Recommendations from Previous Reports

Summary

The recommendations from several reports on the mental health system are listed below. There are some common themes running through them on ways to build the mental health system. Having participated in many of these task forces the idea was to ensure people received the right level of care at the right time in the right place in order to provide earlier intervention and to prevent hospitalizations, jail, and suicide. Several of the recommendations have been implemented or slightly implemented and those are highlighted in yellow.

Common Themes:

- Invest in, ensure quality and consistency, expand our county mobile crisis teams, crisis beds, and psych ERs along with continuing to work with 911 and now 988 and having better collaboration on the local level between crisis teams and police
- Improve access all along the continuum – hospital beds, residential, crisis beds, intensive community care – and:
  - continue to increase telehealth/telephonic care
  - address the barriers faced by IRTS such as MinnesotaCare not covering room and board costs
  - using county borders for services such as ACT teams
  - improve discharge from hospitals or jails
  - Address issues such as nursing homes not taking people with serious mental illnesses who have health care needs
- Ensure our mental health services are reimbursed at a level that pays for the cost of care – including having higher rates and ensuring that private insurance pays for needed services (parity)
- Develop protected transport across the state
- Address the need for all types of housing – affordable and supportive
- Address the workforce shortages and lack of diversity
- Promote greater collaboration on the local level
- Increase capacity to provide integrated services to people with co-occurring mental illnesses and substance use disorders.

Competency Restoration Task Force (2020/2021)

- Fund mental health services across a full continuum of care, and update rate methodologies so that reimbursement covers the cost of services provided and rates grow over time consistent with costs.
- Enforce parity with insurance plans to increase access to mental health care.
- Provide funding for psychiatric emergency rooms integrated into hospital systems.
- Update the statute governing Minnesota mobile crisis teams for uniformity and fully fund them to provide an adequate and full range of services, such as Voluntary Engagement discussed below.
- Establish minimum training requirements for 911 dispatchers including trauma-informed, antiracist education on how to identify a mental health or substance use disorder crisis, community mental health resources, and scenario-based de-escalation and crisis intervention training.

- Require emergency dispatch services to partner with mobile crisis teams and create risks assessment and decision-making procedures for integrating crisis teams into the emergency response system.
- Fund pilot projects to provide tablets and telehealth technology to law enforcement departments to quickly connect with mobile crisis teams when time and distance prevent the crisis team from responding first
- Provide funding for counties to pilot voluntary engagement services under Minn. Statute § 253B.041, including funding for data collection and analysis of measures, outcomes, and possible cost savings.
- Provide funding for protected transport services certified under Non-Emergency Medical Transport including grant funds for county mobile crisis teams, community providers, and coverage from insurance plans.
- Encourage self-insured entities such as local or county government and health systems to operate protected transport vehicles.
- Increase and expand access to a continuum of housing services integrated with treatment and other social supports that prioritize justice-involved individuals with mental illnesses and substance use disorders.
- Invest in rental assistance programs and increase affordable housing.
- Increase funding and expand permanent supportive housing and assistance programs for people with mental illnesses like the Bridges grant.
- Invest in landlord risk mitigation funds to decrease the perception of risk about renting to people with mental illnesses or criminal records.
- Convene stakeholders to examine local ordinances and eviction policies and make recommendations to reduce housing discrimination against justice-involved people and people with mental illnesses or substance use disorders.
- Require private insurance plans to cover treatment from a clinical trainee, a practice that is already allowed under Medical Assistance.
- Provide additional funding and expand the use of DHS grants to pay for supervision of BIPOC trainees and traditional healers in American Indian Communities.
- Provide funding to pay for continuing education credits for BIPOC mental health professionals to become supervisors.
- Expand the definition of a mental health practitioner so that providers who utilize students completing a practicum or internship can bill for services and support both the provider and student.
- Increase funding for loan forgiveness programs for BIPOC mental health professionals and professionals serving rural and other underserved communities and expand programs to include Licensed Alcohol and Drug Counselors.
- Require mental health licensing boards to have representation from rural, BIPOC, and underrepresented communities.
- Convene higher education stakeholders to examine requirements and barriers to recruiting people from BIPOC communities to mental health fields.
- Convene a task force on culturally informed and responsive mental health to create a more diverse workforce and meet the needs of all Minnesotans.

