepin counties. DHS expects that the addition of these 12 beds will be completed by July 1, 2017.

I. *Connect Suicide Postvention*

Minnesota is implementing a post-suicide intervention, or “postvention” based on the *Connect* model developed by NAMI-New Hampshire.⁸⁶ This is a nationally recognized best practice by the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Suicide Prevention Resource Center (SPRC).

A suicide can have a devastating impact on a community or organization. The shock and grief can ripple throughout the community affecting friends, co-workers, schools, and faith communities. Connect postvention training helps service providers respond in a coordinated and comprehensive way in the aftermath of a suicide or any sudden death.

Since knowing someone who has died by suicide is one of the highest risk factors for suicide, postvention becomes an integral part of suicide prevention efforts. Connect has developed postvention protocols for educators, emergency medical services, faith leaders, funeral directors, law enforcement, mental health/substance abuse providers, medical examiners, coroners, military, and social service providers. The training can be customized with consultation with tribal organization.⁸⁷

Training Highlights:

- Best practices on how to coordinate a comprehensive and safe response to a suicide
- Strategies for reducing the risk of contagion
- Review of the complexity of suicide-related grief, especially for different age groups
- Recommendations for funerals and memorial activities
- Suggestions of how to talk to survivors of suicide loss to promote their healing
- Best practices for safe messaging about suicide and responding to the media
- Identification of community resources to promote healing

⁸⁶ <http://www.health.state.mn.us/injury/topic/suicide/>

⁸⁷ Reduce Suicide Risk and Promote Healing - Suicide Postvention Training. (n.d.). Retrieved October 21, 2016, from <http://theconnectprogram.org/training/reduce-suicide-risk-and-promote-healing-suicide-postvention-training>