STATE ADVISORY COUNCIL ON MENTAL HEALTH

and Subcommittee on Children's Mental Health

October 1, 2020 – 10:00am-1:00pm

Attendees:

Cecelia Hughes, Joy Johnson-Lind, Kim Stokes, Michelle Schmid-Egleston, Donna Lekander, Maleenia Mohabir, Sarah Fuerst, Tom Delaney, Elise Holmes, Addyson Moore, BraVada Akinsanya, Dawn Ammesmaki, ,Lisa Hoogheem, Jennifer Bertram, Jeff Lind, Kimberly Baker, Linda Hansen Meredith Jones, Michael Gallagher, Stephanie Podulke, Anna Lynn, Claire Courtney, Dave Lee, Alison Wolbeck, Pa Kong Lee, Jennifer Pedersen, Claudia Daml, Michael Trangle, Claudette Larson, Samantha Hedden, Sam Smith, Rodney Peterson, Rozenia Fuller, Al Levin, Angie Schmitz, Amanda Larson, Mary Kjolsing, Ashwak Hassan, Beth Prewett, David Nathan, Kim Strand, Ellie Miller, Gertrude Matemba Mutasa, Diane Medchill, Chelsea Magadance, Helen Ghebre, Tanya Carter, Kristy Graume, Courtney Iverson, Kris Manning, Tabatha Amundson, Jode Freyholtz-London, Abigail Franklin, Renee Edelhauser

Joint Meeting Minutes

Welcome, Approve Minutes, Approve Agenda

- Psychologist concerned about losing funding for mental health services for telephonic services
    - Draft letter to Governor/Legislature re: concerns related to Mental Health in time of COVID?
    - Warrants special attention because of access issue
    - Unclear when telehealth benefit expires
    - Telehealth is an incredible option for consumers
    - It is very important to make sure that folks don't wake up one day and all of a sudden they can't use telehealth. Governor made it clear that there will be at least 60 day transition. DHS is fighting for telehealth to be business going forward but this requires many approvals. Letters are fine. Gertrude to provide info in writing what the plan is. The council can use this information to draft communication with recommendations.
    - Our advocacy may need to go beyond state but to the federal level as this is a broad issue. We do need to keep in mind the scope of the council with our recommendations.
    - Send input to mhadvisory.council.dhs@state.mn.us to be included in letter

DHS Policy Proposals

- Chelsea Magadance and Kristy Graume, DHS policy bill process and our ideas for 2021 session. Two distinct legislative development processes: budget proposals and policy proposals. 2021 is a budget year but can include some policy changes as well. Trying to address the budget deficit. Currently waiting to hear back from Governor's Office about what they support moving forward. What we are sharing are just ideas at this time. *Draft language is included at end of meeting minutes.*
    - Updating State Advisory Council on Mental Health Membership
        - Update language to remove Consumer Survivor Network as a dedicated seat and replace that with "a consumer run organization." Add a seat for a

representative from the American Indian Mental Health Advisory Council, currently this is a guest seat.
        - Could we discuss adding a Peer Support Specialist seat? Yes, that would be a conversation the Council needs to have to determine if that seat is needed. It will not be included in this current proposal but could be in the future.
    - Allowing Telemedicine for Assertive Community Treatment (ACT) and Intensive Rehabilitative Mental Health Services (IRMHS) Psychiatric Care Providers
        - This would allow services for these programs to be delivered via telemedicine, making clear that psychiatric services are allowable via telemedicine.
        - Concerns from Council/Subcommittee:
            - Need to consider ways to sustain Youth ACT in a more meaningful way.
    - Improving Data Collection for Children's Mental Health Screening Grants
        - Statute currently prohibits DHS from collecting individual data. DHS wants to be able to collect individual level data so that there is follow up and can ensure care is being provided to the children identified in need of services during Children's Mental Health Screening.
        - Question about screening data:
            - What does the proposal include about storing the data and who would access it? Would be private data, not shared with public. Counties have expressed this is important to them. More efficient for DHS to collect via SSIS.
            - What has changed politically to support this? We have not heard back from Governor's office about that.
            - Are they collecting demographics? Currently only summary level data is collected, proposal wants to make this individual level so that follow up can happen.
    - Prohibiting Conversion Therapy
        - Would enable disciplinary actions against providers who use conversion therapy
- Concerns from members about proposed ideas:
    - It is culturally blinding to have an agenda moving forward that does not address the disparities based on color in mental health services
        - Response: We also have budget ideas for 2021 to talk about those ideas and they are more aligned with equity related proposals.
    - Critical to note as a person of color, when I speak of ethnic equity, it immediately changes to budget, but this is about values. Put forth the need that ethnic diversity is a priority and it is the best time for us to keep the focus on this. Need to use policy to specifically target those that are underserved. Please take this back to DHS to explicitly say this in the policies.
        - Response: DHS is open to hearing more ideas about this.

