GOVERNOR'S TASK FORCE ON MENTAL HEALTH

FINAL REPORT

NOVEMBER 15, 2016

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GOVERNOR'S TASK FORCE ON MENTAL HEALTH

EXECUTIVE SUMMARY

Introduction

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

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

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

The task force offers a vision and set of principles that should drive improvements to the mental health system to create a comprehensive continuum of care. They believe that the mental health system should be person- and family-centered, and that it should provide timely, integrated, culturally responsive, community-based services and activities. They recognize that many changes are needed in order for their vision to be realized. They are also keenly aware of the limitations of their work, especially in the amount of time they had to learn about the details of the mental health system, engage deeply on the challenges facing the system, and communicate with stakeholders about the options being considered. The task force thus offers their recommendations in the spirit of an invitation to further engage in ongoing work on the issues raised in this report. In several cases, they recommend that groups (new or existing) be designated to convene more stakeholders and continue the analysis

and planning. They see their recommendations as an initial road map, and look forward to further conversations with a much wider range of participants in the coming years.

Recommendations

- **Recommendation #1: Create a comprehensive mental health continuum of care**. The state should adopt a wide definition of the mental health continuum of care to include mental health promotion and prevention, early intervention, basic clinical treatment, inpatient and residential treatment, community supports, and crisis response services. The state should collaborate with partners and stakeholders to undertake systematic planning to improve availability and access to mental health services and mental health promotion activities in the continuum. Responsibility for ongoing system assessment 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 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-

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.

The task force came to consensus on all nine recommendations, and members are committed to ensuring that their recommendations gain traction and get implemented in the coming years. They understand that their recommendations will be considered by the governor and Legislature and that the recommendations that are chosen for further review and/or implementation will go through the existing policy-making, funding, and implementation structures and processes. Depending on the recommendations that the governor and Legislature decide to pursue, the task force feels strongly that an appropriate implementation structure should be identified to advance the recommendations in alignment with other efforts within the state. This structure should include adequate staffing and funding to support the implementation of the recommendations.

GOVERNOR'S TASK FORCE ON MENTAL HEALTH

FINAL REPORT

Introduction

The Charge to the Task Force

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

1. Advise the Governor and Legislature on mental health system improvements within the State of Minnesota.

2. Develop comprehensive recommendations to design, implement, and sustain a full continuum of mental health services throughout Minnesota.

3. Make recommendations on:

   a. Developing and sustaining a comprehensive and sustainable continuum of care for children and adults with mental illnesses in Minnesota, including policies, legislative changes, and funding;

   b. Clear definition for the roles and responsibilities for the state, counties, hospitals, community mental health service providers, and other responsible entities in designing, developing, delivering, and sustaining Minnesota's continuum of mental health care;

   c. Reforms needed to support timely and successful transition between levels of care, including early intervention services and substance abuse services; and

   d. Expanding the capacity of Minnesota's mental health system to responsively serve people of diverse cultures and backgrounds.

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

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[1] See Appendix I for the complete text of the Governor's Executive Order.
[2] See Appendix II for a list of task force members.

Role of the Task Force

The Governor's Task Force on Mental Health is one activity in a very complex system of subsystems that include mental health care, substance use disorder treatment, primary care, social services, law enforcement, criminal justice, education, and housing. These subsystems operate in the geographic and cultural communities that Minnesotans live in and that ground their wellness. Individuals and organizations in these systems are collaborating with communities on dozens of projects to improve the services they provide and the coordination of those services. The task force wanted to support that work while also identifying opportunities for transforming the existing array of services into an integrated and comprehensive continuum of care. They also recognized that there are several critical issues in the current mental health system and that many stakeholders were relying on them to make recommendations to address those problems.

The task force decided to address two immediate challenges facing Minnesota's mental health system as well as three longer-term transformational opportunities. The two immediate challenges included:

- Crisis response: Improving response to people experiencing a mental health crisis and diverting people with mental illnesses from the criminal justice system.

- Acute care capacity: Addressing the shortage of inpatient psychiatric beds and the barriers that impede patients' transitions between levels of care.

The transformational opportunities included:

- Defining and creating a continuum of care: Defining the dimensions of a continuum of care and laying out a road map for transforming the existing array of services into a true continuum.

- Strengthening the governance structure: Identifying the challenges with the current governance structure and suggesting a process for improving or re-designing that structure to better support a continuum of care.

- Using a cultural lens to reduce mental health disparities: Explicating the importance of culture in understanding mental health and mental illness and identifying opportunities to improve mental health services and activities by infusing cultural awareness throughout the continuum of care.

Together these allowed the task force to respond to the governor's charge and to yield both short-term solutions to pressing problems and a roadmap for more visionary transformation. Through the process described below, they ultimately yielded nine recommendations for transforming the existing mental health system into a comprehensive continuum of care.

Task Force Process

After identifying task force members, the governor appointed Department of Human Services (DHS) Commissioner Emily Piper to chair the task force and gave DHS primary responsibility for supporting the task force's work. Commissioner Piper assigned a fulltime staff person to support the task force and also arranged for a consultant from the state Bureau of Mediation Services to facilitate the task force meetings. Contacts were established with the various state agencies, other government entities, and stakeholder groups relevant to mental health, and a contact list of about 350 people was developed. The staff set up a task force website to communicate with the public about task force activities and share task force documents (at https://mn.gov/dhs/mental-health-tf/).

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

The task force met seven times between July and November of 2016. The first three meetings included overviews of the current mental health system and presentations by people with lived experience of mental illness, their families, and providers of mental health services (including culturally-specific providers). The task force identified a long list of challenges and opportunities in the current mental health system and prioritized those challenges to focus on the five topics introduced above. They established five formulation teams made up of task force members and their designees, each supported by DHS staff. The formulation teams gathered and reviewed background information, formulated issues, and planned task force discussions to help task force members move efficiently toward recommendations. Each formulation team met about six times during September and October and prepared documents that were reviewed at task force meetings.

Before the October 17 meeting, staff incorporated the work of the formulation teams into an integrated draft of recommendations. These were discussed and refined at the October 17 meeting, and additional drafts were circulated and revised such that a final draft was ready for consideration by the task force at their last meeting on November 7. At that meeting, the task force reviewed each recommendation, suggested revisions, and reached final consensus on all nine recommendations such that a majority-rule vote was not needed. After that meeting, staff incorporated the revisions and circulated the final report to task force members. Task force Chair Emily Johnson Piper delivered the report to the governor on November 15, 2016, and the final report was posted to the task force website.

Starting Points

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

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

In early meetings, the task force heard from people with lived experience of mental illnesses and their families about their expectations for the mental health system. They expect:

1. That the general public has an understanding of mental health and mental illness so that reactions and decisions aren't made based on stigma. People should know what they can do to maintain their mental health and wellbeing, and they should know what to do or where to go if they want to engage in wellness/prevention activities. They should also be able to recognize when their experiences might go outside the norms of sadness or worry or creativity and might be the emerging symptoms of a mental illness.

2. That people know enough about the mental health system that they know where to go to learn more when they need to, and where to turn for help with symptoms of mental illness.

3. That there's a place to go and people to help when people first need help, rather than waiting until people are really sick.

4. That those helping places should be responsive to people's individual and cultural backgrounds so the help that is available makes sense to them and is responsive to their needs.

5. That the person experiencing a mental illness has choices—in services, treatments, and providers. The system should be flexible in how it helps, when it's available, where it's provided, who it's provided by, etc. People want options.

6. That the relationship between providers of services and those receiving them will be considered paramount to the success of the services and that both parties need to support strong, trusting relationships. This requires that providers understand people's personal and historical backgrounds.

7. That the person is engaged in their treatment planning and that it is related to their personal goals.

8. That the services should be person- and family-centered—i.e., that the person and the family can articulate what they want, the system offers options, and then the person and family decide how to move forward.

9. That the services and provider options reflect an understanding of how trauma and other social factors can influence mental health.

10. That the person or family seeking help can be assured that any services or treatments being offered are supported by the best evidence available and that the individual, family, and care team make collaborative decisions about choices among the options.

11. That the services needed are available no matter what form of insurance the person has (including uninsured).

12. That the care should be as local as possible. Common treatments should be available close to home, and only very specialized treatments should require significant travel.

13. That the help that is received is integrated into one understandable package of support—it shouldn't be offered by a variety of different providers in different settings with different rules and different access points that need to be figured out by the individual or family.

14. That mental health services are integrated with community supports, including affordable and stable housing, to increase effectiveness of services and a more sustainable recovery.

15. That the system is built on the fundamental assumption that recovery is possible and that people experiencing mental illnesses can have rewarding, satisfying lives and make contributions to their communities.

Task Force Vision and Principles

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

> Minnesota will have a comprehensive, sustainable mental health continuum of care that includes mental health promotion and prevention, early intervention, basic clinical treatment, inpatient and residential treatment, community supports, and crisis response services to promote resilience and recovery. These services and activities will be person- and family-centered, integrated, culturally-responsive, timely, and community-based. It will rely on public/private partnerships to meet the mental health needs of all Minnesotans in order for them to live, work, learn, participate in community life and reach their full potential.

The task force identified the following principles to guide their decision-making:

1. **Anti-stigma**: The stigma surrounding mental illness is very powerful discrimination that isolates people, prevents them from seeking treatment, dramatically complicates recovery, and undercuts public support for mental health services. It also misleadingly links mental illness with violence. It is important to fight stereotypes and misleading information about mental illnesses and to educate society about the reality of these illnesses. Education should also prepare people to respond appropriately when encountering someone with a mental illness or experiencing a mental health crisis.

2. **Resilience and recovery**: Mental health and wellbeing are the result of many individual and societal factors. Improving Minnesotans' mental health will require both addressing biological, social and

economic conditions that can contribute to mental illnesses as well as helping individuals recover from mental illnesses when they occur. For children, the goal of mental health services is to help them heal so that they can adapt to challenges and achieve their full potential (resilience). For adults, the goal of mental health services is recovery, defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[3] For some people resilience and recovery involve freedom from the symptoms of mental illness; for others, they involve effective management of symptoms in order to live a satisfying life. Resilience and recovery are about individuals striving toward maximum participation and performance in appropriate life activities including school, work, family life, civic engagement, spiritual practice, recreation, and socializing. They are mirrored by the need for *systemic* recovery and resilience—the ability of the society to heal its social inequities and stigma and adapt to the changing needs of community members.

3. **Person-centered and family-centered**: Recovery is best achieved by person-centered, person-driven, and family-centered strategies and care, which means that each person and their family directs their own recovery to the greatest extent possible. The approach is summed up in the "Nothing about us, without us" motto. Family and friends can play a crucial role in helping ensure that decision-making and care are driven by the preferences of the person as much as possible. They also provide emotional and financial support for people with mental illnesses.

4. **Prevention and early intervention**: It is better to help someone avoid illness or address symptoms early than to wait to provide services until their condition has become more acute. Essential strategies include: promoting wellbeing for the entire population, primary prevention (preventing a mental illness from occurring), secondary prevention (identification and screening of people with high risk factors or low protective factors for mental illness), and tertiary prevention (halting or slowing the progress of an illness that has already been diagnosed). The system should employ a full range of effective mental health promotion and prevention strategies, including education of the general public about mental health and their role in supporting people with mental illnesses.

5. **Access to the right services, in the right place, at the right time**: People experiencing mental illnesses should be able to find the right services in the right place at the right time. Just like what is expected if someone breaks their arm or experiences a heart attack, people with mental illnesses should have timely access to services that meet their needs in a convenient location when they need them. They should not have to wait until their symptoms become acute or severe to get the services they need. They should also receive services in the least restrictive and most integrated community setting of their choice.

6. **Multi-dimensional**: Mental illnesses and substance use disorders are medical conditions that have emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual dimensions. To support recovery, the healthcare, social service, education, and employment systems should help the person—with their family and community—to address all of these dimensions in flexible ways.

7. **Community-based**: As much as possible, mental health services should be accessible in local communities so that people can pursue recovery while remaining integrated in their communities.

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[3] "SAMHSA Announces a Working Definition of 'Recover' From Mental Disorders and Substance Abuse Disorders." SAMHSA News Release. Accessed 12/22/2013 at http://www.samhsa.gov/newsroom/advisories/1112223420.aspx.

The system of services in each community should reflect the community context and the strengths of that community.

8. **Integration**: Mental health services should be integrated with substance use disorder services and primary care as recommended by SAMHSA. Better integration will also aid transitions between service locations and levels of care. Mental health services should also be integrated with other healthcare services, including housing, education, employment, transportation, criminal justice, public health, and other social services. New payment models are helping promote such integration.

9. **Coordinated**: Where mental health services are not actually integrated, they should at least be coordinated so that the person and family receiving care do not "fall through the cracks" between providers or levels of care.

10. **Consistency of services regardless of payer**: The healthcare system should provide consistent and appropriate services regardless of whether the person's insurance is publicly or privately paid. There also should be mechanisms to assist people as they move between public and private insurance to ensure smooth transitions.

11. **Stewardship**: The mental health system should reflect responsible stewardship of public and private funds, ensuring that funds are used efficiently to have maximum positive impact on health outcomes.

12. **Sustainability and cost-effectiveness**: The system should be based on a sustainable and affordable financial framework with rational incentives.

13. **Commitment**: Policy makers and regulators should commit to following through and implementing the recommendations of the task force. This could require additional financial or human resources.

14. **Capacity**: The system should have ample capacity of staff and programs to meet the needs of all Minnesotans with mental illnesses and emotional disturbances.

15. **Accountability**: The rules and incentives governing the service system should clearly define accountability among all parties.

16. **Data-driven and continuous improvement**: The mental health system should have a transparent system for setting quality goals and measures, gathering data, assessing outcomes against measures, and implementing improvements. Changes to the system should be driven by this data and analysis.

17. **Public-private partnerships:** The mental health service system relies on effective collaboration among a host of government-operated and private entities. The roles of each organization should be clearly understood and there should be adequate support for the joint planning, collaboration, evaluation, and redesign that is necessary for continuous improvement at a system level.

18. **Public and private insurance:** The mental health service system is funded by both private and public insurance. Planning for changes to the service system should consider the needs of all people, no matter the source of the funding of their services, and the impacts of changes on the services funded by both public and private insurers.

19. **Safety net**: The mental health system should ensure that anyone who needs mental health services can access them, regardless of ability to pay, high intensity of illness, symptoms including aggression, history of legal involvement, or other reasons. Even in a community-based system with multiple providers and funders, there should be well-understood responsibility, accountability, and capacity for "no rejections" providers who serve those whom no one else is willing or able to serve.

The safety net function should be clearly spelled out on a local, regional, and statewide basis and funding should be allocated to match responsibility.

20. **Understandability**: The system should be easily navigated by people with mental illnesses and providers because it operates in efficient, understandable pathways.

21. **Cultural responsiveness, competence, and specificity**: The system should respect cultural and social norms of people who might have alternative conceptualizations of mental health and mental illness. As much as possible, services should be responsive to the needs of people from the range of cultural and ethnic groups in Minnesota (culturally responsive and culturally competent) and/or specifically targeted to the needs of a particular cultural or ethnic group (culturally specific). Education about various cultural perspectives should be delivered to create better understanding and awareness.

22. **Accessibility**: Mental health services and information need to be ADA compliant and available in multiple formats and languages to meet the needs of the range of people living in Minnesota. Printing documents in multiple languages and formats is a good start, but assuring that follow-up resources are also available in multiple languages or responsive to the needs of linguistic/cultural subpopulations will also be necessary.

23. **Autonomy**: There is a fundamental tension between involuntary civil commitment as a means to ensure safety and treatment and the protection of civil liberties. The mental health system should be designed to prevent or reduce the use of civil commitment whenever possible, and to ensure that individual autonomy is only constrained when absolutely necessary.

24. **Suicide prevention**: Suicide can result from inadequately-treated mental illness. Suicide is preventable and the mental health system should invest in proven suicide-prevention programs.

25. **Prevent, reduce or eliminate criminal justice involvement**: The mental health service system should be set up to prevent, reduce or eliminate criminal justice involvement by people with mental illnesses whenever possible.

