STATE ADVISORY COUNCIL ON MENTAL HEALTH
and Subcommittee on Children's Mental Health

STATE ADVISORY COUNCIL ON MENTAL HEALTH SUBCOMMITTEE ON CHILDREN'S MENTAL HEALTH

2020 Report to the Governor and Legislature

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $4000.00

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Contents

EXECUTIVE SUMMARY

The State Advisory Council on Mental Health was established in 1987 under Minnesota Statute 245.697 and the Subcommittee on Children's Mental Health in 1989[1]. Members for both the Council and Subcommittee include individuals with lived experience of mental illness, parents and family members of those with mental illness, county commissioners, social service directors, advocacy organizations, educators, psychiatrists, psychologists, social workers, community corrections, legislators, and representatives of state agencies. The Governor appoints members to the State Advisory Council on Mental Health. Members of the Subcommittee on Children's Mental Health are appointed by the chair of the State Advisory Council on Mental Health.

Per statute, the Council and Subcommittee are charged with:

- Advising the Governor and heads of state departments and agencies about policy, programs, and services affecting people with mental illness
- Advising the Commissioner of Human Services on all phases of the development of mental health aspects of the biennial budget
- Advising the Governor about the development of innovative mechanisms for providing and financing services to people with mental illness
- Encouraging state departments and other agencies to conduct needed research in the field of mental health
- Educating the public about mental illness and the needs and potential of people with mental illness
- Reviewing and commenting on all grants dealing with mental health and on the development and implementation of state and local mental health plans
- Coordinating the work of local children's and adult mental health advisory councils and subcommittees

The 2020 Report to the Governor and Legislature provides recommendations from the members of the State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health. The Council and Subcommittee are dedicated to improving mental health services for **ALL** Minnesotans. Members considered current social, cultural, whole family, and person-centered needs when developing these important recommendations.

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health highly encourage that the Governor and the Legislature focus on the areas discussed in this report in order to improve the mental health system and continuum of care in Minnesota. Recommendations are as follows:

- Top Priority: Make no budgetary cuts to the mental health system in Minnesota
- Allocate permanent per pupil funding for specialized instructional support personnel and de-escalation/crisis response training
- Define Comprehensive School Mental Health Systems (CSMHS)
- Create Social Emotional Learning standards
- Create a loan forgiveness pilot program to Enhance the Representation of Black, Indigenous, Person of Color (BIPOC) Mental Health Professionals
- Develop a Minnesota strategy for the creation of an interoperable public/private telepresence platform

- Ensure parity between mental health / substance use disorder and medical care
- Allocate resources to support Local Mental Health Advisory Councils
- Ensure Local Mental Health Advisory Council involvement in the Adult Mental Health Grant application process
- Develop a taskforce to develop an enhanced rate for treatment of highly acute youth in corrections or mental health treatment settings
- Create grant program to reduce residential care recidivism rates for Minnesota youth
- Increase access to affordable housing across Minnesota
- Increase employment support for individuals with mental health barriers to employment

In addition to the recommendations in this report, you will find successes since the 2018 report as well as recent published communications to Governor Walz, the Minnesota State Legislature, and Commissioners of various MN State Agencies recommending actions that required immediate attention. These publications include the importance of developing an interoperable telemedicine platform and expanding school mental health services beyond the school year.

TOP PRIORITY

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health recognize the significant uncertainty that faces Governor Walz, the Legislature, and Minnesota state agencies in the 2021 legislative session. We understand Minnesota is facing a major budget deficit and the tough decisions that attend such financial challenges. However, Minnesota's mental health system was underfunded and underdeveloped before the COVID-19 pandemic. Many desperately needed investments will have to wait for a better financial outlook for Minnesota's budget, but that does not mean that leaders should look to the mental health system for cost savings.

The COVID-19 Pandemic continues to increase the demands upon a mental health system that is already overextended. Medical Assistance rates are not sufficient to sustain our community mental health programs, while private payers are still not adequately following mental health parity regulations. Mental Health Grant programs are currently underfunded and support highly effective programs like school-linked mental health, mobile crisis teams, and programs that support people to transition out of very expensive care at state-operated programs.

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health urge leaders across Minnesota Government to look elsewhere as cuts to government prove to be necessary. Cutting funding for mental health services will not reduce the need for mental health care and, when folks fall through the cracks, they will likely require more expensive treatment in a hospital or state-operated program. Any funding cuts to mental health services would increase already present disparities in accessing vital mental health services. Please do not make any budgetary cuts to our already overburdened mental health system.

RECOMMENDATIONS

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health have organized their recommendations in the following categories:

- Mental Health and Schools
- Integrated Care and Access
- Local Advisory Council
- Mental Health and Juvenile Justice
- Recovery Supports

Mental Health and Schools

Permanent per pupil allocation for specialized instructional support personnel and training

There is currently no permanent per pupil allocation for specialized instructional support personnel such as licensed school social workers, school psychologists, school counselors and school nurses) or funding to train said personnel on how to de-escalate and respond to a student experiencing a mental health crisis. Schools are often the first line of defense in addressing the mental health needs of students, but a lack of funding undermines and prevents schools from providing these crucial mental health services. Expanding our investment in mental health services in schools will help ensure greater student success.