Workgroup plan Discussion

- Workgroup expectations:
    - Each member of the Council/Subcommittee will participate in at least one workgroup

  - Members self-select workgroup(s) of choice
  - Each workgroup will have an identified chair
  - Meet monthly or more often if needed
  - Submit notes from each meeting for inclusion in Council/Subcommittee meeting minutes
  - All workgroups will consider current cultural, social, whole family, and person-centered needs in all aspects of their work efforts
  - All workgroups will gather input from the community
- Please join the Outreach to Cultural Diversity Workgroup for the privilege of working on this. Each workgroup should be sending one representative to this workgroup but all are encouraged to participate. Please know that the Council and Subcommittee were ahead of things in talking about the importance of equity and inclusion and have been trying to keep this as a central focus for a long time.
- Outlook meeting invitations will go to all members and meeting information is posted on our website.
- Meeting times may change in the future if members are not able to attend an adjustments need to be made
- Non-council members may join and participate in workgroups so please share with your networks
- Direct questions to mhadvisory.council.dhs@state.mn.us

UMN Public Health Intern

- Renee Edelhauser, is completing her Master's in Public Health Administration and Policy. She will be working with State Advisory Council Chair, Dave Lee, to complete her Applied Public Health Experience internship. She will be supporting the Council/Subcommittee to development a communications and outreach plan to promote the Legislative Report as well as helping to ensure there is a structure for the workgroups to communicate with the full Council/Subcommittee to further their work. Renee may be reaching out to members with questions and ideas throughout the next several months.

Updates:

- $3 mil of CARES Act will be allotted to mental health community. Still needs to be approved but do not believe this will be a problem.
- DOC struggling with Budget issues. Moving Challenge Incarceration Program (CD Bootcamp) to different facility, COVID response has lead us to get creative in responding to needs
- Is anyone participating in the police / provider panel for autism intervention? Michelle Schmid-Egleston is and her husband who is also a case worker; Kim Baker plans to participate
- Contact Rozenia with information about how you are helping people understand the importance of the Census and Voting.
- MHLN – robust conversations about workforce. Goal to have good policy package for next session.
- Cultural ethnic provider grants need more support

- Kids Count has discussions of disparity daily. Trying to disaggregate the data in order to get the right information. The new data book will focus on families of color.

Closing, Next Steps, Next Meeting

- Check your email and respond to any action items
- Submit your vendor invoices to mhadvisory.council.dhs@state.mn.us
- Reapply to the Subcommittee on Children's Mental Health if your seat is expiring – members have been notified via email
- Submit your Member Profile to mhadvisory.council.dhs@state.mn.us
- Report – plan for communicating with key legislators and agency employees – more discussion about this during the November meeting
- RFP involvement plan next steps will be added to November agenda

Updates from state agencies:

DEED / Vocational Rehabilitation Services (VRS):