26. **Evidence-based**: The system should support evidence-based interventions and treatment to produce the desired outcomes. Where evidence has not yet been developed for a particular treatment or sub-population, research should be initiated to test the intervention and cultural leaders should be consulted about the most appropriate way to proceed. Some people prefer the term "evidence-informed" to acknowledge the importance of cultural differences and the fact that evidence gained about one cultural group may not generalize to other cultural groups.

27. **Housing**: Stable, safe, affordable housing is key to pursuing recovery in the community. The mental health services system should collaborate and coordinate with housing services to prevent homelessness where possible and to quickly address the need for housing—with appropriate services—to avoid or ameliorate mental illness or mental health crises. The system should also identify housing gaps and request resources to fill those gaps, as well as providing up-to-date, useful information about the availability of safe housing and the processes and funds for accessing housing.

28. **Transportation**: Transportation is a key dimension of access to services: if a person has no way to get to appointments, the treatment may be available but it's not accessible. Humane and safe transportation is also especially important during a mental health crisis. The mental health system should include, or coordinate with, transportation services to ensure that people with mental illnesses can access services with reliability, safety and dignity.

29. **Employment**: Employment is a key to maintaining independence and self-identity, which makes it an important factor in recovery. The mental health service system should coordinate with employers and vocational services providers to ensure that people receive the support they need to prepare for and maintain stable employment. It should also work with employers to increase understanding about mental health and mental illnesses.

Mental Health Primer

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

Mental Illness is Biological, Psychological, and Social

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

The precise biological processes that lead to mental illness are not yet understood by scientists. For one person, a significant adverse life event can trigger sadness that deepens into depression, for example, while another person experiencing a similar event mourns temporarily but does not fall into depression. It is very important to recognize that developing a mental illness is not a failing of the person experiencing the mental illness, their family, or their community. It is not useful to try to assign blame or identify the specific cause of the mental illness; the focus should be on supporting the person's recovery and assisting the family.

Mental illnesses can affect many aspects of a person's life, including physical health and relationships with family and friends, co-workers, school mates, and others. With access to treatment, services, and supports, most people with mental illnesses can recover their original wellbeing. For a few, mental illnesses are more chronic but they can still recover and lead satisfying, productive, connected lives in their communities.

The medical model has expanded its understanding of mental illness to the current biopsychosocial model, recognizing the role of biological, social, and environmental dimensions and origins.[4] Robust research on adverse childhood experiences shows that children who experience traumatic events or protracted dangerous or chaotic living situations are more likely to develop mental illnesses as children or adults if they do not have the individual or community resources to heal from those experiences. There is also evidence that other social determinants of mental health, such as experiencing poverty, income inequality, racism, historical trauma, and reduced social capital or collective efficacy, contribute

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

to the onset and development of mental illness.[5] For example, children from ethnic and cultural minorities experience the ongoing trauma of racism, which can lead to internalization of devaluating messages, negative self-perceptions, feelings of voicelessness, and rage.[6] The behaviors that result from racism can be confused with symptoms of a mental illness instead of being recognized as natural responses to adverse social circumstances. If left unaddressed, the chronic stressors may lead to mental illnesses.

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

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

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

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

Minnesota statute defines mental illness as follows:

> "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's

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[5] Compton, Michael, and Ruth Shim, *The Social Determinants of Mental Health*. Washington, D.C.: American Psychiatric Publishing/American Psychiatric Association, 2015.

[6] Hardy, Kenneth V. "Healing the Hidden Wounds of Racial Trauma." *Reclaiming Children and Youth* 22.1 (2013): 24-28.

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

[8] "Mental Health: A State of Well-being." World Health Organization. Accessed on 6/3/16 at: http://www.who.int/features/factfiles/mental_health/en/.

capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.[9]

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

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

Risk and Protective Factors

Risk and protective factors have been identified to help understand and predict who might develop mental illnesses. Protective factors are characteristics or circumstances that can help some people avoid mental illnesses, while risk factors are social, psychological, and biological characteristics or circumstances that can promote the development of mental illnesses. Figure 1 identifies risk and protective factors for mental illness.[12]
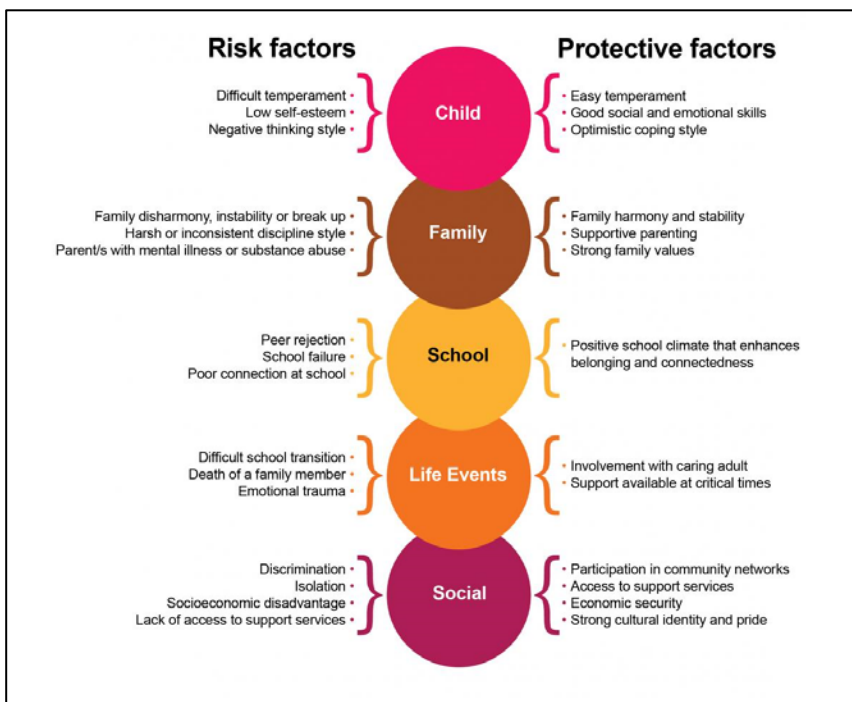
FIGURE 1: RISK AND PROTECTIVE FACTORS FOR MENTAL ILLNESSES

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

[10] Minnesota Statutes, section 245.4871, Subd. 15.

[11] "Mental Illness Surveillance Among Adults in the United States." Center for Disease Control and Prevention. Accessed on 7/12/16 at http://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html.

[12] "How Mental Health Difficulties Affect Children." Kids Matter. Accessed on 6/7/16 at https://www.kidsmatter.edu.au/families/about-mental-health/should-i-be-concerned/how-mental-healthdifficulties-affect-children-0.

The Social Determinants of Health

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

1. The social, economic and political context into which someone is born plays an important role in that person's socioeconomic position.

2. A person's socioeconomic position (as evidenced by class background, gender identity, race, ethnicity, etc.) shapes the social determinants of health, including: a person's living and working environment; their access to food, transportation, and healthcare; their personal behaviors; their biological predisposition to health and disease; and their psychosocial perspectives.

3. These social determinants of health, mediated by the healthcare system and other sectors (for example, education and social services) affect the health of individuals and help create the unequal health outcomes of populations.
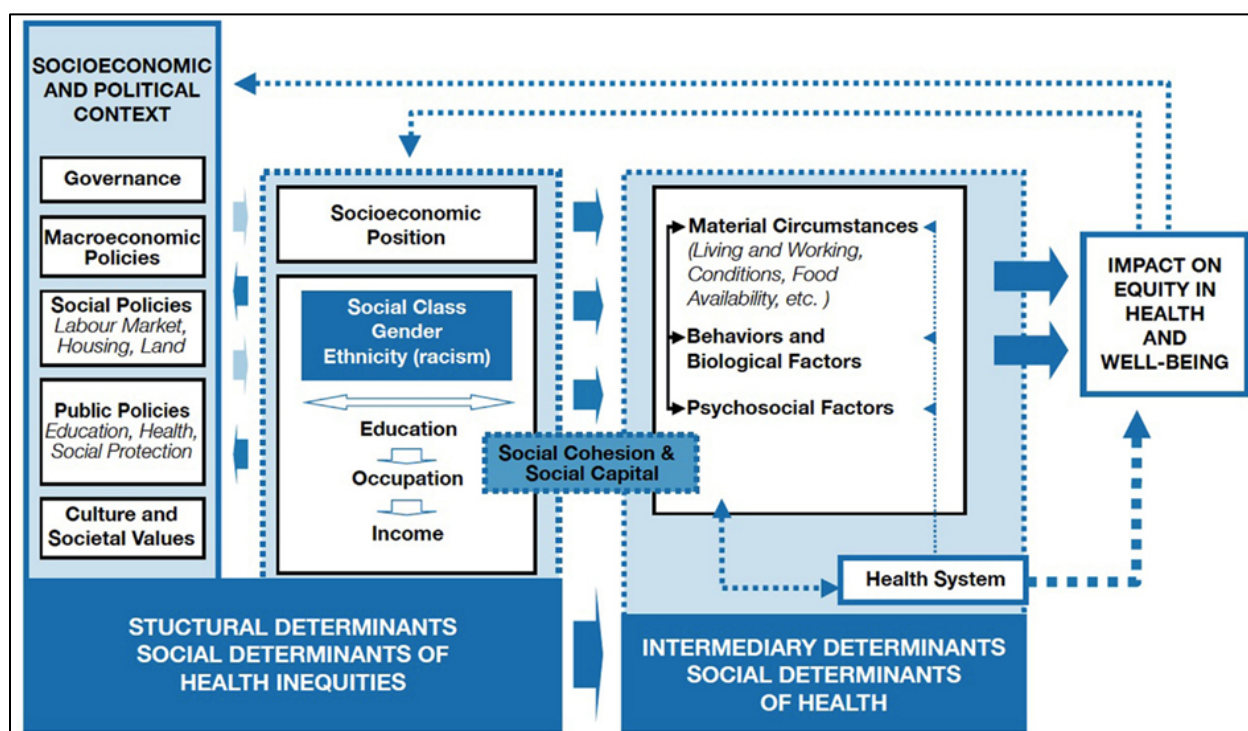
FIGURE 2: SOCIAL DETERMINANTS OF HEALTH[14]

Figure 2 illustrates those relationships. One benefit of this conceptual model is that it provides a very general map of extremely complex interactions among factors that produce mental health and mental

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[13] Solar, Orielle and Alec Irwin. "A Conceptual Framework for Action on the Social Determinants of Health." *Social Determinants of Health Discussion Paper 2, Policy and Practice*, 6. Geneva: World Health Organization, 2010.
[14] Ibid., 6.

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

Co-Occurring Conditions

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

People with mental illnesses are more likely than people without mental illnesses to experience substance use disorders and chronic physical illnesses, and about 45 percent of people seeking substance use disorder treatments have been diagnosed with mental illness as well.[16] According to SAMHSA, the best treatment for people with co-occurring conditions addresses the multiple conditions simultaneously.[17] This requires integrated treatment and collaboration across disciplines.

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

Continuum of Intensity of Mental Illnesses and Mental Health Services

Mental health and mental illnesses are often arrayed on a continuum of intensity, from no mental illness to severe emotional disturbance (children) and serious and persistent mental illness (adults). Because mental illness is often episodic and many people recover fully from mental health symptoms, individuals' intensity of mental illness can fluctuate over time, but it is useful to have estimates of the populations of people with different levels of mental illness intensity in a given year. The DHS

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[15] Trangle, Michael, G. Mager, P. Goering, and R. Christensen. "Minnesota 10 by 10: Reducing Morbidity and Mortality in People with Serious Mental Illnesses." Minnesota Medicine 93.6 (2010): 38-41. "Treatment for Co-occurring Mental and Substance Use Disorders." SAMHSA website. Accessed on 7/12/16 at http://www.samhsa.gov/treatment#co-occurring.

[16] "Behavioral Health Treatments and Services: Treatment for Co-occurring Mental and Substance Use Disorders." SAMHSA Website. Accessed on 10/15/16 at http://www.samhsa.gov/treatment.

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

Community Supports Administration estimates that about 20 percent of children experience an emotional disturbance, and about 20 percent of the adult population experiences a mental illness, in a given year. This translates to more than 300,000 children and 800,000 adults in Minnesota each year.[18] Many of these people do not seek or receive professional help for their illnesses, and most who do are served in public and private outpatient settings and recover fully within a relatively short period of time.

SAMHSA estimates that 5.4 percent, or 221,000 of adults in Minnesota, have a serious mental illness (SMI), defined as having a diagnosable mental illness that has resulted in functional impairment that substantially interferes with or limits one or more major life activities.[19] Unlike many other states and SAMHSA, Minnesota statute has defined a subcategory of adults with serious mental illnesses: adults with serious and persistent mental illnesses. Minnesota has also established a subcategory of emotional disturbances called severe emotional disturbance. These categories were created in order to establish eligibility for certain case management services and they are based on repeated use of mental health services. DHS estimates that about 2.6 percent of Minnesota adults have serious and persistent mental illnesses in a given year, and that 9 percent of Minnesota's school-age children and 5 percent of preschool children have a severe emotional disturbance, which is a mental health problem that has become longer-lasting and interferes significantly with the child's functioning at home and school. This totals about 109,000 children from birth to age 21 with severe emotional disturbances.
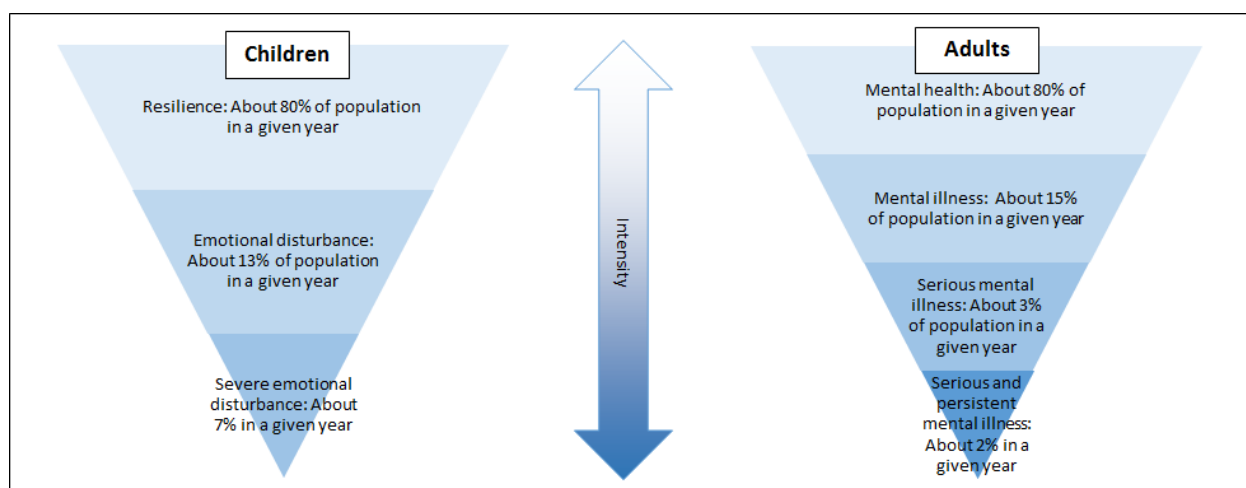

FIGURE 3: INTENSITY CONTINUUM OF EMOTIONAL DISTURBANCE (CHILDREN) AND MENTAL ILLNESS (ADULTS)

Within the category of adults with serious and persistent mental illness is a much smaller subpopulation of adults with co-occurring conditions that complicate their recovery and pose a risk to personal and/or public safety. These co-occurring conditions can include: substance use disorders, traumatic brain injuries, developmental disabilities, chronic physical illnesses, aging-related dementias, and symptoms that include aggression, violence, or self-harm.

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

[19] Epstein, Joan Epstein, P. Barker, M. Vorburger, and C. Murtha. Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders. Washington, D.C.: Department of Health and Human Services, SAMHSA Office of Applied Statistics, 2002. Accessed on 10/3/13 http://www.ce-credit.com/articles/100995/drug_abuse_statistics.pdf.

When these conditions cause someone to present a danger to themselves or others, it is sometimes necessary to pursue temporary restriction of their rights under the Civil Commitment Statute (Chapter 253B of the Minnesota Statutes). This statute lays out the legal process for civil commitment. Once a person is committed (usually to the Commissioner of DHS or to a community provider), there are strict rules for treating the person, assessing their progress, and discharging the commitment.