- Require at least six hours of training and continuing education on culturally informed practice for all mental health professionals and practitioners including cultural competence and humility.
- Convene mental health licensing boards to discuss and make recommendations on alternative pathways to licensure for students, without sacrificing quality
- Create minimum requirements for trauma-informed anti-racist education and training for all health care providers, 911 dispatchers, law enforcement, court officials, and corrections officers.
- Provide funding for diversion programs and create incentives for community partnerships, for example local law enforcement contracting with the county crisis team to co-respond to crises; embedding community social workers in county jails to improve screening, care coordination, and discharge planning; partnerships with community mental health centers to provide care in jails; Certified Crisis Intervention Team implementation.

DHS Crisis Report (2023)

- Address issues with transportation
- Provide leadership and support for multi-agency collaboration and coordination by following SAMHSA best practice guideline
- Collaboratively provide education and address concerns around the implementation of Travis's Law and 988 utilization
- A model crisis system should involve a multi-layered approach, including "co-responder" models
- Consider expanding the role of the LGSW in mobile crisis teams and transport holds
- Increase and enforce CIT for law enforcement officers
- Invest in alternatives to emergency departments and increase crisis bed availability
- Increase utilization of technology through improved broadband capabilities and compatible telehealth platforms

Recommendations on Strengthening Mental Health Care in Rural Minnesota. Workgroup of the Rural Health Advisory Committee (2021)

- Increase awareness of mental health needs and resources
    - Increase Mental Health First Aid training in rural populations
    - Launch targeted and culturally specific public awareness campaigns
    - Include mental health related phone numbers, including the National Suicide Prevention Line, the Minnesota Crisis Text Line, and local mental health crisis phone numbers, on public facing materials, including city and county websites, health care provider websites, and insurance cards
- Increase access to mental health services in rural communities
    - Strengthen telehealth in rural communities by supporting policies that expand broadband and support compatible platforms
    - Support regional and local solutions to increasing transportation for people experiencing a mental health crisis
- Strengthen the rural mental healthcare system
    - Improve response time in rural areas by allotting funding to help increase staffing, including peer specialists
    - Support sustainability by expanding reimbursement to include:

        - Phone screens that result in crisis team interventions
        - Use of a complexity billing code in appropriate situations
        - Identified spaces, such as community buildings, that can be used when crisis team members feel unsafe meeting a patient in a remote area
    - Train crisis teams in both mental health and substance use disorders
    - Develop regional recruitment efforts that introduce youth to a wide variety of healthcare careers
    - Decrease barriers to training by implementing flexible training and graduate school schedules, increasing access to and affordability of supervisory hours, and increasing loan forgiveness for mental health professionals
    - Extend the careers of retiring workers by supporting them in working part-time and/or via telehealth
    - Expand the reach of mental health care by supporting collaboration between primary care providers and mental health professionals
    - Increase support for inpatient psychiatric beds
    - Increase supportive housing and shelter services for adults and youth
- Support Collaboration between Stakeholders
    - Support collaboration between first responders and crisis teams. Specific examples include law enforcement using iPads to access mobile crisis teams, and contracting with crisis teams to embed social workers into first responder teams
    - Implement protocols that prompt emergency department and inpatient units to coordinate with mobile crisis teams when a patient is discharged back into the community so that the crisis teams can offer support through a stabilization plan
    - Encourage and ensure that there is representation from local government bodies, tribal nations, and members of the mental and behavioral health care workforce at local government meetings and/or coalitions
    - Support health systems overburdened by patients presenting in the emergency department with mental health crises through creative staffing models, such as an emergency department sitter program and/or increased use of peer specialists

Governor's Task Force on Mental Health, Final Report. November 15, 2016

- Recommendation #1: Create a comprehensive mental health continuum of care.

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

- Recommendation #2: Strengthen governance of Minnesota's mental health system.