- VRS is the public vocational rehabilitation program in MN. It is a Federal program operated by the State of MN under the umbrella of the Department of Employment and Economic Development (DEED). Funding is 80% Federal with a 20% state match. Most VRS offices are in CareerForce Centers across the State. VRS staff continue to work virtually during this Pandemic as do most DEED employees who are in Telework status.
- VR reduces it's waiting list: Due to pandemic related decline in new applicants the VR program has been able to contact approximately 320 people who have been on the VRS waiting list, and virtually eliminated the current waiting list to apply for services. Please note that Categories 2, 3, and 4 will remain closed. This is called an Order of Selection (OOS) and is a requirement of the Federal regulations for VR programs when they are not able to serve all individuals with disabilities who require services. In an OOS people with the most significant disabilities are prioritized. MN's VR program has been on an order of selection for many years. This is also true for most VR programs nationally.
- IPS (Individual Placement and Support) Data Outcomes: The MN IPS Grant Program is funded by a line item appropriation from the MN State Legislators. 26 programs in MN are funded and all projects report data into an International IPS Learning community. For the last quarter data is available: April-June, the overall employment rate for the 24 states in the U.S. Across the U. S. the country as well as in MN there (April-May**). MN continues to have a high employment engagement rate compared to the other 24 states in the learning community: 56% compared to 40.6%.**
- The IPS Legislative Report is due by the end of this Calendar Year. It has been drafted and it is working its way through the agency for approval. Copies will be shared with the SACMH and Children's Subcommittee when it is published. This report is mandated to be completed every 2 years prior to the start of the 2-year budget funding cycle.
- The State Rehabilitation Council is advisory to the VRS program and mandated by Federal legislation. It produces an annual report and this report is almost finished. This report will be shared with the Council and Children's Subcommittee when it is published.

- VR Success Story: Omar Velazquez - After moving to Minnesota from central Mexico in 2014, Omar Velazquez and his Spanish-speaking family experienced many of the challenges – new language, new culture – that are common to immigrant families. Then age 14, Omar, who is deaf, had the added challenge of learning a whole new way to communicate with others. In Mexico he had communicated largely through hand gestures, modeling, and a little bit of lip-reading. In Minnesota, everything was different. He was able to enroll in the Metro Deaf School, a public charter school in St. Paul that provides a bilingual curriculum using American Sign Language (ASL) and English. By 2018, when Omar was enrolled in the school's transition program and ready to start thinking about work, he was receiving services from Vocational Rehabilitation Services and a community service provider called Career Ventures Inc. Lisa, who speaks Spanish, worked with Omar and his family to help them understand and negotiate his transition from school to work. Chris Marble, a VRS occupational communication specialist, offered communication assistance, and Maddie Eklund from Career Ventures interpreted for job interviews and provided initial on-the-job supports and training when Omar successfully applied for a position prepping and organizing in the kitchen at a local Chick-fil-A restaurant. Omar was hired in February and received job coaching funded by VRS to help him get started. He was soon furloughed because of the pandemic but was able to return to work in May and now works a couple of days a week. He's hoping to gain more work hours and is looking forward to finishing his last year of school.
- Welcoming Week: DEED participated in Welcoming Week September 12-20, a national initiative to celebrate and affirm the importance of inclusivity and connections for immigrants, refugees and long-term residents of Minnesota. The CareerForce system, with counselors and support staff available to assist people in finding jobs, is developing new ways to serve immigrants and refugees who seek professional jobs, in addition to entry-level jobs. Immigrants and refugees have been and continue to be vital to the labor force and economy in Minnesota. 80,000 foreign-born Minnesotans joined the workforce between 2010-2018—that accounts for 60% of the state's labor force growth in those years. Just over 60% of the foreign-born population are in the prime working years of 25-54, compared to just 36% of the rest of the population. Immigrants and refugees make up a large percentage of the labor force in many in-demand and critical infrastructure occupations in Minnesota. In healthcare, the service industry, agriculture and food production and more, immigrants and refugees are critically important to our state, not just as workers, but also in bringing cultural, language and artistic assets to our neighborhoods in rural, suburban and urban communities in Minnesota. Find resources on immigrants and refugees and their impact in Minnesota here.
- Drive-Thru Job Fair**:** The Duluth CareerForce held a Drive-Thru Career Fair event on September 16th. It featured 50 local employers. Nearly 200 Career Seekers drove through and each received a packet of material on jobs currently available in the area. A COVID plan was created to ensure safety and traffic safety measures were implemented.
- Breaking down digital barriers to employment: Dozens of Minnesotans who need computer and internet access to search and apply for jobs received free computer packages on September 23 from PCs for People at the CareerForce location on Lake Street in Minneapolis. A COVID plan was created to ensure safety and traffic safety measures were implemented.