Minnesota's Mental Health System

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

- Individuals and communities: All Minnesotans are a part of the mental health system as sources of resilience for people in their communities, as senders and receivers of messages about mental health and wellbeing, as family members or friends of someone with a mental illness, or as recipients of mental health services. Communities and community organizations can promote health and prevent illness among their residents through community engagement, population health planning, and public education campaigns.

- Mental health treatment providers: Mental health professionals, community mental health centers and outpatient clinics, residential treatment and rehabilitation centers, psychiatric hospitals, psychiatric units of general hospitals, and mental health services in schools, community centers, jails, and other settings. The vast majority of Minnesotans are served by community-based providers, but a small portion are also served by Direct Care and Treatment, the state-operated mental health services provider. Most people served by Direct Care and Treatment have been civilly committed to the commissioner of DHS (although community providers also serve people who have been civilly committed).

- General medical and primary care providers: Primary care doctors, nurse practitioners, and nurses often provide mental health services as part of their physical medicine practices in private clinics, community health centers, and hospitals.

- Human and social services providers: Minnesota has a huge network of social service providers who assist people with direct mental health services as well as support services including income supports, housing, education, employment, food supports, family counseling, etc. Mental health and substance use disorder services are also sometimes provided in schools, community centers, spiritual centers, jails, and prisons.

- Suppliers: Providers of mental health services rely on commercial suppliers of clinical and treatment protocols, pharmaceuticals, medical equipment, and supplies, including the extensive research and evaluation networks that underlie those products.

- Voluntary and community networks: Minnesota has a vibrant network of volunteer- and peer-run organizations that support people with mental illnesses and substance use disorders.

- Policy makers: Federal and state legislatures and agencies, professional boards, counties, and tribes all play a strong role in developing and shaping the mental health provision system by

helping to determine what services are provided and/or funded, setting the standards under which those services will be provided, determining eligibility, and overseeing the licensing, certification, and quality management of the various players in the system. They also facilitate community planning and engagement around mental health promotion, illness prevention, service development and delivery, and ongoing system assessment.

- Insurers/health plans: Mental health services are provided under a number of different insurance and provision arrangements. Insurers and health plans play a significant role in determining members' access to mental health services.

Another way to illustrate the reach and complexity of the mental health system is to show all the related service systems it touches. These include the rest of the healthcare system, education, housing, employment, transportation, criminal justice, public health, and social services. Mental health services are sometimes provided in these settings, and these sectors also collaborate with the mental health system to prevent mental illnesses and support people who are experiencing mental illnesses.

Community-based Mental Health Services Model

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

While almost everyone agrees that de-institutionalization has brought significant improvements in person-centered, recovery-oriented mental health care, the community-based model has made access to services more complex. Services are available at multiple locations and at multiple levels of care, each with their own payment arrangements, eligibility requirements, and criteria for intake and discharge. A person seeking services travels to the provider or providers and is often faced with coordinating among providers to get the treatment and supports needed. Transitions among levels of care (say, from an inpatient hospital stay to one's home with outpatient services) can be difficult to plan because multiple providers—each with their own requirements and timetables—must be coordinated. Some of the gaps identified in the existing mental health system result not from a lack of available services but from inadequate coordination among the many organizations and individuals involved in a person's care.

The Minnesota Olmstead Plan includes dozens of projects and benchmarks for helping to ensure that people disabled by mental illnesses can live integrated lives in their communities[20] A core tenet is that services should be person-centered, with people making informed decisions about all areas of their lives. The Minnesota Olmstead Plan emphasizes that people with disabilities should have options for how and where they live, which will require continued development of the mental health system to provide a range of community-based services and supports.

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[20] Putting the Promise of *Olmstead* into Practice: Minnesota's Olmstead Plan." Saint Paul: State of Minnesota, August 10, 2015. Available at: http://www.dhs.state.mn.us/main/groups/olmstead/documents/pub/dhs16_196300.pdf.

Recommendations

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

The task force members are committed to ensuring that their recommendations gain traction and get implemented in the coming years. They considered various options for "ownership" of the recommendations going forward, including the establishment of a new oversight body to track progress on their recommendations and a set of new workgroups to organize the work. However, the task force was also cognizant of the need for review and possible redesign of Minnesota's governance structure for mental health services more generally (see Recommendation #2 on page 29), and they did not want to suggest adding another formal layer of decision-making across the already existing (and overlapping) layers. They were also sensitive to the demands that new planning structures make on the stakeholder groups involved, many of whom are already stretched thin by the existing planning and advisory bodies. Finally, they respect the existing planning and oversight roles laid out in statute. They understand that their recommendations will be considered by the governor and Legislature and that those that are chosen for further review and/or implementation will go through the existing policy-making, funding, and implementation structures and processes. Depending on the recommendations that the governor and Legislature decide to pursue, the task force feels strongly that an appropriate implementation structure should be identified to advance the recommendations in alignment with other efforts within the state. This structure should include adequate staffing and funding to support the implementation of the recommendations.

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

Summary: The state should adopt a wide definition of the mental health continuum of care (as illustrated on page 24) to include mental health promotion and prevention, early intervention, basic clinical treatment, inpatient and residential treatment, community supports, and crisis response services. The state should collaborate with partners and stakeholders to undertake systematic planning to improve availability and access to mental health services and mental health promotion activities in the continuum. Responsibility for ongoing system assessment, service development, and quality management should be assigned, along with the funding and staffing to fulfill those functions.

Introduction and Background

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

- Complete range of services and activities: The system would have services and activities that respond to the entire range of mental health needs of Minnesotans and that are integrated with the rest of the healthcare system.

- Universal access: The services and activities would be accessible by all Minnesotans, which includes awareness of services available, geographic availability (with realistic expectations for travel or transportation), capacity of providers to serve everyone in their service area, accessibility to people with disabilities, and responsiveness to people's cultural and demographic backgrounds.

- Smooth transitions: A person's experience of services would have continuity across levels of care (for example, from an inpatient hospital stay to outpatient services in their community).

- Integrated care: The various services that a person receives (for example, health care, income supports, housing, education, child welfare, and parole) would be integrated or coordinated so that the person isn't faced with conflicting expectations and doesn't have to struggle to put all of the pieces together as he or she pursues recovery.

A continuum of care that would meet the vision and principles on page 9 would need to comprise six categories of activities and services.[21] These align with SAMHSA's Recovery Oriented Systems of Care model for substance use disorder services.[22]

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

[22] Whitter, Melanie, Donna Hillman and Peggie Powers. "Recovery-Oriented Systems of Care (ROSC) Resource Guide." Washington, DC: SAMHSA, 2010, 2. Available at: http://www.samhsa.gov/sites/default/files/rosc_resource_guide_book.pdf.

- Mental health promotion and illness prevention: Activities to prevent trauma and build resilience across the lifespan, build community capacity to improve the social determinants of health, and help systems better support children, adults, and families to fully develop.

- Early intervention: Activities and services to identify mental health concerns at the earliest signs and respond to them in a timely, effective way.

- Basic clinical services: Mental health treatment services provided by a range of credentialed mental health practitioners and mental health professionals and by primary care providers. These services include diagnostic assessment, treatment planning, and treatment. They are provided by public and private providers in a variety of settings that include community mental health centers, clinics, hospitals, private offices, schools, jails and prisons.

- Inpatient and residential services: Residential and inpatient services provide an intensive level of treatment and rehabilitation. Acute care is provided in specialized psychiatric hospitals, the psychiatric units of community hospitals, and sometimes in general medical units of community hospitals.

- Community services and supports: Services to support people with mental illnesses in their local communities, including case management and care coordination at several levels of intensity, supportive housing, employment supports, personal care assistance, and peer supports.

- Crisis services: Services for people experiencing an acute mental health crisis, including crisis phone lines, mobile crisis teams, short-term residential crisis services, and mental health urgent care services. Crisis services involve coordination across several sectors, often including health care, emergency response, law enforcement, social services, and others.

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

- Collaboration among providers, payers, people with lived experience of mental illness, and others to support operations and improve service delivery: case management, care coordination, discharge planning, care management, shared record-keeping, transition protocols, etc.

- System-wide collaboration and oversight functions: Governance and funding structures; centralized data-sharing, assessment, forecasting, and planning; quality assurance and metrics; workforce development; etc.

- Collaboration with other sectors: Mechanisms to collaborate or integrate with the rest of healthcare (including substance use disorder treatment), public health, housing, employment, education, transportation, criminal justice, and social services at multiple levels. For example, developing processes and infrastructure for better data-sharing (while protecting individual privacy) would improve integration of services.

These components of a comprehensive continuum of care are illustrated in Figure 4. The individual, family, and community are at the center, surrounded by the sectors of social services and support systems available to them. In addition to the mental health system, these include substance use disorder treatment, public health, primary care, housing, employment, education, transportation, criminal justice, and other social services. The mental health continuum of care includes services and

activities in the six functional categories (tan rectangles), with the lines connecting them representing the operational collaboration that enables smooth access and integrated service delivery. System-wide collaboration and oversight functions (gray oval) help ensure that the system as a whole meets the needs of all Minnesotans, has adequate resources (funding, workforce, technology infrastructure, etc.), is sustainable, and engages in ongoing data-driven assessment, planning, innovation, and service and activity development. Lines connect the mental health continuum of care with all of the other sectors to emphasize the importance of collaboration among sectors to meet the needs of individuals and families.
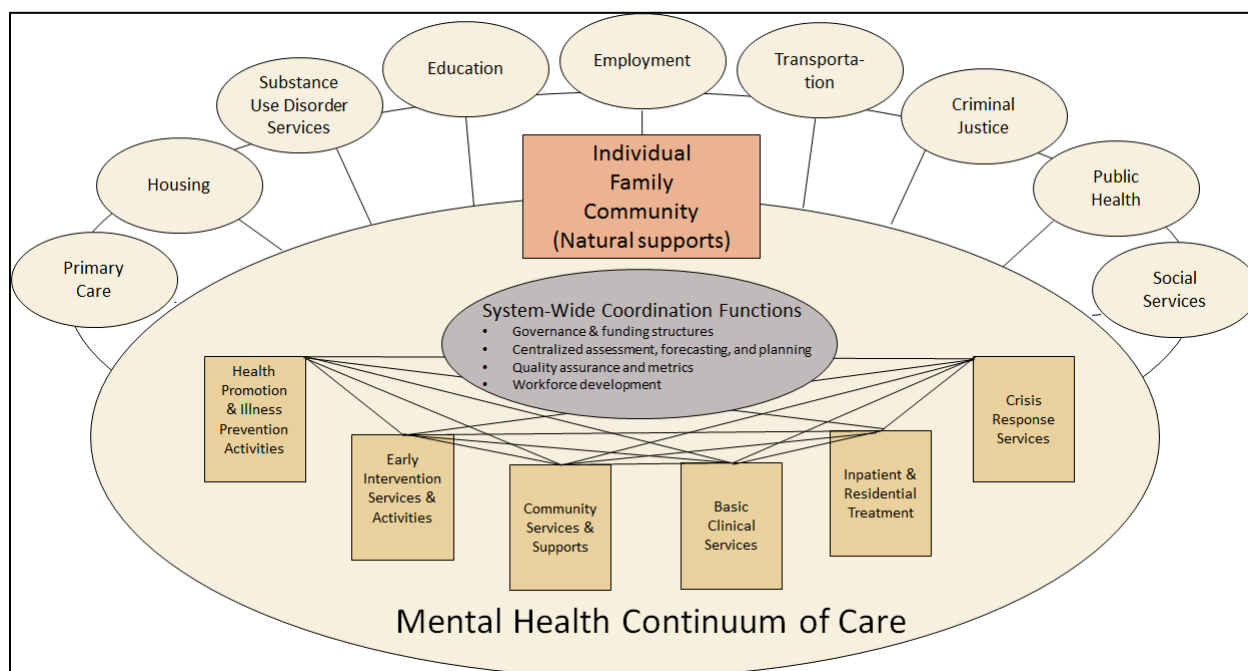
FIGURE 4: ELEMENTS OF A COMPREHENSIVE CONTINUUM OF CARE

Recommendation: Create a Comprehensive Continuum of Care

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

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

Mental Health Promotion and Illness Prevention	Early Intervention	Basic Clinical Services	Community Services and Supports	Hospitalization and Residential Treatment	Crisis Response Services

Individual/Family Level
  Follow Along Program
  Child and Teen Check-Ups
  Birth Defects New Born Follow-Up
  Family Home visiting (eligible families)
  Early Childhood Family Education
  Parent supports
  Integrated Adult/Children's Mental Health
  School- and Classroom-Based Supports and Programs
  Positive Behavioral Interventions and Supports
  Bullying Prevention
  Diversion and Restorative Justice
  Youth Development and Prevention
  Mentoring
  Economic and Nutrition Supports (e.g. WIC)
  Skills Development Initiatives (e.g. Army Soldier and Family Fitness)
  Culture and Language Preservation programs
  Support and Resource Groups
  Senior Initiatives
Community and Systems Level
  Community Capacity (Including Community Resiliency Planning and Implementation)
  Social Connectedness Initiatives
  Education and Outreach (e.g. Adverse Childhood Experience)
  Suicide Prevention Community Planning
  Integrated Mental Health and Primary Care
  Systems improvements & policy changes
  Mental health consultation (e.g., child care)
  Trauma Informed Systems Development
  Workplace wellness initiatives
	Home visiting (M)
	Early childhood mental health (MG)
	First Episode programs (PMG)
	ACES work (Adverse Childhood Experiences) (G)
	Mental Health First Aid (G)
		Physician/Primary Care (PM)
		Psychiatrist (PM)
		Mental Health Professional (PM)
		Community Mental Health Center (PMG)
		Community Health Center (PMG)
		School-linked Mental Health (PMG)
		Clinical Care Consultation (with mental health professionals) (M)
		Dialectic Behavior Therapy (DBT) (PM)
		Telemedicine (PM)
			Case Management (M)
			Targeted Case Management (M)
			Community Support Programs/Club Houses (G)
			Children's Therapeutic Services and Supports (M)
			Adult Rehab Mental Health Services (M)
			Assertive Community Treatment (M)
			Youth Assertive Community Treatment (M)
			Respite Care (child) (G)
			Personal Care Assistance (PCA)
			Community First Services and Supports (M)
			Community Alternatives for People with Disabilities Waiver
			Independent Living Services (ILS) (M)
			Behavioral Health Homes (M)
			Health Care Homes (M)
			Therapeutic Foster Care (M)
			Family Foster Care (G IVE)
			Corporate Foster Care (G)
			Supportive Housing (G)
			Warm Lines
			Wellness Recovery Action Plan Training
			Special Ed/504 Plans and Intermediates and Coops (Ed funding and M)
			Community Paramedics (M)
			Bridges Housing (G)
			Crisis Housing Fund (G)
			Peer-led Support Groups
			Illness Management and Recovery (M)
				Day Treatment (PM)
				Mother/Baby Partial (PMG)
				Partial Hospitalization (PM)
				In-reach Services (M)
				Inpatient (PM)
				Community Behavioral Health Hospital (PM)
				Children's Residential Treatment (PM & IVE)
				Psychiatric Residential Treatment Facilities (child) (PM)
				Intensive Residential Treatment (adults) (MG)
				State Operated Secure (Anoka Metro Regional Treatment Center, Minnesota Security Hospital, Child & Adolescent Behavioral Health Services (G)
				Subacute for Children (MA)
					Crisis numbers (G)
					Crisis teams (PM)
					Crisis stabilization (MG)
					Crisis homes (adults) (G)
					Psych Emergency Departments (PM)
					Psych Urgent Care (MG)

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

Funding Sources: P - Private Insurance; M – Medical Assistance or Minnesota Care; G – County, state, or federal grants or appropriation

TABLE 1: SERVICES AND ACTIVITIES IN THE MENTAL HEALTH CONTINUUM OF CARE

2. For each service or activity, identify the following:

   a. The appropriate service levels for the service (e.g., every person should be within 90 minutes of a mobile crisis team, or there should be one psychiatrist for every 10,000 people in a geographic area). For mental health promotion and prevention activities, define the community engagement expectations.

   b. The categories of population that are most relevant for population-based mental healthcare planning, including categories of age, cultural background, gender identity, ability/disability, etc.

   c. Across all services and activities, define the regions of the state around which service availability and access to services and community planning will be organized. This could be in conjunction with the re-design of the Adult Mental Health Initiatives, or coordinated with that work. Recommendation #2 on page 29 includes more discussion of regional and state planning functions.