A Minnesota Mental Health Governance Workgroup should be convened to make

recommendations to the governor and Legislature about improvement and possible redesign of governance structures for mental health activities and services in Minnesota. This should include researching other state and national models, defining governance roles and responsibilities, defining safety net functions, defining appropriate regional boundaries, and assigning roles and responsibilities to particular agencies, organizations, or individual positions and suggesting changes to those bodies if necessary. The resulting governance structure should include a clear oversight structure with responsibility, accountability, and enforcement for ensuring access to mental health services and activities for all Minnesotans. It should also maintain a quality improvement infrastructure, support innovation, align funding mechanisms with responsibilities and accountabilities, and sustain the governance function.

- Recommendation #3: Use a cultural lens to reduce mental health disparities.

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

- Recommendation #4: Develop Minnesota's mental health workforce.

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

- Recommendation #5: Achieve parity.

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

- Recommendation #6: Promote mental health and prevent mental illnesses.

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

- Recommendation #7: Achieve housing stability.

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

- Recommendation #8: Implement short-term improvements to acute care capacity and level-of-care transitions.

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

- Recommendation #9: Implement short-term improvements to crisis response.

The governor and Legislature should fund and assign responsibility for several short- 4 term improvements to Minnesota's system for responding to mental health crises. These extend ongoing work in the crisis response system and build further capacity and collaboration across the state. They include building Crisis Intervention Team skills and experience into pre-service training for law enforcement, providing additional resources where people already seek help, improving collaboration between mental health and criminal justice, improving data sharing and collaboration, implementing telehealth solutions, and making further improvements to community services.

Offenders with Mental Illness 92015)

- Create sustainable funding methods for mental health urgent care services. Urgent care services include mental health crisis assessment, access to crisis psychiatry, chemical health screening, and crisis stabilization services.
- Encourage local jurisdictions to have regular meetings between law enforcement and mental health communities to facilitate dialogue and collaboration, identify trends, and address barriers.
- Continue medication for inmates after discharge.
- Establish a sustainable payment rate for mobile crisis services that covers not only face-to-face contact but other necessary service elements such as telephone/text support, engagement in treatment, service coordination, and travel
- Require insurance plans operating in Minnesota to include crisis response services as a benefit, or identify another method to compensate crisis programs for uncompensated services to people with private health insurance coverage.
- Define crisis response services as a preventive mental health service with no co-pays.
- Develop uniform service standards and training for mobile crisis teams.
- Include training and protocols for mobile crisis teams on how to work with law enforcement.

- Establish a single statewide phone number for mental health crisis services that links to local crisis resources.
- Explore use of GPS to enable monitoring of location and assure improved dispatching of mobile crisis teams.
- Clarify statute to indicate that mental health crisis teams can be dispatched in addition to law enforcement and/or other responders.
- Provide training to 911 operators on role of crisis response services.
- Address issues related to unsustainability for room and board costs for residential crisis providers.
- Increased funding for the stabilization component of crisis services.
- Establish a mental health urgent care in the west metro and other geographic areas where it could be beneficial and sustainable.
- Offer incentives for expanded use of Crisis Intervention Team (CIT) training.
- Promote CIT as an advanced training
- Develop a one day CIT training.
- Provide additional training for how to respond to returning veterans who are in crisis.
- Integrate mental health into the educational coursework for law enforcement focusing on basic education about mental illnesses and de-escalation skills training.
- Utilize video and scenario-based training where possible.
- Integrate mental health and crisis de-escalation into required annual "use of force" training.
- Develop a Peace Officers Standards and Training (POST) model policy on responding to a mental health crisis. The POST Board develops, coordinates, and approves continuing education programs for peace officers and part-time peace officers.
- Educate law enforcement and emergency medical responders about the role/value of mental health urgent care.
- Develop a tool for law enforcement to facilitate better communication with health care professionals.
- Develop processes for clear communication when law enforcement is handing off an individual to a health care facility.
- Develop a systemic, real-time bed-tracking of available crisis residential beds and hospital beds.
- Utilize health information exchange to better share information, with person's consent and assuring that privacy safeguards are in place.
- Increase resources for mental health services in jails.
- Expand existing models for interagency collaboration between county social services and jails to other communities.
- Increase resources for probation to ensure reasonable caseloads, training, and access to pre-trial services.
- Develop capacity to perform necessary mental health assessments and facilitate timely access to records for individuals in jail to inform decisions around charges, pre-trial release, and potential diversion options.
- Establish more mental health courts.