- Minnesotans looking for work can make an informed choice in your career that could lead to a better match for you. You can take an interest or skills assessment on CareerForceMN.com and based on your results, see recommended career fields and specific jobs that match your interests or skills. This data can help you set career goals and map out your plan for landing the in-demand job you want. On CareerForceMN.com, you can see daily tasks, wage information and short videos about occupations that interest you.
- Data for Workforce Development In order to help people know which jobs are in demand now, and are likely to be in demand for the foreseeable future, DEED's Labor Market Information (LMI) Office does weekly analysis of jobs posted in Minnesota. LMI does this by analyzing new listings in the state on the National Labor Exchange (NLx). LMI share this information in a public way on the Jobs in Demand page on CareerForceMN.com – where any Minnesotan can see a regularly updated list of the top 30 jobs in demand in the state. LMI also keeps an eye on other data that shows demand for workers in Minnesota. Monthly employer surveys through the Current Employment Statistics (CES) program of the Bureau of Labor Statistics provide monthly snapshots of job gains and losses by industry sectors. For example, CES let us know that Minnesota regained 40,500 jobs in August across many industries, though most are still down compared to pre-pandemic levels. Twice a year, LMI conducts a Job Vacancy Survey of Minnesota employers to gauge hiring demand and show which occupations have the most vacancies – and which are the hardest to fill.

DHS:

- Currently in process of interviewing for Behavioral Health Division director.

Department of Corrections (DOC):

- No updates submitted this month

MDH:

- The UMN LEND program has joined with other national partners in Project SCOPE: Supporting Children of the Opioid Epidemic. The project is a national training initiative intended to build nationwide provider capacity and confidence in applying evidence-based practices in screening, monitoring, and interdisciplinary support for children and families diagnosed with Neonatal Abstinence Syndrome (NAS), Neonatal Opioid Withdrawal Syndrome (NOWS), or who are suspected of being impacted by opioid use, trauma, or related exposure. MDH will be partnering with UMN in the training and in an advisory capacity.
- Suicide Prevention: A community conversation series with SAVE will create space to learn about and discuss suicide prevention best practices and topics. Each event will be about one hour long. The conversation will begin with suicide prevention expert, Dr. Dan Reidenberg from SAVE, providing a 15-20 minute overview of the suicide prevention topic. The overview includes general information, best practices, and practical tips. Participants will then be invited to join a moderated discussion on the topic and share their experiences or tips on suicide prevention. Register – Suicide/Sudden Death Postvention Planning – October 20 at 9:00 a.m. CT

Minnesota Housing Finance Agency (MHFA):

- No updates submitted this month

STATE ADVISORY COUNCIL ON MENTAL HEALTH

and Subcommittee on Children's Mental Health

Next Meeting:

Date:	November 5, 2020
Time:	10:00am-1:00pm
Location:	WebEx Only

Reminder:

More information about the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health, including meeting minutes, reports, and membership lists, can be found online: https://mn.gov/dhs/mh-advisory-council/

Draft Language for CS-01: Membership Modifications to the State Advisory Council on Mental Health

Sec. X. Minnesota Statutes 2020, section 245.697, subdivision 1, is amended to read:

Subdivision 1. Creation.
(a) A State Advisory Council on Mental Health is created. The council must have members appointed by the governor in accordance with federal requirements. In making the appointments, the governor shall consider appropriate representation of communities of color. The council must be composed of:
(1) the assistant commissioner of mental health for the department of human services;
(2) a representative of the Department of Human Services responsible for the medical assistance program;
(3) one member of each of the following professions:
(i) psychiatry;
(ii) psychology;
(iii) social work;
(iv) nursing;
(v) marriage and family therapy; and
(vi) professional clinical counseling;
(4) one representative from each of the following advocacy groups: Mental Health Association of Minnesota, NAMI-MN, ~~Mental Health Consumer/Survivor Network of Minnesota, and~~ Minnesota Disability Law Center, American Indian Mental Health Advisory council, and a consumer-run mental health advocacy group;
(5) providers of mental health services;
(6) consumers of mental health services;
(7) family members of persons with mental illnesses;
(8) legislators;
(9) social service agency directors;
(10) county commissioners; and
(11) other members reflecting a broad range of community interests, including family physicians, or members as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor.
(b) The council shall select a chair. Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. Notwithstanding provisions of section 15.059, the council and its subcommittee on children's mental health do not expire. The commissioner of human services shall provide staff support and supplies to the council.