3. With all of the above dimensions laid out, coordinate with regional planning bodies to prepare "continuum maps" that outline what activities and services are available in each region, where, and for whom, and identify what activities and services are still needed in each area for particular populations. Identify where services can be co-located (schools, colleges, clinics, etc.) to enhance access. The regional planning bodies should include people with lived experience of mental illness and their families.

4. Policy planning and funding decisions—including state and county agency strategic plans— should be made with consideration of the continuum maps. The governor and Legislature are urged to build stable funding for the activities and services outlined in the continuum maps. Investments should be considered in three categories: short-term priorities, investments in innovation, and sustained infrastructural investments for proven services and activities. More details about system-wide collaborative functions are included Recommendation #2 on page 29.

5. Implement care and funding models that promote integration and person-centered care. Care management models, including Certified Community Behavioral Health Clinics, Behavioral Health Homes, and Health Care Homes, should be expanded. Substance use disorder services and mental health services should be integrated. Programs to build trauma-informed systems and learning communities across systems (clinics, education, law enforcement, etc.) should be expanded.

6. Collaborate with existing data-sharing organizations and projects to develop mechanisms for better health information exchange and use of electronic health records across the healthcare delivery system where appropriate to enable population-based healthcare planning and delivery.[23] This should always comply with policies to protect privacy and security of information and give people appropriate control over their information.

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[23] For example, the e-Health Roadmap is a statewide collaboration around data-sharing as a strategy for improving healthcare delivery. The Roadmap lays out a process for adoption of electronic health records, health information exchange, and health information technology supports to support communication and care coordination and protect privacy and security. "Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services."

7. While the continuum maps are being created and implemented, the state should continue to expand access to care for core services/activities and key populations. Because mental health promotion and prevention are often overlooked, the task force has highlighted them in Recommendation #6 on page 39. Other key services and populations include:

   a. Expand timely access to children's services, especially for very young children. Build capacity of children's residential mental health services to serve specific populations (for example, children with autism or fetal alcohol syndrome) and different levels of care such as crisis homes and psychiatric residential treatment facilities (PRTFs). Continue to expand school-linked mental health grants and mental health promotion, prevention, and early intervention activities in schools.

   b. For adults, the state should increase access to core mental health services such as crisis, community supports, residential services, and to early intervention efforts such as first-episode programs. Mother/baby programs and child care support for mothers needing to access mental health and/or substance use disorder treatment should also be funded.

   c. The state should improve and expand services for populations who experience significant mental health disparities: people with low incomes, people of color and American Indians, LGBTQ[24] youth and adults, new immigrants, refugees, veterans, active military, first-responders, children and adults involved in the criminal justice system, people with developmental disabilities, and people with complex co-occurring conditions in addition to their mental illness. See Recommendation #3 on page 32 for related recommendations.

   d. The state should ensure that mental health services meet accessibility requirements for people with disabilities and that they are accessible to non-English speakers, people who are deaf or deaf blind, new immigrants, and others. It should also ensure that services are made available whether or not a person has been hospitalized with an acute mental illness.

   e. The state should improve and expand mental health services for elderly Minnesotans, including residential services with capacity to serve people with mental illnesses and dementia, especially those whose symptoms include aggression or sexually inappropriate behavior. Services should also support elderly people with mental illnesses to live in their own homes where possible.

   f. Support ongoing efforts to expand access to employment opportunities for people with mental illnesses.

8. The state should continue to pursue promising collaborations between the mental health service system and other sectors: the rest of the health care system (including substance use disorder treatment), public health, education, housing, corrections, etc. For example,

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Saint Paul: Minnesota Department of Health, 2016. Accessed 10/16/16 at http://www.health.state.mn.us/e-health/ehealthdocs/ehlth_roadmap_final.pdf.

[24] Lesbian, gay, bisexual, transgender, and queer.

collaboration should continue to improve students' access to mental health services in schools; MDH and the Department of Corrections (DOC) should work together to improve state prisons' visiting environments and policies to encourage and foster parent/child relationships.

9. The governor and Legislature should take a strong stand that the needs of people with mental illnesses should not be restricted by zoning laws and/or the "not in my back yard" attitudes that can limit the development of community-based mental health services or the rights of people to live in community settings.

10. DHS and MDH should establish a coordinated planning process to implement the comprehensive continuum described, using existing mechanisms and advisory bodies to collaborate with other agencies, stakeholders, and partners. Designing the continuum must balance unique local and regional circumstances with the need to establish statewide expectations for a comprehensive continuum of care. It must also be driven by the needs and perspectives of the people being served, so local communities and individuals with lived experience of mental illness and their families should be included in the decision-making process. Responsibility for the process should be accompanied by adequate funding, staffing, and time to complete it, across the continuum.

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

Summary: A Minnesota Mental Health Governance Workgroup should be convened to make recommendations to the governor and Legislature about 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.

Introduction and Background

The governance of the mental health continuum of care (which includes governmental and collaborative stakeholder planning bodies, policy making, funding decisions, service and program development and oversight, and accountability and quality assurance functions) is complex, fractured, and overlapping. Multiple federal, state, county, local, and tribal agencies set policies that affect mental health care services and activities, and policies made in one jurisdiction often complicate or even undercut goals and policies set in other jurisdictions. Policies are implemented through complex funding mechanisms that are similarly overlapping and sometimes at cross-purposes. Quality standards and outcomes tracking is often tied to particular policies or funding mechanisms, making it very difficult (and inefficient) to assess the performance of the system as a whole. Transforming Minnesota's array of mental health services into a comprehensive continuum of care will require collaboration across

multiple layers of government and across the entire stakeholder community: state, county, local, and tribal agencies, provider organizations, people who provide direct care, professional organizations, payers, people with lived experience of mental illness, mental health advocates, community leaders, and others. Clear authority, responsibility and accountability are very difficult to achieve in the current complex system.

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

Recommendation: Strengthen Governance of Minnesota's Mental Health System

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

The workgroup process should include senior leaders of organizations with direct involvement in the mental health continuum of care. The process should enable effective dialogue and consensus among the various partners and stakeholders to reach desired outcomes. These should include people with lived experience and their families, mental health advocates, DHS, MDH, DOC, the Department of Education (DOE), existing advisory bodies, regional Adult Mental Health Initiatives and Children's Collaboratives, public health, counties (with geographic representation and inclusion of social services directors), tribes, managed care organizations (included state-funded and private market), private insurers, professional associations and licensing boards, community mental health provider organizations, and people who provide direct care. They should also include collaboration with other sectors, including the rest of the healthcare system, education, criminal justice, employment, transportation, housing, etc.

While the workgroup would determine its specific process and timeline, the task force envisions this general approach:

1. The workgroup should research other national and/or state models of governance for consideration. Alternative models can inform examination of Minnesota statutes, rules, and advisory bodies as the workgroup makes recommendations for improving or possibly redesigning Minnesota's governance structures.

2. The workgroup should define the roles and responsibilities necessary to govern the mental health continuum of care.

3. The workgroup should define the "safety net" function and clarify the roles and accountability for safety net service provision. The task force believes that funding for these roles should be prioritized.

4. It should then critically evaluate the existing governance structure's appropriateness to fulfill the roles and responsibilities. It should identify gaps, overlaps, or lack of clarity in which individuals or groups are responsible for which activities.

5. The workgroup should then assign the roles and responsibilities it has identified to particular agencies, organizations, or individual positions. This will involve determining if new structures, organizations, or positions are needed and/or if existing ones can be changed to meet the needs.

6. The workgroup should define regional boundaries (with consideration of Adult Mental Health Initiative boundaries, children's mental health collaborative boundaries, Alcohol and Drug Abuse Division boundaries, Disability Services regional boundaries, public health boundaries, etc.), and align those with accountability for services. This should include developing, implementing, and sustaining the "continuum maps" as described in Recommendation #1.

7. The workgroup should prepare a description of the improved governance system and recommendations for how it could be implemented.

While the task force recognizes that the workgroup will have a collaborative process for identifying the essential roles and responsibilities in an effective governance structure, the task force wants to emphasize the importance of the following functions. Whatever governance structure is ultimately recommended should include a clear oversight structure with responsibility, accountability, and the ability to enforce policies to fulfill these functions:

- Ensuring the availability and accessibility of a basic set of mental health services and activities for all Minnesotans and the collaboration/integration mechanisms that are necessary for those services and activities to be effective. Recommendation #1 on page 22 outlines a process based on identification of effective services and activities, statewide and regional data collection and planning to inform implementation of continuum maps, and policy prioritizing based on the maps. Ensure that there are clear lines of reporting to accountable authorities and that reporting is streamlined for efficiency.

- Maintaining a quality improvement structure that responds authentically to feedback from individuals and families affected by mental illnesses and from providers. This includes streamlining and integrating duplicative quality processes; setting, tracking, and reporting useful measures; and supporting the data infrastructure necessary to track, share and make decisions based on quality data (while safeguarding individual privacy and security of data).

- Supporting innovation and a data-driven process for development of new services and activities. The process should use data to identify, develop, implement, fund, and evaluate services driven by local need.

- On an ongoing basis, assessing funding structures for mental health services and activities and aligning funding mechanisms with the responsibilities and accountabilities in the governance structure and the overall goals of health care and social services systems.

- Sustaining the governance function by allocating funding and staffing to support its ongoing operation (apart from the funding of particular mental health services and activities in the continuum.

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

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

Introduction and Background

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

A recent needs assessment in conjunction with development of Certified Community Behavioral Health Clinics described disparities in mental health services and outcomes for American Indians, Asian populations, Hispanic/Latino populations, homeless people, older adults, Somali populations, and veterans.[25] Surveys led researchers to conclude that there is a need for more culturally and linguistically appropriate services. Similar conclusions have been drawn for LGBTQ people and veterans: until people feel that mental health providers understand them and their experiences, they are unlikely to access mental health services and the mental health services they do receive are unlikely to be very helpful.

The social determinants of health help explain why diverse cultural communities often experience below average mental health outcomes. Not only do they experience more risk factors, but they also can find it difficult to engage in mental health treatment when the provider does not understand their language,

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[25] Ohnsorg, Trudy. "Needs Assessment 2016: Excellence in Mental Health Act in Minnesota." Saint Paul: Cincinnatus, Inc., June 13, 2016, 40-55.

cultural values, or perspectives on mental health. A recent report by MDE explains that disparities—population-based differences in health outcomes—are closely linked with social, economic, and environmental conditions.[26] Living in poverty has the most measurable effect on the rates of mental illness. People in the lowest strata of income, education, and occupation (known as socioeconomic status) are about two to three times more likely than those in the highest strata to have a mental disorder. Moreover, structural racism, intergenerational trauma, and genocide have lasting effects on people and cultures, leading to disparities that are reproduced generation to generation.[27]

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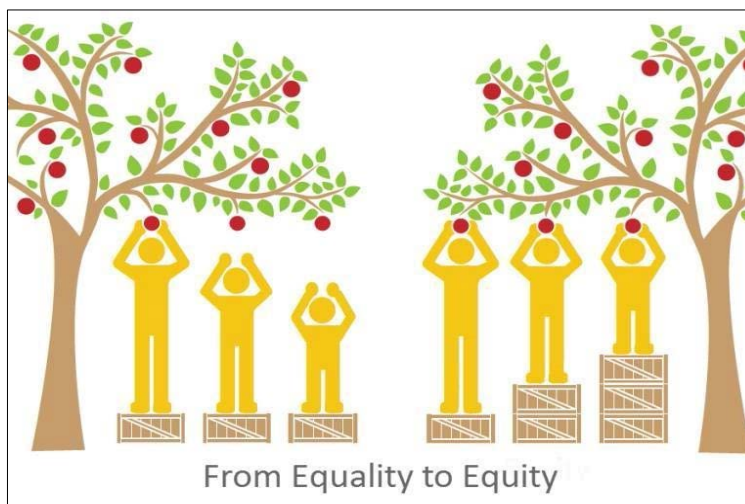

FIGURE 5: EQUALITY TO EQUITY, COPYRIGHT BY SASKATOON HEALTH REGION 2015

Recommendation: Use a Cultural Lens to Reduce Mental Health Disparities

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

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[26] "Advancing Health Equity in Minnesota." Saint Paul: Minnesota Department of Health, February 2014. Accessed on 6/29/16 at http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf.

[27] "Types of Trauma and Violence" SAMHSA website. Accessed on 7/7/16 at: http://www.samhsa.gov/traumaviolence/types; "Behind the Term: Trauma." SAMHSA's National Registry of Evidence-based Programs and Practices, 2. Accessed on 7/7/16 at: http://nrepp.samhsa.gov/Docs%5CLiteratures%5CBehind_the_Term_Trauma.pdf; "Environmental Scan Summary Report." Washington, DC: Native American Center for Excellence report to SAMHSA, November 2008. Accessed on 7/7/16 at: http://www.samhsa.gov/sites/default/files/programs_campaigns/tribal_training/nace-environmental-scansummary.pdf.

1. The governor and Legislature should support more extensive mental health promotion, prevention, and early childhood mental health services and activities that respond to the disparities in Minnesota's mental health outcomes. The state should support mental wellbeing programs that are culturally-responsive and multi-generational and that support individuals and families. Many programs can be offered in the community through trained and culturally representative community leaders.

2. One of SAMHSA's six strategic initiatives is the integration of trauma-informed approaches into mental health and substance use disorder treatment services throughout the United States.[28] To further implement SAMHSA's directive in Minnesota, the state should support the implementation of trauma-focused treatment models that are culturally specific and responsive.[29] The funding should cover training for providers as well as funds to cover trainees' replacements while they are at training and for follow-up costs as the trainees implement the services within their organizations.

3. Mental health providers sometimes lack the cultural knowledge (language, history, norms, social structure, etc.) necessary to provide effective services to people from diverse cultural backgrounds. Language interpretation, already funded in Minnesota, is one example of a service to bridge this gap. Some states also pay for services of "cultural interpreters" who can consult with providers who need more understanding of diverse cultural norms as they diagnose and treat people with mental illnesses. The state should investigate options for funding these cultural consultations, including how consultants could be credentialed and how the service could be funded.[30]

4. Community health workers, mental health practitioners, certified peer specialists, peer recovery specialists, and family peer specialists help improve engagement in health care and provide a variety of health education, navigation, and care coordination services. They are effective because they combine the skills learned in training with their deep knowledge of cultures and life experiences of the people being served. To improve engagement of populations experiencing mental health disparities, it's important that partners across the continuum of care adopt strategies that assist more people from diverse backgrounds to take on these roles. One barrier is funding. For example, community health workers are already established in Minnesota statute and some mental health clinics are deploying them successfully, but funding for the full range of their services is not currently covered by Medicaid fee-for-service plans, most pre-paid medical assistance programs, or private insurers. Another barrier is qualification requirements. Many existing cultural healers, cultural brokers, and elders have deep community connections that would make them effective in supporting people receiving mental health services, but some lack specific qualifications currently required to become certified. The state and licensing boards should review and recommend updates to the qualifications for these positions so that the

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[28] For more information about SAMHSA's initiative, see http://www.samhsa.gov/trauma-violence.

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

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

qualifications reflect multiple possible paths to gaining the life experience necessary to provide effective recovery support.

5. New treatment models that emphasize frequent and authentic feedback mechanisms have been shown to improve engagement in treatment and treatment outcomes. The state should support the implementation and expansion of feedback-informed treatment models that incorporate an intentional process of engagement, feedback, and reparation in therapeutic relationships. This is especially important when it is not possible to connect people from diverse communities with culturally-responsive mental health providers.

6. Minnesota currently pays for one session between a mental health provider and a person receiving services before the provider must complete the diagnostic assessment and develop a treatment plan. Especially for culturally specific providers working with people who don't share a medical model of mental illness, one session is often not enough to establish the rapport and gather the information necessary to make an accurate diagnosis. The state should propose a way to increase the number of reimbursed sessions before a diagnosis is required.

7. There is strong support for services that are developed and funded based on evidence about their effectiveness. However, there has not been enough research and evaluation to identify a wide range of culturally-specific mental health services that are "evidence-based." The state should create demonstration grants and explore additional federal funding to gather evidence that could lead to more sustainable funding options for culturally specific mental health services.