- Establish discharge teams in jails to connect persons with community resources.
- Integrate peer specialists into jail discharge programs.
- Incorporate housing assistance into jail discharge planning.
- Invest in the creation of supportive housing options.
- Get medical consent forms as early as possible in the booking process.

Chemical and Mental Health Services Transformation Advisory Task Force: Recommendations on the Continuum of Services (2010)

Levels of Care Workgroup recommendations include:

- Community capacity, both acute care and community-based services, must be developed and implemented before reducing capacity within the State Operated Services system.
- Service level agreements need to be developed between acute care and community based providers [governing the transition of shared clients between levels of care] and protocols established to monitor and evaluate said agreements.
- For the target population, a model of intensive case coordination should be developed and funded. This model has case coordinators as active members of the treatment team and not merely brokering services.

Neurocognitive Services Workgroup recommendations include:

- People should be empowered to direct their lives and the services they need to live where and how they want to live. In order to accomplish this it may be necessary to:
- Work to relax categorical funding and eligibility structures;
- Educate people about the services that are possible (not just those that currently exist or are readily available)
- Allow people to have greater ability to control the resources allocated to them and have choice of who provides the services they receive
- People should feel encouraged to consider employment and have meaningful jobs with support available as needed. In order to accomplish this it may be necessary to:
- Make employment services available to all individuals interested in employment, regardless of their identified potential for work by professionals.
- Encourage employers to consider creative options for employees, including telecommuting, flexible schedules, an array of employment options and focus on getting to know the person and their needs as an employee; and,
- Minimize financial disincentives related to working.

Access of Care Workgroup recommendations include:

- Robust mobile adult and children's crisis teams should be accessible across the state and should be able to provide services collaboratively with emergency departments, jails and detention centers
- Mobile Crisis Team Services should be reimbursable when provided in emergency departments, jails and detention centers.
- Collaboration psychiatric consultation should exist from screening in a primary care to variety of community, chronic and acute care settings
- Collaborative psychiatric consultation should be available psychiatrist to psychiatrist to bridge continuity of service needs between acute and community-based levels of care.

- Address the difficulty of recruiting or attracting mental health professionals who are willing to work on crisis teams.
- Provide additional training to crisis teams that provide services to both children and adults to ensure that they understand the parent perspective.

Housing with Services Workgroup recommendations include:

- A statewide housing with services analysis is needed that examines on a regional basis the availability of supportive and affordable housing; the service availability; needs of persons with a serious mental illness in the region; and the community capacity to develop, fund, and manage housing with services.
- The Phase I Target Population should be individuals with serious mental illness and complex needs must meet the following diagnostic, service, and housing criteria: mental health service Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) rating of 4 or 5; and the individual does not meet medical necessity for inpatient hospitalization; and has complex, or multiple, service and support needs that are essential to be met in order for the person to obtain and retain housing; and the individual has a demonstrated history of being unable to retain housing; or there is a documented history that makes the person ineligible for a housing subsidy, rental voucher, or unable to obtain affordable housing

Getting there with Dignity (Transportation) Workgroup recommendations include:

- All regions should establish a psychiatric responder round table which would promote collaboration between ambulance services, law enforcement, mental health mobile crisis intervention services and other transportation entities involved in the medical transportation of persons who need quick access to mental health treatment.
- The role of the mobile crisis intervention team should be clarified to include assessing the individual‘s need for emergency hospital services, acute care hospital treatment, crisis residential stabilization services, or Community Behavioral Health Hospital services and determine the most appropriate means of transportation to get the individual to the service.