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Draft Language for Prohibiting Conversion Therapy

Sec. X. Minnesota Statutes 2020, chapter 214 is amended by adding a section to read:

Section 1. [214.078] PROTECTION FROM CONVERSION THERAPY.
Subdivision 1. Definition. "Conversion therapy" means any practice by a mental health practitioner or mental health professional as defined in section 245.462 that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender. Conversion therapy does not include counseling that provides assistance to an individual undergoing gender transition, or counseling that provides acceptance, support, and understanding of an individual or facilitates an individual's coping, social support, and identity exploration and development, including sexual-orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, as long as the counseling does not seek to change an individual's sexual orientation or gender identity.
Subd. 2. Prohibition. (a) No mental health practitioner or mental health professional shall engage in conversion therapy with a client younger than 18 years of age or with a vulnerable adult as defined in section 626.5572, subdivision 21.
(b) Conversion therapy attempted by a mental health practitioner or mental health professional with a client younger than 18 years of age or with vulnerable adults shall be considered unprofessional conduct and the mental health practitioner or mental health professional may be subject to disciplinary action by the licensing board of the mental health practitioner or mental health professional.

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

Sec. X. Minnesota Statutes 2020, section 256B.0625 is amended by adding a subdivision to read:

Subd. 5n. Conversion therapy. Conversion therapy, as defined in section 214.078, is not covered.

Sec. X. Minnesota Statutes 2020, section 325F.69 is amended by adding a subdivision to read:

Subd. 7. Advertisement and sales; misrepresentation of conversion therapy. No person or entity shall, while conducting any trade or commerce, use or employ any fraud, false pretense, false promise, false guarantee, misrepresentation, false or misleading statements, or deceptive practice when advertising or otherwise offering conversion therapy services. For purposes of this subdivision, "conversion therapy" means services or products that are intended to change an individual's sexual orientation or gender identity, including efforts to change behaviors and gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender.

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Draft Language for CS-05: Improving Data Collection for Children's Mental Health Screening Grants

Sec. X. Minnesota Statutes 2020, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. Duties of county board.
(a) The county board must:
(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;
(2) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;
(3) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;
(4) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;
(5) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;
(6) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;
(7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;
(8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;
(9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;
(10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;
(11) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and
(12) consistent with section 245.486, arrange for or provide a children's mental health screening for:
(i) a child receiving child protective services;
(ii) a child in out-of-home placement;
(iii) a child for whom parental rights have been terminated;
(iv) a child found to be delinquent; or
(v) a child found to have committed a juvenile petty offense for the third or subsequent time.
A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.
(b) When a child is receiving protective services or is in out-of-home placement, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

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(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.
(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:
(1) training in the administration of the instrument;
(2) the interpretation of its validity given the child's current circumstances;
(3) the state and federal data practices laws and confidentiality standards;
(4) the parental consent requirement; and
(5) providing respect for families and cultural values.
If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data. ~~and the commissioner shall not collect individual screening results.~~ The commissioner may collect individual screening results for the purposes of program evaluation and improvement.
(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

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Draft Language for CS-04: ACT and IRMHS Telemedicine Modifications

Sec. X. Minnesota Statutes 2020, section 256B.0622, subdivision 7a, is amended to read:

(a) The required treatment staff qualifications and roles for an ACT team are:
(1) the team leader:
(i) shall be a licensed mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role but must obtain full licensure within 24 months of assuming the role of team leader;
(ii) must be an active member of the ACT team and provide some direct services to clients;
(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team, providing clinical oversight of services in conjunction with the psychiatrist or psychiatric care provider, and supervising team members to ensure delivery of best and ethical practices; and
(iv) must be available to provide overall clinical oversight to the ACT team after regular business hours and on weekends and holidays. The team leader may delegate this duty to another qualified member of the ACT team;
(2) the psychiatric care provider:
(i) must be a licensed psychiatrist certified by the American Board of Psychiatry and Neurology or eligible for board certification or certified by the American Osteopathic Board of Neurology and Psychiatry or eligible for board certification, or a psychiatric nurse who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;
(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide clinical supervision to the team;
(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;
(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;
(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role;
(vi) ~~may not provide specific roles and responsibilities by telemedicine unless approved by the commissioner; and~~ psychiatric care provider services may be provided by telemedicine when necessary to ensure both the

continuation of psychiatric and medication services availability for clients, as well as to maintain statutory requirements for psychiatric care provider staffing levels.

(vii) shall provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider;

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) should not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent mental health certified peer specialist as defined in section 256B.0615. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

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(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and
(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;
(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and
(8) additional staff:
(i) shall be based on team size. Additional treatment team staff may include licensed mental health professionals as defined in Minnesota Rules, part 9505.0371, subpart 5, item A; mental health practitioners as defined in section 245.462, subdivision 17; a mental health practitioner working as a clinical trainee according to Minnesota Rules, part 9505.0371, subpart 5, item C; or mental health rehabilitation workers as defined in section 256B.0623, subdivision 5, paragraph (a), clause (4). These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and
(ii) shall be selected based on specific program needs or the population served.
(b) Each ACT team must clearly document schedules for all ACT team members.
(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.
(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.
(e) Each ACT team member must fulfill training requirements established by the commissioner.

Sec. X. Minnesota Statutes 2020, section 256B.0947, subdivision 6, is amended to read:

The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.
(a) The treatment team shall use team treatment, not an individual treatment model.
(b) Services must be available at times that meet client needs.
(c) The initial functional assessment must be completed within ten days of intake and updated at least every three months or prior to discharge from the service, whichever comes first.
(d) An individual treatment plan must be completed for each client, according to criteria specified in section 256B.0943, subdivision 6, paragraph (b), clause (2), and, additionally, must:
(1) be completed in consultation with the client's current therapist and key providers and provide for ongoing consultation with the client's current therapist to ensure therapeutic continuity and to facilitate the client's return to the community;
(2) if a need for substance use disorder treatment is indicated by validated assessment:

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(i) identify goals, objectives, and strategies of substance use disorder treatment; develop a schedule for accomplishing treatment goals and objectives; and identify the individuals responsible for providing treatment services and supports;
(ii) be reviewed at least once every 90 days and revised, if necessary;
(3) be signed by the clinical supervisor and by the client and, if the client is a minor, by the client's parent or other person authorized by statute to consent to mental health treatment and substance use disorder treatment for the client; and
(4) provide for the client's transition out of intensive nonresidential rehabilitative mental health services by defining the team's actions to assist the client and subsequent providers in the transition to less intensive or "stepped down" services.
(e) The treatment team shall actively and assertively engage the client's family members and significant others by establishing communication and collaboration with the family and significant others and educating the family and significant others about the client's mental illness, symptom management, and the family's role in treatment, unless the team knows or has reason to suspect that the client has suffered or faces a threat of suffering any physical or mental injury, abuse, or neglect from a family member or significant other.
(f) For a client age 18 or older, the treatment team may disclose to a family member, other relative, or a close personal friend of the client, or other person identified by the client, the protected health information directly relevant to such person's involvement with the client's care, as provided in Code of Federal Regulations, title 45, part 164.502(b). If the client is present, the treatment team shall obtain the client's agreement, provide the client with an opportunity to object, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the client does not object. If the client is not present or is unable, by incapacity or emergency circumstances, to agree or object, the treatment team may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the client and, if so, disclose only the protected health information that is directly relevant to the family member's, relative's, friend's, or client-identified person's involvement with the client's health care. The client may orally agree or object to the disclosure and may prohibit or restrict disclosure to specific individuals.
(g) The treatment team shall provide interventions to promote positive interpersonal relationships.
(h) The services and responsibilities of the psychiatric provider may be provided through telemedicine when necessary to prevent disruption in client services or to maintain the required psychiatric staffing level.

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