8. The state should continue to pursue models to improve the integration of primary care, mental health care, and substance use disorder treatment and to ensure that all are equipped to serve and partner with diverse communities in a way that is person and community-centered, culturally appropriate, and trauma-informed.[31] The state should support mental health and wellbeing learning collaboratives and encourage implementation of best practices and emerging culturally-responsive promising practices. It should also explore support for community liaisons who can address social determinants of health at the individual and community levels.

9. The workgroup should review state rules, statutes, and processes to identify opportunities to remove barriers to access for people from culturally diverse communities.[32]

Recommendation #4: Develop the Mental Health Workforce

Summary: The governor and Legislature should continue to support development of Minnesota's mental health workforce, including implementation of the recommendations in "Gearing Up for Action: Mental Health Workforce Plan for Minnesota." DHS and MDH should work with the Mental Health Steering

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

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

Committee (responsible for the Mental Health Workforce Plan) to ensure progress on those recommendations.

Introduction and Background

Workforce challenges are, and will continue to be, one of the most daunting barriers to development of a robust continuum of care. Providers across the state are already struggling to deliver existing services because of the difficulty of finding qualified staff, and expansion is impossible in many areas and services because of workforce shortages. Moreover, the aging of the workforce threatens to shrink the pool of workers even more. For example, Minnesota is already experiencing a severe shortage of psychiatrists in most parts of the state, and about half of Minnesota's psychiatrists are over age 55 and thus are likely to retire in the next 10 years, further exacerbating the shortage. Similar shortages are felt in most other occupational categories as well.

In 2013, the Legislature directed Minnesota State Colleges and Universities (MnSCU) to hold a mental health summit and prepare a state workforce plan. The plan, "Gearing Up for Action: Mental Health Workforce Plan for Minnesota," was delivered to the Legislature in 2015.[33] Recommendations were made to improve recruitment, education and training, and retention:

- Recruitment: Attracting students to mental health careers, supporting biomedical science curricula, and improving mental health workforce data at all levels

- Education and Training: Ensuring access, affordability, and reimbursement of supervision, expanding mental health degree programs in rural Minnesota, increasing and improving psychiatric residencies and psychology internships, expanding recruitment and support for diverse students in mental health disciplines, expanding opportunities for practicum experience during education, and expanding tuition reimbursement programs.

- Retention: Better supporting pathways from entry-level positions to terminal degrees and licensure as independent professionals and increasing reimbursement rates.

Implementation of the workforce plan has already begun. The Mental Health Steering Committee (a committee of stakeholders who developed the plan with facilitation by HealthForce Minnesota) continues to monitor implementation of the plan. HealthForce Minnesota recently circulated an update on implementation of the plan, indicating which recommendations had been implemented and which still need attention.[34]

Recommendation: Develop Minnesota's Mental Health Workforce

The governor and Legislature should continue to support implementation of the recommendations in the Mental Health Workforce Plan for Minnesota. DHS and MDH should collaborate with the Mental Health Steering Committee to ensure progress on those recommendations. For example, the direct care workforce planning that occurred at the Direct Care/Support Workforce Summit, and the Advisory Committee being established to pursue that work, should collaborate with the Steering Committee overseeing the Mental Health Workforce Plan. In addition, the task force recommends the state

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[33] The plan, and updates on its implementation, are available at http://www.healthforceminnesota.org/mental-health/.

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

continue to look for ways to build a culturally-diverse mental health workforce across all occupational categories. See Recommendation #3 on page 32 for more specific recommendations. Finally, the task force recognizes the especially acute shortage of psychiatrists in Minnesota and supports efforts to ensure that Minnesota psychiatry residencies are filled and that residents are selected who indicate a commitment to continue practicing in Minnesota.

Recommendation #5: Achieve Parity

Summary: 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.

Introduction and Background

In general terms, "parity" is the concept that people should have access to mental health services under the same conditions that they have access to other healthcare services. For example, if someone experiences symptoms that indicate they may have cancer, they expect to be able to get immediate appointments for the diagnostic and treatment services they need. The system responds differently if someone experiences symptoms of a mental illness, however. In many cases, mental health services aren't available (or covered by insurance) until someone has severe mental illness symptoms. This is markedly different from the response to other illnesses, which are quickly diagnosed and treated to prevent further illness.

There are other system-level aspects of parity, as well. Reimbursement rates for mental health treatment services are often lower than comparable services in other health care sectors, for example. This makes it difficult for providers to offer a sustainable range of services because costs can exceed payments and because they can't compete for the workforce necessary to provide the services. Another limitation is the availability of providers who are "in network" for a particular health plan. If a health plan's network of mental health providers is so narrow that getting an appointment can take six months, this should not be considered acceptable access.

Minnesota was an early proponent of parity, and now both federal and state laws require that insurance benefits for mental health and substance use disorders are equal to coverage for other types of healthcare services. However, studies have concluded that parity laws have not yet had much effect on access to a full range of mental health services in Minnesota and that parity has not been achieved in either Minnesota law or in common practice.[35] There are several ways that mental health services are treated differently: a) the financial requirements (e.g., deductibles and co-payments) and treatment limitations (e.g., number of visits or days of coverage) for services; b) network adequacy, availability of

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[35] "Insurance for Behavioral Health Care." Saint Paul: Minnesota Office of the Legislative Auditor, February 12, 2001. Accessed on 6/29/16 at http://www.auditor.leg.state.mn.us/ped/PEDREP/0104all.pdf.

providers and rules for out-of-network coverage; c) definitions of medical necessity and treatment denials; d) coverage for new treatments; e) unequal coverage of similar services (for example, if a policy covers residential rehabilitation after heart surgery but does not cover residential rehabilitation after in an inpatient psychiatric hospital stay); f) higher standards for medication like prior authorizations, step therapy, or special formulary requirements; and g) measurement and reporting on the performance of the healthcare system often focuses on physical medicine outcomes and gives little attention to mental health measures.

In October 2016, the federal Mental Health and Substance Abuse Disorder Parity Task Force announced a series of actions and recommendations at the federal level to address the parity problem.[36] These included:

- Addressing network adequacy issue by developing lists of "warning signs" that would suggest parity issues in networks

- Providing education, state agency training academies, tool kits, and funding to states to boost parity enforcement

- Launching a complaint website to assist consumers with parity complaints and appeals

- Releasing a consumer guide to disclosure rights

- Reporting publicly on parity investigations and their results

- Issuing guidance on parity for opioid use disorder treatment

- Recommendations to Congress to increase random parity audits of health plans, assess civil penalties against non-compliant plans, extend disclosure requirements to plans not covered by the Employee Retirement Income Security Act, and eliminate state-funded plans' ability to opt out of the Mental Health Parity and Addiction Equity Act

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

Recommendation: Strengthen Systems and Accountability to Achieve Parity

The governor and Legislature should strengthen the capacity of the Department of Commerce and MDH to review health plans to assess alignment with parity laws, improve complaint mechanisms to enforce parity laws, and increase transparency. This should include market conduct exams of insurers and evaluation of plans' network adequacy. There should be a robust method of collecting, public reporting (including insurers' information), and investigating complaints by consumers about coverage of mental health services and treatment. Any consumer complaints about coverage received should include a

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[36] "Mental Health and Substance Use Disorder Parity Task Force Final Report." October 2016. Available at http://www.hhs.gov/about/agencies/advisory-committees/parity/index.html.

requirement for insurance providers to respond within an appropriate timeframe, as crisis situations require timely mental health treatment and services.

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

Recommendation #6:
Promote Mental Health and Prevent Mental Illnesses

Summary: The governor and Legislature should support efforts to build robust mental health promotion and prevention capacity within the state. Infrastructure and programs should be developed to 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.

Introduction and Background

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

Mental health promotion and prevention activities occur at two levels: information and support to individuals and families, and support for communities to organize themselves to build protective factors and reduce risk factors at the community level. At both levels, fighting stigma is essential so that people can better understand mental health and mental illness, reduce discrimination against people with mental illness, and learn to recognize and support people who are experiencing a mental illness.

Given the stigma that surrounds mental illness, an important function of the public health and mental health systems is to work with communities to help individuals, families and communities understand what shapes their health and consider steps they can take together to create mental health and wellbeing, individually and community-wide. Communities need local resources and ongoing support to engage multidisciplinary, cross-cultural community teams to share their lived experiences, develop a common understanding about the local health challenges, and develop strategies to address them, particularly the structural inequities associated with trauma, violence and suicide.

Prevention of mental illnesses is a key public health priority because of the high human and financial costs of mental illness.[37] The human costs can include damage to family and social connections, loss of livelihood, psychological and physical suffering, and even death. The financial cost is also significant, with the mental disorders costing the United States an estimated $201 billion in 2013.[38] This amount puts treatments for mental illnesses (in both community-based and institutional settings) at the top of the list of national spending on medical conditions (ahead of heart conditions, trauma, and cancer).

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

Prevention can support some adults who may be at risk for mental illnesses as well. Prevention activities can include supports for the social determinants of health (nutrition, safe housing and neighborhoods, transportation, education, employment, etc.). Screening and early intervention can help prevent mental illness from becoming a chronic or disabling condition. For people who have experienced chronic mental illnesses, prevention can include any supports or activities that help the person maintain stability in the community. These efforts can prevent relapse and assist the person's ongoing recovery journey.

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

Recommendation: Promote Mental Health and Prevent Mental Illnesses

The Minnesota Department of Health, in collaboration with other agencies and stakeholders, should take the lead in implementing the following activities:

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[37] "Prevention of Mental Disorders: Effective Interventions and Policy Implications." Geneva: World Health Organization, 2004: 15.

[38] Roehrig, Charles. "Mental Disorders Top the List of the Most Costly Conditions in the United States: $201 Billion." *Health Affairs* 35.6 (2016): 1.

1. Develop a statewide campaign to fight stigma and build understanding about what creates mental health and wellbeing.[39] Include communication and awareness about health, positive psychology practices, resilience, social determinants of health, and trauma. Emphasize that mental illness is a medical issue and that stigmatizing mental illness can discourage people from talking about their symptoms or seeking treatment. Target those who work directly with children and families (primary care, child care, schools, and local public health) and communities that experience mental health disparities. Partner with existing efforts to implement and expand anti-stigma campaigns and include evidence-based training models where available. Partner with cultural groups to develop culturally-responsive messages.

2. Support the development of local community resilience plans aimed at improving mental health and wellbeing of residents, especially children, adolescents and families. Local initiatives would focus on engaging and mobilizing residents, including cultural healers and spiritual and civic leaders, assessing local needs and resources, developing action plans that includes multiple sectors, customizing models or policies in response to local needs and strengths, and evaluating progress. The plans can address community issues ranging from addressing adolescent risk and protective factors to preventing drug addiction, overdoses, and violence. To support development of the plans, MDH should provide grant funding for local organizing and planning, facilitate a statewide community of practice to support local leaders, and develop materials that can be adapted by local communities and used in their planning.

3. Provide targeted support for communities that experience violence, suicide, and drug overdose at high rates. These are serious and unique sources of stress that contribute to disparities and poor mental health and wellbeing for the whole community. Institutional responses to these deaths are often reactive and occur in isolation. Community action teams made up of leaders and residents interested in responding to community challenges should have access to resources, information, and decision-making structures that would help shape their communities in healthy ways. Cross-sector teams can provide data analysis and promote coordination and shared learning. They can evaluate the specific experiences and partner with institutions to develop real solutions to the trauma, violence, drug overdoses, and suicide.

4. Develop resources and learning communities for organizations to improve their emotional literacy and trauma-informed organizational cultures, beginning with health care facilities and including early childhood providers, juvenile justice programs, and schools.[40] Models for supporting organizational change typically involve a multi-year process and require time and resources to fully engage in this effort. This includes activities such as training and assessment of policies, environments, practices, and organizational culture.

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

[40] Emotional literacy is the ability to identify, understand, and respond to emotions in oneself and others in a health manner. "Fostering Emotional Literacy in Young Children, What Works Brief Training Kit #21." Center on the Social and Emotional Foundations for Early Learning, Vanderbilt University, 2009. Accessed on 11/7/16 at http://csefel.vanderbilt.edu/kits/wwbtk21.pdf.

5. Develop evidence-based and promising mental health promotion programs designed to help individuals and families who experience significant risk factors for developing mental illnesses. These programs can be implemented in community settings and homes or facilitated by health care providers.

6. Ensure that family home visit programs are available to all high risk families, including low-income families, first-time families, homeless families, incarcerated pregnant women, and teenagers with multiple children.[41] Home visit programs link pregnant women with quality prenatal care, support parents early in their role as a child's first teacher, help parents develop safe and healthy environments for their children, and share parenting skills and support that decrease the risk of child abuse. Family home visitors also provide critical referrals and follow-up to mental health services for at-risk parents. Current state and federal funding addresses only about 25% of Minnesota's home visiting needs. Without additional funding, the system will miss opportunities to support people with known risk factors for poor mental health.

7. Expand programs to reach all newborns, toddlers, and young children for anticipatory guidance, access to culturally and linguistically appropriate developmental and social emotional screenings and referral. These programs help ensure that babies and young children are developing appropriately and that parents understand how they can support their child's emotional and social development.[42]

8. Develop supports and education for parents of adolescents that are accessible, evidence-based, and teach positive parenting skills. Adolescence is a critical window of socio-emotional and cognitive development, and caregivers consistently report the need for more parenting resources for this age group.

9. Integrate mental health promotion strategies into primary care. Develop mental health and wellbeing learning communities and fund implementation of identified best practices for healthcare providers and community mental health partners. Integration may include adjustments in clinical practices such as using trauma assessment tools, and in overall approaches to health care, such as developing community partnerships and addressing community-specific needs.

10. Build capacity to collect and analyze population health data regarding current mental health conditions and risk and protective factors associated with mental wellbeing and illness. Use tools such as the Minnesota Student Survey, Pregnancy Risk Assessment Monitoring System, and Behavior Risk Factor Survey. State and local communities and organizations, especially school districts, need support to analyze the data and apply the information for local planning of mental health promotion and prevention activities.

11. Expand transition supports for new immigrants and their families. Many immigrants and refugees have experienced trauma, poor living conditions, loss of culture and family connections, and social isolation. These experiences increase their risk of poor mental health and wellbeing. DHS should consider expanding transition supports for new immigrants and their

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[41] Examples include Living Life to the Full and the Mother and Babies Program.

[42] One example is MDH's Follow-Along program. For more information, see http://www.health.state.mn.us/divs/cfh/program/cyshn/follow.cfm.

families from 3 months to a minimum of 6 months, or as needed, especially if families have experienced trauma or have young children. The state should also ensure a warm hand-off to local resources after transition supports end. Immigrant communities also need support and resources to implement community-based strategies to reduce isolation, such as family mentors and welcome centers.

12. Continue to support and expand suicide prevention activities and programs.

Recommendation #7: Achieve Housing Stability

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

Introduction and Background

A growing number of Minnesota families and individuals are struggling to afford a place to live in their chosen community. Since 2000, the number of Minnesota households spending more than 30 percent of their income on housing increased 69 percent from 350,000 to 590,000. Incomes have decreased by 5.6 percent and monthly housing costs have increased by 8.1 percent since 2000. The rental vacancy rate is about 3 percent around the state (5 percent reflects a balanced market). All of these factors make housing very difficult to both find and afford.[43] Many of the Minnesotans least likely to be able to afford housing are also living with mental illness. According to the Wilder Research Center, 55% of all homeless adults in the state are living with a serious mental illness.

The importance of housing stability for a strong mental health system has been articulated by task force members and the public at every task force meeting. It is clear that housing stability is a foundation of mental wellbeing. Housing stability is also crucial if mental health services are to be effective and for recovery to be possible. For example, people who have been referred for residential treatment may decide to forego that treatment for fear of losing their housing while they are in treatment, or they may struggle during treatment because they are so worried about their housing. Someone who has just been discharged from treatment can struggle to find an available apartment or house and can encounter long waiting lists for programs that would subsidize the costs. Medical or other debt, prior evictions, or a criminal record can make the search almost impossible. Even people who are able to find safe, affordable housing can face the challenge of getting to the treatment and services necessary to pursue recovery, especially in rural areas with little or no public transit.