Approximately 80% of children and adolescents with mental health diagnoses have unmet mental health needs. Minnesota students increasingly report experiencing mental health problems that affect their lives. In 2019, 82% of regular public school districts participated in the Minnesota Student Survey (MSS). The MSS asks students, "Over the last two weeks, how often have you been bothered by: 1) Little interest or pleasure in doing things, 2) Feeling down, depressed or hopeless, 3) Feeling nervous, anxious or on edge, 4) Not being able to stop or control worrying." More than one-third of students who answered affirmatively to an emotional distress question answered yes to at least one question. Nearly one-fourth of students who answered affirmatively to an emotional distress question answered yes to all four questions. Students of color experience mental health distress at higher rates relative to their peers; and, students who identify as LGBTQ are nearly twice as likely to report mental health concerns as students who do not identify as LGBTQ.[2]

There is a tremendous need for additional specialized instructional support personnel to support students with mental health concerns. Ratios of specialized instructional support personnel (i.e. licensed school social workers, school psychologists, school counselors and school nurses) to students in Minnesota do not meet the national recommendations by their respective professional associations, with the exception of school nurses.

Minnesota Ratio	Position Title	Recommended Ratio
1:407	Social Worker	1:250
1:754	School Psychologist	1:500-1:700
1:654	School Counselor	1:250
1:695	School Nurse	1:750

Recommendation:

- Designate a permanent per pupil allocation to hire specialized instructional support personnel including but not limited to licensed school social workers, school psychologists, school counselors and school nurses in schools.
- Provide training to all school personnel so they may provide de-escalation and crisis response support to students who are in crisis.

Comprehensive school mental health systems (CSMHS)

Comprehensive school mental health systems is NOT currently cited in Minnesota statute. It is necessary to define a comprehensive school mental health system in order to align with related legislation and state statutes (e.g. PBIS, SEL, school-linked mental health grants, etc.). Defining comprehensive school mental health will ensure consistency in state and local school district implementation.

Recommendation:

- The Minnesota Department of Education in cooperation with the Minnesota Department of Human Services and the Minnesota Department of Health define comprehensive school mental health systems (CSMHS) in statute and provide implementation guidelines for all schools in Minnesota.*
- Provide a 25% funding carve-out that requires school districts with School-Linked Mental Health services to contract with culturally specific mental health organizations/providers to render culturally congruent services to children, youth, and families.

*Example definition – Comprehensive School Mental Health Systems (CSMHS) are defined as school district-community partnerships that provide a continuum of mental health services to support students, families and the school community. CSMHS provide a full array of supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness. Core features of a CSMHS include: 1) Well-trained educators and specialized instructional support personnel; 2) Family-School-Community Collaboration and teaming; 3) Access to school-linked mental health services; 4) Comprehensive suicide prevention strategy; 5) Needs assessment and resource mapping; 6) Multi-tiered system of support; 7) Mental health screening; 8) Culturally responsive evidence-based

and emerging best practices; 9) Data and data driven decision-making; 10) Funding and sustainability. It is important to note that consultation with Tribal Governments needs to occur when developing a CSMHS to ensure Tribal Schools and Native Immersion Programs have access to mental health services and supports while recognizing their sovereignty.

Social Emotional Learning standards

Minnesota Statute 121A.031, Minnesota's bullying prevention law, requires schools to implement evidence-based Social-Emotional Learning (SEL) practices but few schools do so due to ambiguous language[3]. SEL requirements are embedded in Subd. 5 Safe and supportive schools programming, which is a paragraph that uses the terms "encouraged" and "upon request." There currently is limited educator pre-service or in-service preparation programs and licensure requirements to reflect the knowledge base and competencies required to support students' comprehensive development.

By clarifying SEL requirements in statute, Minnesota would increase the number of schools implementing SEL and increase fidelity of implementation in order to address the comprehensive learning needs of all students. In addition, the existing Positive Behavioral Intervention and Supports (PBIS) program would be enhanced by implementing SEL standards in all schools.

Recommendation:

- Create state standards for social-emotional learning
- Require school districts to adopt the state social-emotional learning standards
- Simplify the language in Minnesota Statute 121A.031, Subdivision 5 to reduce confusion and edit Subdivision 5 (b) (1) to emphasize SEL
- Add two new responsibilities for the commissioner in Minnesota Statute 121A.031, Subdivision 6: create a sustainability strategy ensuring MDE supports SEL implementation and adopt MDE's SEL competencies as state standards.

Integrated Care and Access

Loan Forgiveness Program for Black, Indigenous, Person of Color (BIPOC) Mental Health Professionals

A shortage of mental health professionals of color exists in agencies that serve diverse communities throughout Minnesota. A State Loan Forgiveness Program[4] already exists in communities where there is an identified shortage of mental health professionals. These shortage areas are most often found in rural areas; however, there is also a significant shortage of mental health professionals that identify as BIPOC in mental health agencies that serve communities of color. Agencies that fall under this category are located in rural Minnesota as well as the Twin Cities metropolitan area. In particular, non-profit organizations who often have an embedded mission of serving marginalized communities have historically had difficulty attracting and maintaining licensed professionals; they have fewer resources and are unable to provide the same level of financial incentives that private, for-profit organizations offer.

There is legislative precedence of changes to the designation of a shortage area related to diversity. In 2017, the MN Loan Forgiveness Program for Teachers was expanded to designate shortage areas as regions where there was a shortage of teachers that reflect the racial/ethnic diversity of the students in the region.

