DEPARTMENT OF HUMAN SERVICES
DIRECT CARE AND TREATMENT

Priority Admission Task Force Member Recommendations

Part Three: Options for Providing Treatment

Question 3: What are your recommended options for providing treatment to individuals referred according to the priority admissions required under Minnesota Statutes, section 253B.10, subdivision 1, paragraph (b), and other individuals in the community who require treatment at state-operated treatment programs?

Treatment within State-Operated Treatment Programs

Funding

A. Consider additional funding to hospitals with patients on a waitlist to mirror support the patient would receive in a state hospital setting.
B. Fund state-operated programs to provide services in the community, such as through consultative teams, outpatient care, and intensive case management.
C. Build additional facilities to address treatment needs and provide incentives to ensure there are staff to meet the increased needs.
D. Increase the number of state-operated treatment programs.
E. Expand IRTS to offer additional sites across Minnesota.

Staffing

A. More appropriately trained staff to help ensure that people who work in these places can work to the top of their license.
B. Improve programming at state hospitals, including increased staff, training, pay, and security.

Legislation

A. Decisions should be made by DCT medical staff and not governed by a specific rule that prioritizes one group of people over another.
B. Allow medical discretion in determining which patients should be admitted to a state facility in which order to best meet needs.
C. Change language requiring admission to a state-operated treatment facility, instead using a more person-centered approach that contemplates the person's individualized needs for treatment and supports and where those needs could reasonably best be met.
D. Allow state programs to promptly discharge those in care when it is clinically appropriate to do so.
E. Eliminate the current language of the priority admissions rule to ensure community treatment standards are met and hospitalization is based upon the clinical judgment of a physician or a licensed mental health professional.

F. Allow those committed as MI&D to be revoked to settings outside of the Forensic Mental Health Program (in St. Peter).

Other

A. Ensure those in state-operated treatment programs need to be there and that they are discharged as soon as they no longer need treatment.
B. Provide mental health services to security at state-operated services, local hospitals, community security, police, etc.
C. Reimagine the current state-operated systems to addresses the heterogeneous population living with mental health disorders.
D. Address the gap in assessments where those who do not meet criteria for mentally ill and dangerous are deemed not sick enough for state-operated services and are released back into the community.
E. Prioritize referrals by identifying those individuals requiring immediate intervention and placement, rather than basing decisions on whether they are incarcerated, committed, and/or deemed unfit to stand trial.
F. Targeted expansion of Direct Care and Treatment settings designed to promote discharge to the community for individuals currently at AMRTC and/or FMHP who no longer meet medical necessity.
G. Look into Medicare how policies and practices complicate discharge from state-operated services.
H. Create centralized triage, criteria for general prioritization, while retaining capacity to make individual decisions based on individual area needs.
I. More step-down spaces that are less institutional then AMRTC but are not just releasing folks back into the same place they were before, encourage flow in the system.
J. Collect data on the number of people waiting or never assessed.

Treatment within Jails

A. Provide basic mental health training for corrections employees.
B. Improve the type of treatment provided in the jails by working with community mental health centers and DHS.
C. Incorporate workforce strategies that address the need for staff to be mentally and physically well to take care of patients and address burnout as well as support services for both jail services and medical staff.
D. Improve access to mental health care for people while they are in jails.

Treatment within Community-Based Settings

A. Partner with hospitals to provide increased services in a community-based setting.
B. Improve long-term community placements/resources to help solve the throughput problem for state-operated and all hospital/ER programs.
C. Incentivize programs/hospitals/jails to provide competency attainment services.
D. Fund counties or regions to support community-based treatment and settings.
E. Community-based planning should occur through enhanced funding and support of the regional Adult Mental Health Initiative structures.

F. Community hospitals should be financially incentivized to have mental health beds or provide psychiatric treatment in the emergency department.

Treatment within non-DCT Hospitals and Programs

A. Develop a plan to eliminate county-based treatment financing for individuals living with mental health disorders including substance use disorders.
B. Fund programs in other settings to provide competency attainment services.
C. Expand chemical dependency treatment in the conversation and context of psychiatry.
D. Increase ability to share information across all partners involved in the mental health care system.

Prevention and Early Intervention

A. Incorporate prevention by allocating more time for exercise during the school day, starting in grade school and continuing through high school, as exercise has been identified to be as effective as a pharmaceutical treatment of depression and anxiety.
B. Provide community education on mental health and when to seek treatment. This could assist with preventing mental health issues from progressing to the ER.
C. Fund voluntary engagement services designed to get people the help they need to avoid incarceration or hospitalization.
D. Provide police with on-call mental health professionals who have been trained in tactical response to handle themselves in dangerous situations. Both St. Paul and Minneapolis police departments have mental health crisis response teams. By studying these programs, we can develop better plans to create response teams around the state to help other jurisdictions.

Treatment Professionals

A. Pay direct care providers a livable wage and provide adequate training and emotional support.
B. Identify students who are interested in mental health or medical training and use the PSEO program to expedite their graduation.

Other Treatment Recommendations

A. Obtain broad understanding and acceptance from the community to prioritize mental health care of both the patient and the employee.
B. Incentivize the development of a public/private partnership to create a treatment facility with multiple stages of security management so justice-involved individuals are confined to a program with the least restrictions based upon their clinical needs.
C. Reserve civil commitment for those who are incompetent and unlikely to be restored in the foreseeable future. That way most individuals will be guided toward the new competency attainment process and resources allocated therein.