Without housing stability, people remain in expensive and restrictive settings far longer than is necessary or, in many cases, do not receive the mental health care they need while living in shelters, on the streets, or in places not meant for human habitation. Sometimes people are forced to move to

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[43] "Minnesota Housing 2017 Affordable Housing Plan." Saint Paul: Minnesota Housing Finance Agency, 2016, 2. Available at: http://www.mnhousing.gov.

unfamiliar neighborhoods or cities to find housing or to access mental health care, and thus lose their connections to family, friends, and other natural supports that could help them pursue recovery.

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

Recommendation: Implement Strategies to Achieve Housing Stability

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

1. Protect and target existing state investments in housing and support services for people with mental illnesses (see Recommendation #8-b-1 on page 47 for additional information). Look for opportunities to integrate housing and support funding where appropriate.

2. Support the policy and budget requests for housing and supports that are recommended by the Commissioners on the Interagency Council on Homelessness, including:

   - An increase in bonding for capital to support the preservation and development of affordable and supportive housing

   - Additional rental assistance to increase access to the existing housing market

   - Targeted prevention resources for families to prevent them from losing their housing and assistance due to a mental health crisis

   - Individualized community living supports (Group Residential Housing/Minnesota Supplemental Aid reform) for adults with disabilities who have low incomes and housing instability, including access to Medicaid services to help improve housing stability

   - Increased connections between the juvenile justice, mental health and child protection systems in order to provide a more robust safety net for the most at-risk youth

   - Emergency funding for postsecondary students facing food and housing insecurity

3. Direct that DHS, Minnesota Housing, the State's Office to Prevent and End Homelessness, and the Olmstead Implementation Office work together to provide an analysis (modeling) of existing resources, identify strategies to leverage additional housing opportunities utilizing existing resources, and document the remaining gap of housing opportunities (by type) needed to ensure all Minnesotans living with mental illnesses have access to affordable and supportive housing.

4. Provide additional funding for incentives and support to local communities to prevent and address the loss of naturally-occurring affordable housing and ensure that the housing is of decent quality.[44]

5. Explore the state's potential role in helping local communities ensure that their policies do not make it difficult for people with mental illnesses to access housing. Sometimes zoning restrictions and/or overly restrictive tenant screening policies can be barriers for people with mental illness. Examples include when zoning is used to prevent the creation of community-based mental health services or when having a payment plan for outstanding medical debt (due to a residential treatment stay) results in the rejection of a lease application.

6. Amend Minnesota law that protects a tenant's right to seek police and emergency assistance to include mental health emergency calls. This would prevent landlords or city ordinances from evicting or penalizing tenants for seeking help for a mental health crisis.

7. Consider increased investments in the newly formed landlord risk mitigation fund, based on the outcomes of the initial pilot.

8. The Minnesota Department of Human Rights should monitor and ensure enforcement of Fair Housing laws and promote adoption of recent Fair Housing guidance that restricts use of blanket policies to screen out potential tenants with mental health or criminal histories.

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

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

Introduction and Background

The mental health system challenge that generated the most written comments to the task force involved the problems related to inpatient psychiatric bed capacity and the attendant difficulties with level-of-care transitions. There are long waits for admission to hospitals with inpatient psychiatric beds,

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[44] Naturally-occurring affordable housing is rental housing that is affordable to low-income households without additional public investments or assistance. An example program is the Greater Minnesota Housing Fund's NOAH Impact Fund, which provides equity investments to developers to support preservation of existing affordable rental housing in the Twin Cities metro area.

particularly those that serve people with mental illnesses and complex co-occurring conditions that include substance use disorders, chronic physical illnesses, intellectual disabilities, and mental illness symptoms that include aggression and violence. People in mental health crises are forced to wait in inappropriate locations (EDs, jails, general hospital wards, at home, and other community settings) for inpatient psychiatric treatment. This creates a host of secondary problems for the patients and families involved and for the people in all of those other settings.

The shortage of inpatient psychiatric bed can be best understood as a "patient flow" problem. Seen at the system level, when people cannot access the treatment they need in a timely manner, the flow of people through the system is impeded. Like a traffic jam caused by construction, the slow-down reverberates through the system and multiple roads are soon affected. Minnesota's patient flow problem is actually a complex set of intertwined problems (see the Appendix on page 72 for more information) that includes the following:

- Inadequate community-based services and recovery supports such that a person does not receive the support they need when mental health symptoms first arise and they thus get sicker until they experience a mental health crisis.

- Inadequate community-based treatment services at an acuity level below inpatient hospitalization, including Intensive Residential Treatment Services (IRTS) and Assertive Community Treatment (ACT) services.

- Inadequate coordination of services to support individuals toward recovery.

- Inadequate crisis-response services that could help divert some individuals from needing inpatient psychiatric care.

- Problems with discharge planning (which should start at admission), resulting in people being ready for discharge but not having a destination in their home community that can provide the level of treatment and/or supports required.

- Inefficient administrative processes (especially in the commitment process, funding eligibility determinations, and community placements) that delay both treatment and recovery in community settings.

- The long waiting times for admission to community psychiatric inpatient beds and especially for state-operated psychiatric beds for people who are under commitment. A 2013 law that requires the Anoka Metro Regional Treatment Center (AMRTC) to admit jail inmates within 48 hours of referral has severely limited access to AMRTC for people from other locations.

- Uneven access to inpatient care across the state, leaving many areas with little access to this level of care and individuals receiving treatment far from home.

- The "cycling" of some patients through EDs, inpatient hospital stays, and discharges back to the community without adequate supports.

- The secondary effects of these psychiatric patient flow problems on other people and services, including friends and families, community hospitals and their other patients, lower intensity psychiatric services, law enforcement, courts, etc. These patient flow problems reverberate throughout the service system, creating backups at community hospitals, preventing people

from receiving "right time, right place" care, and taxing community resources, including law enforcement.

- Questions about what the appropriate number of inpatient psychiatric hospital beds in Minnesota should be and about where policymakers should best invest in order to ensure that people receive "right place, right time" care.

This list of problems demonstrates that what appears as a problem of inpatient psychiatric bed capacity is actually a more complex set of problems in acute care capacity, access to services at lower levels of care intensity, care coordination, discharge planning, and system-wide assessment, planning, and coordination. The task force chose the term "acute care capacity" to capture this wider range of issues instead of focusing specifically on inpatient psychiatric bed capacity.

Recommendation: Implement Short-term Improvements to Inadequate Acute Care Capacity

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

1.   Strengthen Housing and Supports

Recognizing that housing stability is a critical social determinant of mental health, the task force recommends increasing the availability of affordable housing with supports as needed to ensure access to—and effectiveness of—mental health services (see Recommendation #7 on page 43 for more information). To ensure adequate capacity and appropriate transitions in levels of care, the task force also recommends expansion of evidence-based intervention housing models, such as permanent supportive housing. In permanent supportive housing models, affordable housing is paired with or linked to services to assist individuals to remain in their homes, like tenancy skill-building. Providing housing with supports has been shown to create a level of stability that serves as a basis for recovery. In addition, bringing services to a person's home lessens the need for transportation which can help someone who is experiencing a mental health crisis. Supportive housing has been shown to decrease the need for hospitalizations and involvement with law enforcement.[45]

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

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[45] For more information see https://www.usich.gov/solutions/housing/supportive-housing.

2. Improve Local Coordination around Crisis Response

The task force recommends strengthening crisis response services, as detailed in Recommendation #9 on page 52. Strengthening connections between mobile crisis teams, hospitals and law enforcement will ensure that individuals experiencing a crisis receive the right care, while relieving the pressure on hospitals and law enforcement to address acute crises with limited resources. There is also an opportunity for strengthening crisis teams to work with families, along with children and youth. Effective mobile and respite crisis services can prevent unnecessary hospitalizations and ED visits for both adults and children, thus both supporting recovery and helping to ensure that hospital beds are available for people who truly need them.

3. Expand Competency Restoration

The task force recommends expansion of community-based competency restoration services. There are opportunities to expand community-based competency restoration that would open up beds at the Minnesota Security Hospital in St. Peter and at AMRTC, which would make those beds more available for others.

4. Establish a Group to Coordinate Work on Acute Care Capacity

The task force recommends that DHS convene and facilitate a workgroup to coordinate work on acute care capacity for the state of Minnesota. Part of the difficulty of addressing patient flow problems is the fact that the problems are so multi-faceted and that many stakeholders are involved, each with their own missions and goals, legal and administrative requirements, funding models, work processes, and professional perspectives. A collaborative group of these stakeholders would provide the opportunity for better communication and a multi-dimensional approach to the issue. That work should include:

- Sharing data to determine what levels and capacity of adult and children/adolescent inpatient services are needed and where.

- Collaboration with other organizations and workgroups on data collection to better plan and coordinate the continuum of care across the state.

- Discussion of roles and accountability of AMRTC and community hospitals in providing services, particularly for acute care for adults living with serious mental illnesses and complex co-occurring conditions, including symptoms of violence and aggression. This should coordinate with the "safety net" discussions recommended in Recommendation #2 on page 29.

- Addressing the 48 hour law's unintended consequences, particularly for community hospitals and AMRTC.

- Exploring how to better utilize current resources to ensure access to inpatient mental health care across the state and supporting mental health workforce development, recruitment, and retention to make this possible.

- Building inpatient and intensive mental health treatment to accommodate families.

- Discussion of financial disincentives to serving people with complex co-occurring conditions.

- Discussion of operational and financial barriers to the development of more transitional community-based services for people leaving inpatient hospital stays, correctional facilities, and jails.

- Assessing the availability of mental health professionals needed to complete the examinations required by the commitment process in a timely way.

5. Strengthen Community Infrastructure

a. *Increase Intensive Residential Treatment Services*

The task force recommends an increase in IRTS, including exploring the development of IRTS that offer different levels of service intensity or are different sizes.[46] This will involve removing impediments to IRTS development, which include requiring providers to have a county contract in place before building or opening a new IRTS program. Increasing IRTS capacity in Minnesota will also depend on support of the neighborhoods and communities where these programs will be located. IRTS programs should be included in the data collection mentioned above to ensure the right capacity is created within Minnesota's system.

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

b. *Increase access to crisis residential treatment*

The task force also recommends increasing access to crisis residential treatment through the development of additional crisis residential services. These services could be developed as stand-alone programs or included in IRTS settings or other residential programs.

c. *Improve discharge planning*

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

- Expand initiatives that currently assist individuals facing unique barriers to transitioning from AMRTC and Minnesota Security Hospital in St. Peter. Include individuals in community hospitals who are on the AMRTC waiting list.[47]

- Support the recommendations of the RARE collaborative on comprehensive transition planning for people with mental illnesses, particularly regarding effective medication management and engagement in medication treatment.[48] Every person being discharged should participate in the development of a person-centered, plain-language discharge plan that covers diagnoses, medications to be taken and instructions, self-care activities, crisis management plan, follow-up appointments, coping skills, nutrition and exercise, primary care follow-up, and recovery plan.

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[46] Increasing IRTS capacity does not preclude the importance of increasing the capacity of other intensive community-based service such as Assertive Community Treatment teams.

[47] The program is called Transitions to Community Initiative, a state program that as of April 2016 had successfully assisted 99 individuals move from AMRTC or the Minnesota Security Hospital in St. Peter back into the community. See "Transitions to Community." St. Paul: State of Minnesota, April 2016.

[48] See "Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders." St. Paul: Institute for Clinical Systems Improvement, Minnesota Hospital Association, and Stratis Health, October 15, 2012. These recommendations were developed with many community stakeholders, and many hospitals have implemented at least some of the recommendations.

- Develop and expand culturally-sensitive and culturally-relevant discharge planning to ensure successful recovery for all people living with mental illnesses.

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

6.   Improve the Civil Commitment Process

Given its significant impact on individuals' civil rights and its expense, the task force considers the civil commitment process to be a tool of last resort for assisting people with mental illnesses or substance use disorders to get the services they need. The task force recommends that the Legislature clarify Minnesota's Civil Commitment Act to emphasize the option of committing individuals to lesser-restrictive settings than inpatient hospitals. The Act should also be amended to allow the option of dual-commitments to hospitals and to the Commissioner of DHS. This option would give hospitals the opportunity to discharge individuals without waiting for a remote provisional discharge from the State, thereby speeding up the discharge process from a hospital.

The task force recommends including tribes in the commitment process for their members and establishing mechanisms for this inclusion that don't unduly slow the commitment process. Currently, an individual tribal member can be committed without tribal input or consultation, which can leave the courts making decisions based on incomplete information. Tribes often have strong personal connections with their members and clinical information to contribute to treatment planning. Because connections to culturally appropriate treatment and clinical history are important components of recovery, tribes should be involved whenever a tribal member is undergoing the commitment process.

Concerns have also been raised regarding the lack of mental health examiners available to complete assessments during the civil commitment process and the delays this creates. These delays can extend the commitment period, which unduly deprives people under commitment from their civil liberties. The task force recommends further study of this issue as part of Recommendation #4 on page 35.

7.   Expand Options for Parents and their Children

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

- Intensive mother-baby postpartum mental health treatment that allows mothers to receive mental health treatment while caring for their infants.[49]

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[49] Examples include Hennepin County Medical Center's (HCMC) Mother Baby Partial Hospitalization, Intensive Outpatient, and Outpatient treatment programs.

- Inpatient mother-baby postpartum units, such as those in the United Kingdom, Australia, Canada, New Zealand, France, and Belgium.[50]

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

- Programs to ensure access to childcare for parents who need childcare in order to access mental health treatment.

The task force also recommends that the governor and Legislature ensure the implementation of PRTFs for children and adolescents who need intensive residential treatment. Unlike current residential treatment for children and adolescents, this option does not require families to go through out-of-home placement for their children. Admission to a PRTF will still be determined by medical criteria, but families will be able to get treatment for their children without losing parental rights. Implementation of PRTFs will be even more important if Minnesota loses federal funding for current children's residential treatment services.[51]

8.   Support Efforts to Reform Addiction Treatment

The task force supports efforts to reform Minnesota's addiction treatment system. A current reform effort will move Minnesota's substance use disorder treatment system from an acute, episodic-based system to a modern, person-centered, and equitable model of care with an emphasis on care for a chronic disease. It will establish a streamlined, person-centered process for accessing substance use disorder services; expand the continuum of care to include withdrawal management, peer recovery support and care coordination services and allow treatment to be delivered outside of a licensed setting. These changes are necessary to advance the integration of substance use disorder services with the rest of the health care system, which should reduce mental health crises and the need for inpatient hospitalization. They will also help remove one barrier to people leaving hospitals when they no longer need a hospital level of care. Waiting for an available addiction treatment setting has been cited as one reason why individuals become stuck in inpatient hospital units after they no longer need a hospital level care. According to a recent study by the Minnesota Hospital Association and Wilder Research of the time people spent in psychiatric hospital beds when they did not meet criteria for that level of care, 11 percent of those "potentially avoidable days" were due to a lack of availability of addiction treatment settings.[52]

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[50] Vliegan, Nicole, S. Casalin, P. Luyten, R. Docx, M. Lenaerts, E. Tang, and S. Kempe. "Hospitalization-Based Treatment for Postpartum Depressed Mothers and Their Babies: Rationale, Principles, and Preliminary Follow-Up Data." *Psychiatry: Interpersonal and Biological Processes* 76.2 (2013): 150-268. Kenny, Maeve, S. Conroy, C. Pariante, G. Seneviratne. "Mother-Infant Interaction in Mother and Baby Unit Patients: Before and After Treatment." *Journal of Psychiatric Research* 47 (2013): 1192-1198. Glangeaud-Freudenthal, Nine, A. Sutter, A. Thieulin, V. Dagens-Lafont, M. Zimmerman, A. Debourg, B. Massari, et. al. "Inpatient Mother and Child Postpartum Psychiatric Care: Factors Associated with Improvement in Maternal Mental Health." *European Psychiatry* 26 (2011): 2215-223.

[51] The federal Center for Medicare and Medicaid Services has expressed concerns that Minnesota's children's residential treatment settings have the characteristics of "Institutes of Mental Disease," or IMDs, and could therefore be ruled ineligible for federal reimbursement.