By implementing a loan forgiveness program, we expect to see an increase in professionals of color in mental health agencies that serve diverse clientele. Mental health agencies will be more representative of the communities that they serve

Recommendation:

- Create a 3 year loan forgiveness pilot program to attract and incentivize BIPOC mental health professionals to work in non-profit agencies that are striving to increase and retain diversity in their professional representation in order to provide the best care possible within their community
- Allocate $3 million to the current loan forgiveness program managed by MDH
- Set aside these funds specifically for the BIPOC Mental Health Professionals Pilot Program
    - Participants in the Pilot Program must hold a current license to practice mental health in the State of Minnesota and may reapply for the program on a yearly basis for a maximum of three years.*
    - Qualifying agencies must be non-profit entities and demonstrate a significant discrepancy between the number of mental health providers that identify as BIPOC staff and the racial/ethnic makeup of their client base and underserved populations in their community.
    - Efficacy of the Pilot Program will be reviewed at the end of the three years.
- If the pilot program is successful, the State should adopt it into their regular legislative expenditures as they would other State Loan Forgiveness programs

*Mirroring the current expectations of the Health Professional Loan Forgiveness program, full-time (at least 32-hours per week) mental health professionals will be eligible to receive 15 percent of what the average educational debt load **is** for graduates in their profession on an annual basis. The award amount cannot exceed the participant's loan balance. Candidates must work at the agency for a full year and funds will be distributed once they reach their anniversary date. There will be no pro-rating for leaves or voluntary/involuntary termination of employment.

Minnesota strategy for an interoperable public/private telepresence platform

Telepresence can increase access to culturally appropriate services across the state by increasing the reach and utilization of limited resources. Telepresence can increase access to services for Minnesotan's of all ages, from children receiving tele-mental health support in schools to isolated older adults receiving services and support in their homes. Work force shortages impacts health equity. Telepresence can maximize use of existing workforce capacity by reducing windshield time for both clients and providers, reducing or eliminating lost time due to cancelled appointments caused by weather or transportation barriers, and providing access to services in homes and community-based settings across the state. Telepresence supports person-centered care, regardless of where in the state an individual may reside.

The DHS/MNIT owned-and-operated telepresence network provides secure, encrypted, HIPAA compliant connections to over 6000 users –which include Minnesota Tribal Nations, counties, law enforcement, courts, schools, mental health providers, other human service agencies, and those they serve. In order to continue to

serve our communities and provide these critical services we need to ensure this telepresence platform is strong and able to withstand the continually and rapidly increasing number of users as well as allow for interoperability between all users of the system.

An Interoperable telepresence platform allows providers of services to rapidly communicate, integrate and innovate across disciplines, geographic barriers and other silos that currently prevent the delivery of high quality, person-centered behavioral health services throughout Minnesota. The goal is to quickly evaluate options then leverage the State of Minnesota purchasing power to implement a cost effective, interoperable telepresence platform for all interested Minnesota providers and agencies.

Creating a single, inter-operable, secure, low-cost statewide telepresence network will increase access to services and support for Minnesotans of all ages, all races and all ethnicities in all areas of the state, including Tribes, remote rural regions and under-served urban areas.

Recommendation:

- Develop a Minnesota strategy for the creation of an interoperable public/private telepresence platform that allows connections between providers of behavioral health services and other services
- Allow telemedicine visits for mental health and substance use disorder treatment, including telephone calls, to be reimbursed on par for face to face visits
- Ensure all Minnesotans have internet access and the devices needed (tablets/smartphones) to access telemedicine services

Ensure parity between mental health/substance use disorder care and medical care

Parity between medical and mental health/substance use disorder care is lacking in Minnesota. Parity means equal treatment of mental health conditions, substance use disorders, and physical health conditions on private insurance plans and public insurance programs (Medical Assistance). This includes access to treatment and payment for services. Traditionally most people diagnosed with Substance Use Disorders never start treatment and even if they do, many drop out before they really are engaged in treatment. Commerce needs to analyze health plan data and ensure that they improve their results until engagement in treatment are as good as for chronic medical illnesses.

Recommendation:

- Commerce will ensure that there is parity between medical and mental health/substance use disorder care
- Health plans and DHS (Fee for Service Medical Assistance patients) submit analyzed quarterly data, disaggregated by race, ethnicity, and geographic region to the relevant state agency. Data includes:
    - The average # of days it takes new patients to access a new appointment/service (defined as starting with the day the request for an initial appointment/service to the day the first appointment/service occurs). Subdivide this data into a few categories:
        - Access to a psychiatrically trained prescriber (includes psychiatrists and psychiatrically trained nurse practitioners, physician assistants, and clinical nurse specialists)

categorized by: Adults 18 years and older, Children/Adolescents up to but not including 18 years of age
        - Access to a psychotherapist (to include all types that are reimbursed by public and private payers) subdivided by: Adults 18 years and older, Children/Adolescents up to but not including 18 years of age
    - Access to licensed and staffed psychiatric beds so it meets demand as measured by number and percentage of patients waiting more than 8 hours for psychiatric admission from Emergency Departments, medical/surgical units, and home
    - Integration of Behavioral Health and primary care documented by use of the best practice collaborative care model as measured by increased utilization of the following CPT codes:
        - 99492
        - 99493
        - 99494
        - 99484 (used for most clinics)
        - G0512 and G0511 (for Federally Qualified Health Centers and Rural Health Clinics)
        - Note: Increased utilization will be documented by reviewing quarterly the total number of such codes billed and the percentage such codes represent of the total outpatient codes billed by the health plan/Medical Assistance
    - Compare the percentage of mental health members to medical/surgical members for: the percentage who need to request prior authorizations; percentage of visits/services denied; percentage who appeal denials; percentage of appeals overturned
    - Access and engagement in Substance Use Disorder Treatment (NQF Measure 0004) as measured by:
        - The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis
        - The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit

Local Advisory Council

Resources to Support Local Mental Health Advisory Councils

The Adult and Children's Mental Health Acts of 1987 and 1989 requires counties to establish Local Mental Health Advisory Councils (LAC)[5]. LACs offer individuals with a lived experience of mental illness, parents, families, and providers the opportunity to make a difference in their community's mental health system. Despite legislation requiring counties to have LACs addressing both the adult and children's mental health systems, some counties have not established LACs to serve their communities.

Minnesota Statute 245.697 states that one of the roles of the State Advisory Council on Mental Health is to coordinate the work of local children's and adult mental health advisory councils and subcommittees[1]. The State Advisory Council on Mental Health does not have the resources available to appropriately fulfill this responsibility.

In previous years, DHS has funded an organization to work with LACs, however that effort was not coordinated with the State Advisory Council on Mental Health and the deliverables of those contracts were not adequate to assist with this duty. Currently, DHS has not contracted with an organization, nor have they dedicated DHS staff, to provide training, coordination, or technical assistance to LACs or counties looking to establish mental health advisory councils.

Recommendation:

- DHS dedicate FTE to coordinate, train, and support LACs across the state
- DHS continuously collaborate with the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health in all efforts to support LACs

Local Mental Health Advisory Council Involvement in Adult Mental Health Grants

Local Mental Health Advisory Councils should be playing an important advisory role to counties. The main purpose of their existence is to give county leaders an opportunity to hear recommendations about their local mental health systems. DHS requires counties to provide information about their unmet needs for the adult mental health grant legislative report. This is not an adequate level of inquiry into how LACs participate and communicate with counties.

Recommendation:

- DHS add the following question to ALL County Mental Health Grant Applications: "Identify how Local Mental Health Advisory Councils were involved in developing, implementing and evaluating this grant plan. Describe how Local Mental Health Advisory Councils provided input or comment on the grant plan." Where applicable, "Describe how Tribal governments were included in the planning process."*
- DHS coordinate with the Local Advisory Council Workgroup of the State Advisory Council on Mental Health to implement this and similar questions into future mental health grant applications.

*While working with Tribes, recognize their sovereignty and right to act according to Tribal law.

Mental Health and Juvenile Justice

Enhanced rate for treatment of highly acute youth

Many youth with significant aggressive behaviors or highly acute symptoms are denied admission to appropriate mental health treatment facilities in Minnesota due to these facilities being unable to provide adequate staffing to support youth with high levels of aggression. In addition, many mental health treatment facilities are required to reduce their census in order to provide adequate care for highly aggressive patients. Because the majority of these facilities are operated by private not-for-profit organizations, admission of these youth is often denied due to the negative financial impacts of increased staffing or decreased census. Many youth are sent to facilities outside the state of Minnesota for mental health treatment. Youth are also placed in juvenile correctional facilities, which do not have appropriate staffing or funding to provide the level of mental health

services and supports needed. It is also important to recognize that youth in juvenile correctional facilities are disproportionately minorities.

An increased rate for providers who are providing care to highly aggressive patients would give the financial support necessary to increase admission of these youth to Minnesota based facilities. This will improve outcomes by increasing the ability of family/community support systems to be involved in the treatment process. It will also help to develop sustainable services for youth who are currently significantly underserved. The majority of these youth have experienced significant trauma in their short lives and are dealing with mental health issues contributing to their aggressive behaviors. They require close supervision, high structure, trauma informed and culturally responsive settings and services. They require higher level of staff to respond to and address their unsafe behaviors.

Increasing the reimbursement rate for individual youth based on their specific needs will support facilities to manage the additional costs associated with increased staffing, workers' compensation insurance and other costs associated with providing care to highly aggressive juveniles. In addition, it will aid Minnesota in bringing back youth placed in out of state facilities while improving person-centered care. It will allow facilities to focus on providing high quality care for youth who are most in need of these services. It will increase the ability for family and community connections in the treatment process, thus reducing recidivism rates.

Recommendation:

- DHS convene a 3 year taskforce to research rates, licensing standards and additional funding sources (e.g. waiver funds) to inform an enhanced rate structure for facilities that provide care for highly aggressive juveniles
- DHS and DOC develop a set of shared licensing standards for the management of highly aggressive juvenile behaviors to help facilities manage the increased risk of harm to self and others, restrictive techniques and provider oversight

Grant program to reduce residential care recidivism rates

Youth who enter into residential settings generally do fairly well in those settings. Upon returning to their home community, many of these youth return to homes where few changes have occurred and thus return to the behaviors that caused their placement in residential settings.

Many facilities have limited capacity to provide culturally appropriate therapeutic services that may include parent education, substance and mental health treatment as well as the development of ongoing supportive services for the youth and their family. Due to billing constraints, ongoing transitional services are challenging to provide and yet, without them, the youth's chances of making lasting change are severely diminished.