Mental Health Acute Care Needs Report (2009)

- Develop a process that objectively establishes an agreed upon set of metrics to determine- on an ongoing basis- pressure points in the system that are creating barriers to smooth transition across all levels of care.
    - Convene a working group of behavioral health representatives from hospitals, counties, managed care organization, providers, Minnesota Hospital Association and Minnesota Department of Human Services to design standard metrics regarding access. This group would also recommend a process to quantitatively monitor the data on a regular basis and to re-allocate resources to ensure adequate safety, access, quality and fiscal efficiencies. This would begin in the Twin Cities metropolitan area and would begin on July 1, 2009.
- Design a chronic care model of treatment and services across the service array for the growing numbers of individuals with multiple and challenging diagnoses and complex co-morbidities including medical care and cognitive deficits.
    - Convene a working group to review national studies addressing acute and continuing care management for adults with clinically complex issues and develop a business plan

by December 2009 that includes service design, regulatory changes and funding requirements.
    - Realign funding and regulatory silos for persons with co-occurring mental illness and substance use/abuse - learn from strategies developed by the Co-Occurring System Improvement Grant currently administered by DHS.
    - Explore the feasibility of specialized psychiatric acute care inpatient and community-based intermediate care settings designed to serve individuals with a serious mental illness and co-morbid medical conditions.
    - Create incentives such as the ability to call in a mental health professional to do a temporary care plan or to fund staff to provide time limited one-to-one observations for unstable clients.
    - Work with nursing home organizations and the Minnesota Department of Health as a regulatory body to address nursing facilities' reluctance to admit or transfer back to their facility individuals with medical conditions who also have a mental illness.
    - Implement a disease management methodology that would assure continuity of critical professional services across levels of care delivery.
- Address procedural and programmatic/policy areas that create barriers to smooth transitions across levels of care
    - Create a single treatment plan across all service categories
    - Create uniform data practices, including standard release of information, for use across all service categories
    - Align Minnesota Data Privacy laws with HIPPA
    - Require case managers to arrange for annual physical exams for their clients and establish protocols to assure that this occurs.
    - Explore continuation funding for expansion of the Mental Health Drug Assistance Program that has successfully reduced hospitalizations.
    - Conduct a survey of referral sources to Community Behavorial Health hospitals (CBHH) including suggestions to improve utilization of this service.
    - Review existing protocols and develop greater uniformity in placement criteria by piloting the LOCUS level of care criteria for community-based services, beginning July 2009 with expansion statewide by January 2011.
    - Examine the current Medicare requirements that limit expansion of partial hospitalization to certain populations and determine if an alternative option exists.
    - Develop a working group of key stakeholders to develop strategies and recommendations for greater use of advance directives, shared decision making approaches and service models as alternatives to civil commitments.
    - Develop a standardized intake form for Intensive Residential Treatment (IRT) and Assertive Community Treatment (ACT) teams that is used statewide.
    - Conduct a comprehensive housing needs assessment that addresses the range of housing options from independent living arrangements to housing with supports for those in need of 24 hour oversight and monitoring.
    - Conduct an analysis by the Office of the Ombudsman for Mental Retardation and Mental Health on the data they are collecting on suicides and make recommendations on approaches to improve access to mental health services.

- Improve access to the full array of intensive mental health services; especially during non-business hours, week ends and holidays
    - Implement a single phone number to access crisis services and educate families, 911 operators, emergency department staff, community-based providers about this number as well as information about crisis services and their availability.
    - Monitor the expectation that Assertive Community Treatment (ACT) teams will be at full capacity by July 2009 and accepting direct referrals from hospitals.
    - Assure that direct referrals to Intensive Residential Treatment (IRT) facilities for individuals who have health care insurance will be operational by July 2009. Monitor on an ongoing basis, that access to this service is not being restricted by requirements for a case manager prior to admission. Counties will retain the ability to triage individuals and to be involved with admission decisions for individuals who are uninsured.
    - Fund 45 day operating subsidy contracts to community hospitals with psychiatric acute care inpatient capacity in the Twin City metropolitan area to serve individuals who are uninsured or under-insured. This option is currently in place for Greater Minnesota hospitals as well as in other states.
    - Expand Crisis Intervention Team (CIT) training for law enforcement and dispatch staff to cover all regions of the state and require that CIT be incorporated into day to day operations.
    - Streamline barriers and approvals on weekends and nights for short term alternative service assessment at emergency departments regarding risk level, crisis bed access, funds for temporary housing and medications and on-line access to apply for Medicaid.