[52] Dillon, Kristin and Darcie Thomsen. "Reasons for Delays in Hospital Discharges of Behavioral Health Patients: Results from the Minnesota Hospital Association Mental and Behavioral Health Data Collection Pilot." Saint Paul: Wilder Research, 2016, 1. Available at: http://www.mnhospitals.org/Portals/0/Documents/policy-advocacy/mental-health/MHA%20Mental%20Health%20Avoidable%20Days%20Study%20Report%20July%202016.pdf

9. Assess Impact of the County Share

The task force recommends DHS collaborate with stakeholders and partners to assess the impact of recent increases in the amounts that counties pay to the state for patients at AMRTC and the Community Behavioral Health Hospitals who no longer meet criteria for a hospital level of care. Counties now pay 100 percent of costs for county residents who are served in a state hospital without meeting criteria for that level of care. All of the funds collected go into the state's General Fund, where they support the entire range of state-funded priorities. It is not clear whether the increase in the counties' share of payments has driven a decrease in non-acute bed days, and it is possible that there are alternative or additional ways to incentivize the development of community-based services. For example, re-investing those dollars into community services is one possible option for strengthening the community-based mental health system that could be considered.

10. For Longer-term Consideration

Providers have told the task force that individuals from community residential settings (foster care) and nursing homes are being admitted to inpatient psychiatric hospitals and then are facing barriers to discharge when they are ready to return to their previous living situation or treatment setting. This raises questions about possible gaps in care or funding such that community residential settings are not able to prevent the need for hospitalization, and also about situations in which residential settings are not able to accept patients back after they no longer require hospitalization because they lack the staff or expertise to support them. The task force did not have time to study this question sufficiently to make a recommendation, but acknowledges the importance of examining transition issues for patients residing in community residential settings and nursing homes.

Recommendation #9:
Implement Short-Term Improvements to Crisis Response

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

Introduction and Background

1. The Current Crisis Response System

A comprehensive mental health continuum of care must include an effective crisis response system to assist people and families experiencing a mental health crisis. To design such an effective response, it is essential to recognize that mental health crises are not the inevitable consequences of having a mental illness.[53] They usually occur after significant challenging events like loss of housing, employment, or a significant relationship; conflict with a family member or friend; experience of trauma or abuse; a

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[53] Bernstein, Robert. "Practice Guidelines: Core Elements for Responding to Mental Health Crises." Washington, DC: SAMHSA, 2009. Accessed on 11/11/16 at http://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf

change in treatment without adequate transition planning; or increased substance use or abuse. The culmination of these stressors can be a highly visible event, but preceding that crisis event is usually a history of unmet needs. In order to be effective, crisis response must not just address immediate needs for care and safety, but help connect people to the broader resources they need to pursue recovery.

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

If law enforcement responds to a crisis, officers enter the situation with a primary focus of assessing risk, maintaining safety and gaining control of the situation. This can sometimes cause trauma or escalation of symptoms for a person in crisis. A person experiencing high anxiety or paranoia may react strongly to law enforcement, creating a situation that is potentially dangerous to all involved. With little background information, officers must decide whether the person should remain in their home or be transported to the hospital, crisis center, or to jail if a crime has been committed. If the person is taken to a local ED, the officer sometimes must wait with the person until appropriate treatment is located. Law enforcement agencies consistently report that they lack adequate training and resources to respond to mental health crises.

If a person experiencing a mental health crisis goes to the ED, they are assessed by a physician who determines whether they meet the criteria for needing a hospital level of care. If they do, they are admitted to the hospital's psychiatric ward (if they have one), or to the general ward, or they remain in the ED while social workers try to find an available psychiatric bed for the person. One significant challenge is that if the person in crisis does not agree to voluntary treatment, the hospital assesses them using the standard for involuntary care, which requires a very high level of medical need for admission that many people in crisis will not meet. People in crisis are often not offered admission because they do not fit the criteria for inpatient hospitalization, or they are discharged quickly when they no longer meet those criteria. If they are admitted, but an appropriate bed is not available, they may stay for long periods in the ED without appropriate mental health treatment. Hospitals do perform discharge planning, but the short duration of contact often means that individuals leave without a discharge plan that they are ready to implement.

If the person in crisis accesses mental health crisis services, they will either connect with a live person over the phone, engage with a mobile crisis team in their home, or go to a residential crisis provider for a short stay. They complete a screening process to determine what level of care is needed, and if hospitalization is needed or residential crisis services are needed, transportation is arranged. The crisis provider may use therapeutic interventions to help de-escalate the crisis. The provider works with the person to develop a short term crisis plan and coordinates with other providers for referrals to the appropriate services.

Crisis services capacity varies significantly from community to community. Some regions are still building their crisis teams and others do not have enough staff to respond in the timeframe required. This can be a significant point of contention when teams try to build collaboration with law enforcement.

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

- Individuals frequently call 911 or go to an emergency department because it is a known and familiar resource and they don't know about more specialized mental health resources.

- Many mental health emergencies are still responded to by law enforcement following a 911 call. Law enforcement officers often lack the training and experience to recognize and de-escalate mental health crises, which can lead to tragic consequences including the injury or death of the person in crisis, the responding officers, or others involved.

- Staff in EDs often lack specialized mental health expertise, leaving them ill-prepared to support people experiencing a mental health crisis. Some community hospitals do not have a psychiatrist or psychologist on staff at all, and many do not have them available 24/7.

- There are not enough inpatient psychiatric hospital beds for people who need that level of care, forcing people experiencing a mental health crisis to wait in inappropriate facilities for care.

- Even where mental health crisis services are robust and available, there is often inadequate awareness or collaboration among law enforcement, crisis services, and community health providers.

- People with chronic mental illnesses and substance use disorders who frequently come in contact with law enforcement sometimes end up in cycles of hospitalization, incarceration, and residential treatment. This impedes recovery and may disconnect them from the mental health care and community support services they need. They might not be able to see a specialist during a short stay, or they may be removed from Medical Assistance coverage due to a longer one. People with chronic mental illnesses also often face significant barriers to housing and services that could support recovery and stability.

- Travel times in rural areas present a significant challenge to timely response to calls (for mobile crisis teams, law enforcement, or ambulance).

- Communities around the state often lack some of the specialized resources that people in crisis may need, especially in rural areas.

- In urban areas, mobile crisis teams and law enforcement can struggle with a call volume that outpaces available staffing.

- Schools often lack the expertise to deal with children's significant emotional or behavioral crises, and may be forced to call on law enforcement to maintain safety. This can lead to significant trauma and set up further conflicts for children at school. Children whose symptoms include aggression are at significant risk of involvement in the juvenile justice system.

- Physical health urgent care settings, which help reduce unnecessary visits to the ED, usually do not have behavioral health resources onsite. They may offer an appointment within the next few days, but that is not soon enough to address a mental health crisis.

- People who have experienced a mental health crisis and received services in short-term acute settings like hospitals often leave without a solid understanding of what will happen next. Without the right supports and engagement in a longer-term plan, the person may quickly experience another crisis.

- A person may have a well-developed plan, including trusted supporters named as health care agents who can authorize treatment. But during a crisis, the person may be unable or unwilling to relay that information to the people trying to help.

3.   Current Strategies for Improving Crisis Response

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

- In 2015, Minnesota invested $8.6 million for the next biennium in improved crisis services for children and adults. New crisis residential crisis capacity is being developed with 12 additional beds to be available by July 2017. Crisis services are now defined as being a part of emergency services for the purposes of Minnesota-based health insurance plans. This helps individuals with private insurance, not just Medical Assistance, utilize crisis teams. DHS is also working on a pilot to automatically redirect crisis calls to the appropriate local agency, thus making progress toward having one phone number to access crisis services for all Minnesotans. The funds will also support phone consultation for teams serving individuals in crisis who also have co-occurring intellectual disabilities or traumatic brain injuries.

- As Minnesota expands mobile crisis response, significant implementation issues have emerged. The authorizing language for crisis services called for the development of statewide standards for crisis response. DHS is working with stakeholders to develop language that is clear and comprehensive. Key goals include creating common expectations for when teams will dispatch a mobile response, promoting collaboration with hospitals in rural areas, ensuring that crisis team members are able to authorize transport holds so hospitals have a better understanding of why an individual was brought there, and improving the training that team members receive so that they can address the unique needs of children, older adults, individuals who speak other languages, or come from different cultural backgrounds.[54]

- Many communities are implementing Crisis Intervention Team (CIT) training, a model developed in Memphis, TN. The 40-hour course helps officers develop and hone their ability to respond to individuals in crisis, but it is costly and creates challenges, especially for smaller departments, to cover officers' shifts while they train. If only some officers in the unit are trained, it can be difficult to match the trained officers to calls that could require the crisis intervention skills.

- While Minnesota has and is expanding access to crisis residential care for adults, this service is not yet available for children. Crisis residential treatment usually involves a stay of six to ten days, and offers the opportunity to receive intensive care but does not involve a locked/secure unit. DHS is contracting with a vendor to conduct a study on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement. Recommendations submitted to the DHS's Mental Health Division will inform the establishment of children's mental health crisis residential services as a new benefit with approval from the Center for Medicare and Medicaid Services.

However, more could be done to improve crisis response. The task force feels strongly that the recommendations below would improve crisis response services and collaboration and thus significantly

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[54] More information is available from the Mental Health Crisis Standards Workgroup, which can be reached at Dhs.Mentalhealth@state.mn.us or 651-431-2225.

improve the mental health continuum of care. They would help ensure that people in crisis are assessed and treated in a timely, person-centered way, that people can avoid unnecessary hospital visits, and that people can connect with treatment and supports to help prevent further crises. For responders who do not specialize in mental health, these recommendations help connect them to resources and training to help them safely play an assisting role in crisis response. Perhaps most importantly, they would promote the level of community-wide collaboration that is needed to create integrated response to mental health crises.

The task force also recognizes that one barrier to better response is the need to clarify roles and responsibilities. At the local level, this can be achieved through local collaboration among the many players involved. At a regional and state level, however, there is a need to consider mental health crises as moments in a person's path to recovery, and responsibility for crisis response should be considered alongside the rest of the mental health continuum of care. In a sense, there are not just individual mental health crises; there are also systemic crises when the system lacks the mechanisms to promote health, prevent illness, intervene early if symptoms appear, and provide treatment and recovery supports. The task force recommends that the Governance Workgroup (see Recommendation #2 on page 29) consider how roles and responsibilities for crisis response are integrated with the rest of the continuum. They envision a day when the response to a mental health crisis is at least as well funded and coordinated as the response to a heart attack or stroke.

Recommendation: Implement Short-term Improvements to Crisis Response Services

1.   Expand Pre-service Crisis Intervention Training

To better prepare law enforcement officers to respond to the needs of people experiencing a mental health crisis and ensure safety, the POST Board should ensure that the skills and experience currently included in 40-hour Crisis Intervention Team (CIT) training are included in pre-service training for law enforcement and other first responders. In addition, in-service officers should get 4-8 hours of refresher training every 3 years. Because of the high cost of taking in-service officers off patrol for 40 hours, pre-service training is the best approach as Minnesota seeks 100% CIT training, or its equivalent, for law enforcement. In addition, courses should be made available for fire/EMS responders and 911 dispatch staff. Task force members expressed interest in also integrating training on trauma, including sexual assault.[55]

New officers may be more receptive to training, but each agency will need veteran officers and leaders who are trained and invested in the CIT model and can help younger officers understand how to apply the training. Changes in policy may be needed to realize best outcomes, including clarifying who is the lead officer at a scene involving a mental health crisis.[56] Trainees should also get information about coping skills and resources for themselves, so that they are better equipped to handle the stresses of responding to crisis situations.

Current practice has been to restrict the 40-hour CIT course to in-service officers, and focusing on pre-service training would create a lag time before a critical mass of officers would have the training. This

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[55] Task force member Sara Suerth recommended "Understanding Trauma" as presented by Central Minnesota Sexual Assault Center.

[56] Dupont, Randolph, Sam Cochran, and Sarah Pillsbury. "Crisis Intervention Team Core Elements." Memphis: University of Memphis, 2007. Accessed 10/21/16 at http://www.cit.memphis.edu/information_files/CoreElements.pdf.

may require a transitions strategy for training existing officers until all new officers entering the force have had the pre-service training. To work out the details of this recommendation, the following groups should collaborate: Law enforcement agencies, schools, cities, counties and tribal authorities, Fire/EMS, MnSCU, CIT training organizations, individuals with lived experience, mental health advocates, the Minnesota Post Board, the Minnesota Crime Prevention Association, the Minnesota Sherriff's Association, the Minnesota Police and Peace Officers Association, DHS and the Department of Public Safety.

Although this recommendation focuses on training for law enforcement personnel, the task force recognizes that other professional groups may also need crisis intervention training, including educators and primary care staff, especially nurses who frequently encounter individuals experiencing a mental health crisis. Training for each group would need to be designed appropriately for the specific situations that the trainees face to ensure that the needs of the person experiencing the mental health crisis are met and that the trainees are equipped with the knowledge and skills they need to be effective and maintain safety.

2. Provide Additional Resources Where People Already Seek Help

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

Minnesota should prioritize the co-location of outpatient mental health services delivered by Community Mental Health Centers into Critical Access Hospitals (CAH). CAHs are 25-bed or smaller hospitals and are eligible for cost-based payments through Medicare and Medicaid. They must be a certain distance from the next available hospital, and most provide primary care and outpatient services in attached or satellite clinics. The CAHs maintain a level of access to treatment in less densely populated areas. Residents of these areas are used to going to the hospital for regular outpatient services, as providers see a mix of clinic and hospital patients throughout the day. Sometimes, it may be the only primary care provider located nearby. Both providers and the people being served benefit from ease of accessing multiple kinds of care from a single site. The co-location can support better care and opportunities for joint system engagement. In crisis situations, mental health staff are on site and can offer consultation. In some CAHs, hospital staff also comprise the local crisis intervention team.

This model would start with the integration of less intensive services such as outpatient mental health therapy. But the onsite presences and increased collaboration will allow organic growth of the CAH staff in handling crisis situations. Many CAHs are already serving people experiencing mental health crises, and they need better support and specialized expertise to respond. Minnesota could also consider supporting a statewide community of practice to promote more understanding among primary care providers on how they can support individuals with mental health needs.[57]

The goal of this model is to significantly increase access to mental health care access in rural communities through CAHs. As a secondary benefit, those providers would be better able to offer consultation or services on an as-needed basis in the ED. Workforce is and will continue to be a significant barrier. Improvements currently being implemented may assist in this process, including development of more rural-focused programs and clinical training through the University and MnSCU systems and additional funds for targeted student loan forgiveness. Co-location can reduce

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[57] See "Zero Suicide" in Appendix V on page 79.

capital/overhead expense for the Community Mental Health Center, and can help drive additional patient volume to the local hospital and clinic.

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

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

Minnesota should develop more Urgent Care for Mental Health settings, combining detoxification and/or withdrawal management services, crisis response services, and urgent access to psychiatry and medications. This model offers services at a lower level of intensity than inpatient hospitalization, and it does not use locked or secure units. Data shows promising outcomes for providing crisis stabilization using this model:[58]

- ED utilization decreased significantly after people were served in the Urgent Care, including people who had previously had many visits to the ED.

- Use of outpatient mental health services increased significantly after people who were infrequent users of the ED were served in the Urgent Care; no statistically significant change in utilization was observed for frequent users of the ED.

- All-cause inpatient hospitalization and admissions for acute mental health illnesses both decreased significantly for all users of the Urgent Care, including those who had had frequent ED visits.

- A cost-benefit analysis found that for every one dollar spent on Crisis Stabilization services, there is a savings of $2.00 - 3.00 in hospitalization costs.

Additional data indicated that even fewer people subsequently went to the ED or were admitted to a hospital if they saw a psychiatric provider (who could prescribe medication when appropriate) at the Urgent Care. In addition, the Urgent Care could connect people with medication assistance programs.[59] As teams reach 24/7 mobile coverage, Minnesota could commit to integrated psychiatry within crisis response as the next benchmark for service.

Per-area spending for mental health Urgent Care will probably be similar to what counties and tribes are spending already, according to one county official. [60] However, physical co-location with other services could provide significant operational improvements and efficiencies. Staff can be cross trained between programs and better able to respond to ebbs and flows in the needs of the programs. This can deliver more coordinated and integrated care, and advance Minnesota's ability to achieve a recovery-focused model of care. Prior Urgent Care projects have taken about three years to implement. A new project

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[58] Bennett, Amy, and Jose Diaz. "The Impact of Community-Based Mental Health Crisis Stabilization." Saint Paul: Wilder Research, 2013. Accessed on 10/3/16 at http://www.wilder.org/Wilder-Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/The%20Impact%20of%20Community-Based%20Mental%20Health%20Crisis%20Stabilization,%20Brief.pdf

[59] Trangle, Michael, Senior Medical Director for Behavioral Health, HealthPartners. Interview conducted 9/20/16.