Tracking recidivism rates and supporting agencies to provide transitional services and ongoing support once a child or adolescent has left a residential setting will result in a reduction in youth returning to residential settings. It is expected that this transition care and ongoing support will also result in fewer encounters with Law Enforcement, decreased school disciplinary referrals and better overall long-term outcomes.

Recommendation:

- Allocate $3 Million to a grant program to fund four agencies, at least one of which should be a correctional facility, over three years ($250,000/year/agency) to pilot culturally appropriate transitional services to youth placed in residential facilities.*
- Participating grantees will provide mental health services to the resident and family while in a residential treatment facility and in the home both before and after release from the facility. Ongoing case management services will be provided for at least 6 months following discharge
- Grantees will track recidivism at 6 and 12 months and disaggregate the data based on race, ethnicity, age, geographic location
- At year two a report would be generated showing results to assess the grant program for continuation and expansion

*The RFP will encourage innovative and culturally appropriate approaches to correcting the recidivism that often occurs following residential placements.

Recovery Supports

Increase access to affordable housing across Minnesota

People with mental illnesses are much more likely to face housing instability or even homelessness. Unmanaged mental health symptoms, job loss, inpatient mental health treatment, or an experience with the criminal justice system all increase the challenges that people with mental illnesses face when trying to find and maintain a stable housing situation. In addition, there is limited affordable housing in the state and access to supportive housing programs is lacking.

People with mental illnesses cannot achieve recovery without stable housing. Many studies show that supportive housing successfully interrupts this cycle. For those with a history of incarceration or treatment in a state operated facility, access to permanent supportive housing significantly reduces their time in these systems.

The grant program called Housing with Supports for Adults with Serious Mental Illness provides grants to housing developers/agencies, counties, and tribes to increase the availability of supportive housing options. In the 2017 Legislative Session, supportive housing funding was increased by $2.15 million dollars in one-time funding. The 2018 bonding bill also included $30 million dollars to develop or renovate supportive housing for people with mental illnesses. As of October 2018, over 5,280 Minnesotans with mental illnesses were on a waiting list to receive supportive housing, including 2,390 outside of Ramsey and Hennepin Counties. Bridges provides housing subsidies to people living with serious mental illnesses while they are on the waiting list for federal Section 8 housing assistance. There are long waiting lists for this program. The 2018 Minnesota Homeless Study by Wilder Research identifies that the percentage and number of adults and youth with Serious Mental Illness (SMI) who are homeless continues to rise, while federal and state funding for homeless outreach services to persons with SMI has remained flat for 10 years.

Recommendation:

- Increase funding for the Bridges Program.
- Increase funding for Housing with Supports for Adults with Serious Mental Illnesses grants.
- Expand the landlord risk mitigation fund and provide the funds to agencies serving people who are homeless.
- Increase funding for homeless outreach services in order to assure that persons with SMI and SMI/SUD (Substance Use Disorder) get access to housing, behavioral health services and other resources.

Increase employment support for individuals with mental health barriers to employment

Unemployment affects both physical and mental health of an individual. Lack of confidence, low self-esteem, and depression are among the commonly observed psychological effects of unemployment. People with serious mental illness have among the lowest employment rates in the United States. In 2015, only 21.7% of individuals receiving public mental health services had any form of employment (temporary, part-time, or full-time). These low employment rates persist despite studies suggesting that nearly everyone with serious mental illness has prior work experience and two-thirds want to work[6].

Currently, 60-80 percent of people who live with serious mental illness are unemployed**.** This disproportionately high unemployment rate of people living with mental illness is both unnecessary and very costly. People living with mental illness face a number of barriers to finding and keeping a job. They often face discrimination when applying for jobs. A lack of safe, reliable transportation keeps them from getting to and from work. They may be unable to get time off work to attend needed mental health appointments and risk losing their providers and managing their medications In addition, few receive the supported employment opportunities shown to be effective for people with mental illness and few employers know about job accommodations for a mental illness.

Individual Placement and Support (IPS) is an evidence-based employment program for people with serious mental illness. IPS grant projects are available in only about 50% of Minnesota. Statewide expansion would require new funding for direct service (grants to providers) and infrastructure to support training, technical assistance, data collection, program monitoring, and evaluation. Not all counties use state mental health funds for IPS and there are no consequences for counties or Adult Mental Health Initiatives that continue to use their resources to fund employment services that are not evidence based (IPS). Vocational Rehabilitation Services partners with IPS programs but continues to have three out of four service categories closed, limiting the number of people with mental illness who can access public vocational rehabilitation services. Access to effective evidence based employment services to most people with serious mental illness remains quite limited in Minnesota.

Recommendation:

- Increase funding for the IPS state grant program for expansion and infrastructure
- DHS Behavioral Health Division explore the use of Medicaid for IPS
- Require a memorandum of understanding (MOU) between DEED-VRS (Vocational Rehabilitation Services) and DHS-BHD (Behavioral Health Division) regarding employment services for people with mental illness.*

- Require DHS-BHD and DEED-VRS to consider racial, ethnic, and geographic disparities in their efforts to help people with disabilities obtain competitive, integrated employment

*The MOU should define the ways the two lead public agencies work together to expand and sustain the implementation of this evidence-based practice of supported employment in Minnesota. Ultimately, the MOU would address the strategies to increase the quality and quantity of employment services to people with serious mental illness in Minnesota so that all individuals who want to work receive the services they need to find, maintain and advance in employment.

SUCCESSES SINCE 2018 REPORT

August 31, 2020 marked the 3rd Annual Mental Health Awareness Day at the Minnesota State Fair sponsored by the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health and NAMI Minnesota. This year's activities were all virtual and included videos and online resources about mental health.

In 2019, Mental Health Awareness Day at the State Fair activities brought together over 50 organizations from all corners of Minnesota to promote education and awareness of mental health needs in our communities. The event was kicked off with a Native American drum circle by the Cedar Creek Drummers. Other performances included the Fidgety Fairy Tales and The Renovators (a music group of adults with lived experience of mental illness). The Subcommittee on Children's Mental Health posed the following question to fairgoers: "What makes you happy, what do you do to take care of yourself?" 189 responses were all about self-care. Spending time with family, friends, and animals makes people happy. Being in nature, reading, and being creative all make people happy. Listening to music and singing make people happy. Walking, hiking, running, and yoga make people happy. Therapy, medication, meditation, and time alone make people happy.

A review of the 2018 Report to the Governor and Legislature shows that seven (7) of the recommendations from the Council and Subcommittee were included in statutory changes during the 2019 legislative session. These changes resulted in the expansion of School-Linked Mental Health, increased funding for Safe Schools, one-time funding for expanding Individual Placements and Supports (IPS, an evidenced-based employment services program designed to help individuals with serious mental illness find and keep employment) to areas of the state which do not currently have the program, increased funding for housing vouchers and supportive housing programs, increased Minnesota Family Investment Program (MFIP) cash assistance by $100/month, reimbursement under Medical Assistance for travel costs to provide mental health services, and the appropriation of $2million per year through 2024 for Traditional Healing grants. These traditional healing grants support tribal nations and urban Indian communities to offer traditional healing and to increase the capacity for culturally specific providers to offer mental health and substance use disorder services.

RECENT PUBLISHED COMMUNICATIONS

Blue Ribbon Commission Public Comment

July 21, 2020

To: Members of the Minnesota Blue Ribbon Commission
From: State Advisory Council on Mental Health & Subcommittee on Children's Mental Health

Thank you for your work on behalf of the State of Minnesota to explore ways in which services can be provided more efficiently and effectively to the people of Minnesota. Given the complication provided by the COVID-19 pandemic, it is understandable that the Commission's work could not be completed as originally planned. Of the 42 strategies that were selected by the Commission, 20 were not fully reviewed. We are asking that the Commission further explore one of those strategies – "Develop a Single, Inter-operable, Secure, Low-Cost Telepresence Network". This recommendation had strong merit pre-COVID, and is **now clearly a priority need for both the public and private sectors in Minnesota, to increase access to services and effective collaboration.**

Below are examples of why we believe this strategy needs to be a high priority for Minnesota, based on the criteria outlined for the Blue Ribbon Commission:

Transform the health and human services system

We have new world realities as a result of COVID-19, which has brought telepresence to center stage as applicable, desirable, acceptable, and much sought after by Minnesota residents and providers. The benefits of telepresence have been widely demonstrated during the initial months of the pandemic and now is the time to fully harness the opportunities this technology offers to transform the health and human services systems in Minnesota, building upon the strong foundation already in place and creating a single, interoperable, easily accessed, secure, low cost internet based telepresence system.

Examples:

- Public and private Health and Human Services Agencies can share resources regardless of geography. Person-centered work can be offered anywhere in Minnesota with all involved agencies collaborating on a single platform.
- Counties contract for services from outside organizations for services such as Psychiatry. If those services can be provided via telepresence (jail telepsychiatry services) costs are reduced and/or more individuals can receive services because the funding for psychiatry goes to actual client services and not drive time.
- Health and Human services agencies have limited human resources. Often times counties, especially smaller counties, have staff who take on multiple roles. Reducing travel time increases time available for client services, improving efficiencies, producing savings and improving outcomes for individuals served.

- Significant savings in travel expense including mileage, room and board, meals produced when individuals can attend meetings or provide services through telepresence.
- People needing services, such as mental health, public health nursing, family home visiting, in rural remote areas can have those services provided via telepresence, which in some cases could be the difference between receiving the service or going without.

Increase administrative efficiencies and improve program simplification within health and human services public programs

Telepresence can enhance inter-agency communication and collaboration between multiple state, or private, agencies serving the same client base, including the Minnesota Departments of Health, Human Services, Corrections and Education. This streamlines service delivery, improves integration of services between agencies and improves client outcomes. In addition, there is strong interest within private sector agencies to collaborate on a statewide telepresence system so that a public-private partnership can lead to the bold innovative solutions that are needed to deal with the significant issues we face in Minnesota.

Examples:

- In rural areas significant time is spent traveling to meetings for both general administrative (work groups) and supervision (public health nursing). With few exceptions these meetings can be held remotely via telepresence thus:
    - Reducing travel cost
    - Increasing individual employee productivity
    - Reducing travel related risk
    - Increasing the number of employees who can take part in trainings
- There are community members who for a variety of reasons are not able to travel. This could be related to income, health, transportation issues or family responsibilities. These individuals may go without services when options are not available to them through telepresence. Examples of these services include but are not limited to:
    - Mental Health (professional and practitioner level support)
    - Public Health Visits
    - Financial worker supports
    - Chemical Dependency
    - Health and Welfare checks

Identify evidence-based strategies for addressing the significant cost drivers of State spending on health and human services, including the medical assistance program

Telepresence platforms, when engineered to maximize utilization, can significantly contain costs, increase efficiencies, and most importantly, increase effectiveness. Both financial costs and opportunity costs will be positively impacted by a collaborative, interoperable, secure, public-private telepresence platform.

If we are to move funds upstream to allow for a greater impact on our public health and human services systems, we need to realign spending.

Examples:

- Population Health is a significant cost driver for any state. Improving population health drives down cost. Telepresence allows for increasing health services available to the entire population. Improving access improves population health.

Reduce waste in administrative and service spending in health and human services

A single, shared, interoperable telepresence network will create cost savings and efficiencies across multiple state agencies, with even greater savings and efficiencies when collaborating in a public-private partnership. Without an investment in a shared network, multiple siloed networks will be developed, impeding integration and increasing costs for years to come. Evidence of this can be found in the development of our multiple Electronic Health Record systems which has resulted in high cost both financially and in opportunity. The timeframe to create a shared solution is limited. Once an investment in disparate technologies has been made, fragmentation is difficult to overcome. There is a high opportunity cost to not acting in a timely manner.

Examples:

- In a Person-Centered service environment, maximum impact is achieved by having all members of the service "ecosystem" connected in order to efficiently and effectively integrate services. Healthcare, including mental health care, coordinated with other social, educational and justice system services allows for the greatest positive impact with the lowest cost.
- Travel time reduces the amount of direct care service time available resulting in the need for additional staff to provide direct care service. For example if a specific service requires 160 hours of staff time per week but the individual employees providing this service must travel 25% of their time to provide the service an additional full time employee will need to be hired to achieve 160 hours of service time. Eliminating the need for travel in some cases will eliminate the need for additional employees thus reducing costs while providing the same level of service.

Advance health equity across geographies and racial and ethnic groups

Creating a single, inter-operable, secure, low-cost statewide telepresence network will increase access to services and support for Minnesotans of all ages, all races and all ethnicities in all areas of the state, including Tribes, remote rural regions and under-served urban areas.

Telepresence can increase access to culturally appropriate services across the state by increasing the reach and utilization of limited resources. Telepresence can increase access to services for Minnesotan's of all ages, from children receiving tele-mental health support in schools to isolated older adults receiving services and support in their homes.

Health equity can be impacted by work force shortages. Telepresence can maximize use of existing workforce capacity by reducing windshield time for both clients and providers, reducing or eliminating lost time due to cancelled appointments caused by weather or transportation barriers, and providing access to services in homes and community-based settings across the state. Telepresence supports person-centered care, regardless of where in the state an individual may reside.

Examples:

- Telepresence seems specifically designed to advance health equality across geographic and racial and ethnic groups
- Telepresence reduces access issues for all populations
- **Allowing telemedicine visits, including telephone calls, to be reimbursed at par with face to face visits has allowed greater access to services for underserved populations, while allowing for this access to be provided in a sustainable manner**

Sincerely,

Michelle Schmid-Egleston, MA, LP
Co-Chair
Subcommittee on Children's Mental Health

Dave Lee, MA, LP, LMFT, LICSW
Chair
State Advisory Council on Mental Health

Jeffrey Lind
Co-Chair
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Michael Trangle, MD
Vice-Chair
State Advisory Council on Mental Health

Letter to Commissioners re: expanded school mental health for non-school year

May 22, 2020

RE: Request to extend school-linked mental health services through summer

Dear Commissioner Ricker and Commissioner Harpstead,

On behalf of the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health we are writing to request school-linked mental health grant services be extended beyond the end of the school year and funding be provided to allow mental health support staff to continue working during the summer months. In addition, we request that **DHS temporarily remove CTSS requirements for school districts in order to obtain third party billing for mental health services.** Currently school districts are not able to bill for mental health services provided to students on IEPs due to the COVID-19 pandemic; this barrier is causing a lack of funds to pay for school social worker salaries, ultimately taking away needed services from children with mental health concerns.

The current pandemic has impacted families across the State of Minnesota in countless ways. Families are counting on schools to provide mental health supports in order to remain safe and well. We have heard from Adult Mental Health Initiatives (AMHI) that caregivers living with mental illness are lacking in-home supports during this time and are struggling to be the "teacher" to the children in their care; therefor, families are relying on schools now more than ever to assist them with obtaining basic needs.

School social workers, cultural liaisons, homeless liaisons and para professionals have worked hard to create trusting relationships with families. These relationships are vital during the stressful times we are currently experiencing and help to maintain connections with our most at-risk and struggling families. During this time of extra burden and stress brought about by the COVID-19 pandemic, families need reliable and trustworthy supports to help them access resources and stay connected with their schools.

With summer break quickly approaching, the many school supports that families have become accustomed to will be "off" and those hard sought connections may be lost. During periods of isolation, we know that youth with mental health disorders are at greater risk for emotional and behavioral crises as well as abuse and neglect. Youth and their caregivers need access to check-ins and other contacts with their trusted school staff over the summer. This is essential to their mental health and wellbeing over the summer as well as a much-needed component of their transition back to school in the fall.

If ever we thought it was important to have school staff work during the summer, NOW is the time. School social workers, cultural liaisons, homeless liaisons and other support staff are the lynchpin to families who will need access to school-linked community resources. Without these school supports, we lose our conduit and our connector between student/family needs and community resources.

Now is the time for cross-agency collaboration between MDE and DHS. We are requesting the following:

- extend the school-linked mental health grant services beyond the school year
- use stimulus funds to pay support staff (school social workers, cultural liaisons, homeless liaisons, etc.) over the summer months allowing the level of service provision necessary for the safety of children and families
- temporarily remove CTSS requirements for school districts in order to obtain third party billing for mental health services provided to students on IEPs
- increase access to the State of Minnesota's secure telepresence platform, Vidyo, to allow for students to connect with the mental health workers

Please make this investment in our families and children. If you have any questions, do not hesitate to reach out to any one of us.

Sincerely,

Michelle Schmid-Egleston, MA, LP
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CC:
Governor Tim Walz
Lt. Governor Peggy Flanagan
Hali Kolkind
Anna Burke
Governor's Children's Cabinet
Tarek Tomes, MN.IT Commissioner and CIO
Gertrude Matemba-Mutasa, DHS Assistant Commissioner

Letter to Governor re: Telemedicine Platform

April 10, 2020

The Honorable Tim Walz
Governor of Minnesota
130 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd
St. Paul, MN 55155

Dear Governor Walz,

We are contacting you today on behalf of the Minnesota State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health. We ask you to make an investment in our state's telepresence platform to allow for continued and expanded use of the system during the COVID-19 crisis and beyond.

The DHS/MNIT owned-and-operated telepresence network provides secure, encrypted, HIPAA compliant connections to over 6000 users –which include Minnesota tribal nations, counties, law enforcement, courts, schools, mental health providers, other human service agencies, and those they serve. In order to continue to serve our communities and provide these critical services during the COVID-19 pandemic, we need to ensure this telepresence platform is strong and able to withstand the continually and rapidly increasing number of users. Funding in the amount of $2 million is needed to upgrade the DHS/MNIT telepresence system.

In addition to these upgrades, we are asking that efforts be made to ensure Minnesotans have internet access and the devices needed (tablets/smartphones) to access telemedicine services. We also request the Department of Health and the Department of Commerce ensure mental health and substance use disorder telehealth services are processed and paid on par with medical telehealth services.

Please make this investment in our state's telepresence platform to allow us to continue to serve our communities in this time of crisis. This is a One Minnesota investment that supports ALL Minnesotans including the marginalized, often overlooked, and most vulnerable among us to access vital mental health services.

Sincerely,

Michelle Schmid-Egleston, MA, LP
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CC: Lt. Governor Peggy Flanagan, Hali Kolkind (Governor's Policy Lead for PHHS), Dominic McQuerry (Governor's Policy Lead for Broadband Development), Minnesota State Legislature

Letter to St. Joe's re: opposition of closing the hospital

December 12, 2019

James Hereford, President
Fairview Health Services, Corporate Building
2450 Riverside Avenue
Minneapolis, MN 55454

Dear Mr. Hereford,

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health are deeply concerned about the potential closure of St. Joseph's Hospital in downtown St. Paul. This is a health equity issue and feels like M Health Fairview is abandoning individuals and families impacted by mental illness and substance use concerns. Losing this hospital would be devastating to St. Paul and the mental health community throughout Minnesota.

The need for mental health and substance use treatment beds is a collective problem which needs a collective solution. Long emergency department wait times and the lack of available inpatient services lead to individuals with mental illness being transported hundreds of miles away from their own community for care; even worse, some individuals are turned away from hospital care altogether because no beds are available. These problems will be made worse if St. Joseph's Hospital closes its doors. How can we come up with a creative solution to meet the rising need for mental health services in Minnesota that does not include closing over 100 treatment beds?

St. Joseph's history of connecting patients with community supports and services has not gone unnoticed. At a recent State Advisory Council on Mental Health meeting, one member spoke very passionately about the work St. Joseph's does in supporting individuals and families experiencing a mental health crisis. This hospital is a lifeline for many struggling with mental illness and substance use disorders.

Closing St. Joseph's Hospital would be in direct conflict with the mission and values of M Health Fairview and the identified priorities in your 2018 Community Health Needs Assessment which notes mental health and well-being as the number one issue across all Fairview hospitals. In addition, it conflicts with the larger goals in St. Paul and the entire metro area to reduce disparities in our communities.

We are asking that you strongly consider the human cost of any decision that would result in less access to needed mental health care in Minnesota. To keep with our goals of advising and educating the state about the needs of individuals with mental illness, we cordially invite you to attend any State Advisory Council on Mental Health and Subcommittee on Children's Mental Health meetings in the future. This would allow you to gain feedback on programming changes you are considering that impact the mental health community. We meet the first Thursday of every month from 10am-2pm at DHS Elmer L Andersen Building.

We urge you and the board of directors to vote against any measure that would result in the closure of mental health beds.

Sincerely,

Michelle Schmid-Egleston, MA, LP
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CC: Governor Tim Walz
M Health Fairview Board of Directors
St. Paul Mayor Melvin Carter
East Metro Mental Health Round Table
NAMI Minnesota

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REFERENCES

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