[60] Conducy, Alyssa, Chemical and Adult Mental Health Manager, Ramsey County Community Human Services. Correspondence 10/7/16.

might proceed somewhat faster based on lessons learned, but construction alone took 20 months for one project.

This model is focused on Medicaid and other publically-funded care. Clinic networks and healthcare systems that focus on individuals with private insurance are more likely to offer reserve appointments in general healthcare clinics during daytime hours than through a psychiatric specialty Urgent Care clinic.[61] The state could consider what barriers may exist for such models to adapt for greater integration with health plans and clinic networks. Counties and tribal authorities, health plans, DHS, hospitals, and community mental health centers would need to work together to determine local needs and advance this work. Workforce shortages would remain a key issue.

3.   Improve Collaboration between Mental Health and Criminal Justice

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

Minnesota should encourage pilots and evaluate models for embedding mental health providers within law enforcement. Some co-responder models involve establishing a stand-alone mental health unit within a police department. The mental health provider is directly hired and is accountable to the law enforcement agency. Other models involve collaboration between mental health crisis services and law enforcement to develop joint expertise in crisis assessment, intervention and stabilization. They cover distinct geographic regions, and have 24/7 access to a mental health professional, even if the assigned "embedded" clinician is not on duty.[62] Because Minnesota already has a county-based mental health crisis response infrastructure, this may be a useful approach to promote collaboration among crisis services and law enforcement. The state or communities could direct grant funding to support co-location of existing crisis teams with law enforcement, or to pay for time spent in ride-alongs or other collaboration.

Co-responder models are not a substitute for more traditional paths to accessing mental health treatment, but they can assist law enforcement officers as they respond to people experiencing a mental health crisis. Without a professional assessment of a person's mental health needs, officers tend to err on the side of caution, bringing the person to the ED even if that might not be the best fit with the person's needs. This can further complicate the person's recovery and lead to wasted time and resources. Having mental health providers as part of law enforcement's crisis response can help ensure that people experiencing mental health crises receive the services and supports they need in a timely way and in settings they feel are most appropriate. Co-responder models can also help bridge the cultures of health care and law enforcement and promote further collaboration.

Some co-responder models involve proactive outreach to individuals who come in frequent contact with crisis providers or law enforcement, or who have experienced trauma. Models in Texas and California emphasize this function.[63] In most cases the mental health provider leads the conversation and the officer is there to build trust in the event law enforcement does have contact with that person in the

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[61] Trangle, Michael, op. cit.

[62] Abbott, Sarah. "Advocates Jail Diversion Program: A Step by Step Toolkit," Framingham, MA: Advocates, 2015, 4. Available at https://mn.gov/dhs/assets/czech-advocates-jds-manual-12_tcm1053-256994.pdf.

[63] Smith-Kea, Nicola, Michael Yarbrough, and Sam Myers. "Police-Mental Health Collaboration Programs: A Different Way of Policing." Webinar held 9/28/16. Washington, DC: Council of State Governments Justice Center. Accessed on 10/4/16 from https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/.

future. Mental health providers, such as case managers, seek a release of information that covers the mental health team's collaboration with the law enforcement agency.

While national models are available, they will need to be adapted to Minnesota's service system. One major concern will be the availability of a qualified workforce. Nationally, models for co-responders have emphasized having a master's level provider as the embedded person. They have a more significant clinical background, are better equipped to accurately assess risk, and have a licensing board to whom they are accountable.[64] Members of the task force affirmed this as an important principle.

Another concern to be addressed is that communities that have significant levels of distrust towards police may be less likely to call for crisis services if they believe that they are connected to law enforcement. A third concern is the strength of the community services available to support the recovery of the person experiencing the mental health crisis. If the community-based services available are insufficient, the co-responder model will struggle.[65]

The goal of pilot projects should be to test co-responder models' ability to provide timely, on-scene assessment of people's needs and connection to community resources in a sustainable way. Pilots could also assess how to best deliver proactive outreach to individuals who come into frequent contact with hospitals, crisis services, and law enforcement. This will require the collaboration of law enforcement, crisis teams, people with lived experience of mental illness, mental health advocates, community mental health providers, counties and tribal authorities. Because each community's implementation of co-responder models would be somewhat unique to respond to local needs and strengths, it will be useful to pilot and evaluate a range of models.

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

Whenever possible, children with emotional disturbances should receive the services and supports they need so that their symptoms don't lead to situations that involve them in the criminal justice system. For children in the criminal justice system, Minnesota should build on diversion programs for children whose primary need is mental health treatment. For children with emotional disturbances, involvement in the criminal justice system can have negative consequences for the child and family, including self-identification as a delinquent, restricted access to therapeutic settings, family separation, interruption of educational progress, and additional stress from an uncertain process.[66]

Minnesota needs more high quality diversion options for youth with mental health needs and criminal justice involvement. The priority should to identify services and supports needed to maximize safe and therapeutic outcomes for children and their families. The task force supports the recommendations of the Juvenile Justice Work Group, which included:[67]

- Expanding the availability of community-based treatment, services, and supports

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[64] Ibid.

[65] Helfgott, Jacqueline, Matthew Hickman, and Andre Labossiere. "A Descriptive Evaluation of the Seattle Police Department's Crisis Response Team Officer/Mental Health Professional Partnership Pilot Program." *International Journal of Law and Psychiatry* 44 (2015): 109-122. Available at: http://dx.doi.org/10.1016/j.ijlp.2015.08.038.

[66] For example, the model developed in Stearns County, MN could be considered for possible broader replication.

[67] "Juvenile Justice Work Group: Report to the Minnesota Legislature." Saint Paul, MN: NAMI Minnesota, 2014. Accessed on 11/8/16 at: https://www.leg.state.mn.us/docs/2014/mandated/140345.pdf.

- Improving the mental health screening process within the child protection and juvenile justice systems and ensuring post-screening coordination

- Collecting county and tribal data to track outcomes and identify unmet needs

- Increasing family support and engagement

- Promoting school-based interventions

4. Improve Data Sharing and Collaboration

Data-sharing across healthcare and social service systems, both public and private, can improve integrated services for people with mental illness. Better integration can help ensure that people get access to the right services at the right time and place and that those services are responsive to the unique situation and needs of each person. This can help prevent mental health crises.

In addition, data-sharing and collaboration that inform person-centered decision-making can improve the response when someone does experience a mental health crisis. Often people experiencing mental health crises can provide information and be actively involved in decision-making about solutions, but in some cases their mental health symptoms can prevent them from doing so. Families can also be helpful sources of information, but in crisis situations it can sometimes be difficult to locate family members or to understand family relationships and dynamics. First responders, crisis response teams, and ED staff can be left making quick decisions with inadequate information. Better data sharing and collaboration could help improve the experience of the person in crisis, the outcomes of the crisis, and the safety of everyone involved.

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

Between 2011 and 2014, the Institute for Clinical Systems Improvement, the Minnesota Hospital Association (MHA) and Stratis Health partnered to reduce avoidable hospital readmissions in the Reducing Avoidable Readmissions Effectively (RARE) campaign.[68] A subgroup, the Mental Health Collaborative, convened hospitals with inpatient psychiatric units to identify best practices and reduce psychiatric readmissions. They focused on five key areas: patient/family engagement, medication management, comprehensive transition planning, care transition support, and transition communication.[69] They also outlined measures that could be used to assess improvements in each of these areas.

Minnesota hospitals have been implementing the policies and practices recommended by the RARE collaborative, and analysis of shared data is at the center of ascertaining progress. However, staff turnover and/or a lack of identified ownership for these projects can undo progress. Minnesota hospitals can continue to improve by increasing the quality of resource databases, improving staff retention in care planning roles, and reinforcing recovery strategies in discharge plans.[70]

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[68] "RARE: Reducing Avoidable Readmissions Effectively." Website accessed on 10/12/16 at http://www.rarereadmissions.org/index.html.

[69] "Recommended Actions for Improved Care Transitions: Mental Illnesses and/or Substance Use Disorders." Minneapolis, MN: Institute for Clinical Systems Improvement, 2012. Available at http://www.rarereadmissions.org/documents/Recommended_Actions_Mental_Health.pdf.

[70] Kemper, Jill, Health Care Consultant, Institute for Clinical Systems Improvement. Interview held 10/5/16.

The e-Health Roadmap is another statewide collaboration around data-sharing as a strategy for improving healthcare delivery. Part of a State Innovation Model cooperative agreement, awarded to DHS and MDH in 2013 by the Center for Medicare & Medicaid Innovation, partners have created the Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services.[71] The Roadmap lays out a process for adoption of electronic health records, health information exchange, and health information technology supports to support communication and care coordination. The goal of the Roadmap is to ensure that the right information is available to the right person at the right time to make the right person-centered decision and that information is collected and used according to privacy, security, and consent laws.

Projects like these can improve data-sharing and collaboration that can help prevent mental health crises and improve the experience of receiving mental health services. When healthcare, social services, and other supports are coordinating their efforts and sharing information according to the wishes and consent of the person, it is more likely that people will get the support they need to maintain their mental health. If healthcare and social service resources are not coordinating efforts, a breakdown in supports can easily trigger a crisis. With proper consent, data sharing can also allow a person to access services without having to continually provide basic information and re-tell their story, which can be frustrating for the person receiving services.

b. Access to Personal Data during a Crisis

The data sharing projects described in the previous section could eventually help improve first-responders' access to individuals' healthcare and social services records during a crisis if those individuals have previously agreed to that sharing and all data privacy and security laws are followed. Given the number of different data standards, databases, organizations, and laws involved, this is likely to be a long-term prospect.

In the shorter term, the task force is interested in models that could provide first-responders with data they need to assist people experiencing mental health crises when those people have previously given permission for such sharing. One model could be the approach that some states have taken to establish centralized registries of advance directives. Individuals complete their plans and store them through a secure online portal.[72] They may print a wallet card with a bar code or store information on their phone that links their name and registry identification. In case of an emergency, a healthcare provider can access their documents with the individual's name and registry identification or date of birth. Similarly, it's possible that Minnesota could implement an option for individuals to declare that they wish to have information disclosed to law enforcement in a crisis situation. While a registry does not necessarily mean the advance directive is integrated directly into the patient record, it does make the information more accessible to the healthcare provider. Minnesota could also consider other models to help ensure that law enforcement and other first responders have the information that a person with mental illness wants them to have if they should experience a mental health crisis.

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[71] "Minnesota e-Health Roadmap for Behavioral Health, Local Public Health, Long-Term and Post-Acute Care, and Social Services." Saint Paul: Minnesota Department of Health, 2016. Accessed 10/16/16 at http://www.health.state.mn.us/e-health/ehealthdocs/ehlth_roadmap_final.pdf.

[72] Models from Virginia, California, and Idaho were reviewed.

5.   Implement Telehealth Solutions

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

a.   *Establish common network and protocols*

Minnesota should expand a single interoperable network standard for telehealth mental health services, and identify sustainable support for those infrastructure costs. Parallel to this, DHS should consult with stakeholders as they establish best practices for the workflows used to implement telehealth for crisis situations. This would include adopting a common cloud-based platform for connecting providers and individuals, identifying a mechanism for other emergency responders to connect from remote locations through a tablet or other device, and setting timelines and responsibilities each partner in the project. This should build on prior work. For example, providers in Minnesota have invested significant effort into developing protocols and workflows to support the deployment of telehealth connections between crisis teams and small hospitals.[73]

DHS and Adult Mental Health Initiative Region 3 (northeast Minnesota) have partnered to pilot the deployment of a common standard and network for telehealth connections. Hospitals, schools, and clinics all can gain access to the DHS network which allows for fast and easy connections. One of the core principles that the group has affirmed is that telehealth services should adapt to the needs of individuals, not be limited to fixed locations. Their system allows one member of a crisis team to stay in contact with a child in crisis at a school, while another travels to the school to respond in person. It also allows a psychiatrist from the community mental health center to conduct a diagnostic assessment and prescribe medication to an inmate at the county jail without any transportation time or cost.[74] MN.IT, the state information technology agency, provides helpdesk to support for all users.

For expansion, MN.IT staff who have worked on the pilot have recommended that Minnesota use HIPPA-compliant, cloud based services instead of buying and maintaining a dedicated physical infrastructure.[75] Cloud based services can be deployed quickly, but providers and recipients would need support to understand how best to use the technology. MDH's Office of Rural Health has experience managing grants for capital expenditures that rural health systems would otherwise be unable to afford. Further stakeholder work would require broad representation: hospital systems, community mental health centers, crisis teams, schools, jails, etc. Establishing a statewide conference or community of practice could help develop and spread best practices.

b.   *Reserve Capacity for Crisis Response via Telehealth*

Crisis response services in local communities can sometimes experience high volumes of calls that overwhelm their capacity. When this happens, they can't respond in a timely fashion to support the person experiencing the crisis. To address this problem, Minnesota should establish a centralized telehealth resource that can respond to calls until the local crisis response providers are available. When

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[73] Reitmeier, Shauna, Chief Executive Officer, Northwestern Mental Health. Correspondence on 9/9/16.

[74] Lee, Dave. "Vidyo Telepresence System Live Demonstration to State Advisory Council and Children's Subcommittee." Saint Paul: Minnesota Department of Human Services. Presentation held 10/6/16.

[75] The Health Insurance Portability and Accountability Act (HIPPA) regulates the use and disclosure of individuals' health information.

a person's call is transferred to the pool, they would be presented with the option of waiting for the local crisis team (with an accurate estimate of the likely timeframe), or given directions to other sites that could provide assistance. Those could include crisis services in adjacent communities, urgent care clinics, hospital, or fire station/paramedic bases. The local site would need to be able to provide some level of support, possibly from a paramedic or a triage nurse, and the ability to call for further resources when required.

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

The goal would be to significantly reduce the number of times a potential recipient is told that crisis services are unavailable because all staff are already committed to calls. Utilization of data from the telehealth team could drive further development of the mobile teams. Strong consideration must be given to how this service would help connect individuals to ongoing assistance and develop a relationship with local resources. This model would focus on providing intervention only, and referring back to the local team for crisis stabilization/follow-up services as appropriate.

Successful collaboration would need to include 911 responding agencies, counties and tribal authorities, existing mobile crisis teams, host site locations, and DHS. Implementing local sites (hospitals, paramedic stations, etc.) would need buy-in from community stakeholders, including healthcare staff.

6.   Improve Community Services

a.   Expand Forensic Assertive Community Treatment Capacity

Minnesota should invest in specialized Forensic Assertive Community Treatment (FACT) teams to meet the needs of people at risk of future or continued involvement in the justice system due to their mental illnesses. This follows a recommendation in the 2016 Office of the Legislative Auditor report on mental health care in jails.[76]

Assertive Community Treatment (ACT) is an evidence-based service for people with severe mental illness (schizophrenia and bipolar disorders) and is a multidisciplinary, team-based approach with a small staffing ratio and 24/7 hour staff availability. ACT is a non-residential service, working with people in their homes and communities, and the team provides treatment, rehabilitation, and support. ACT is sometimes described as a "hospital without walls".

Forensic assertive community treatment (FACT) is an adaptation of the traditional model that is designed to help people who have higher risk of repeated involvement with the criminal justice system or incarceration than those served by traditional ACT services. These people have complex symptoms and they require a high level of treatment, rehabilitation and services in order to pursue recovery in their communities. One FACT team is already operating as a collaboration between DHS, DOC, Ramsey County, and South Metro Human Services. Hennepin County is also starting a FACT team to work with people who enter the county jail or are involved in the Mental Health Court.

Expanding FACT would provide high quality, community based mental health services to individuals whose treatment and services needs are currently underserved. Past evidence shows that individuals receiving FACT services have fewer jail and hospital bed days and longer periods of time living in the community. The staffing requirements to meet fidelity standards are rigorous, and it can take 6-12 months to find qualified individuals to establish a team. In order to succeed, counties and tribal authorities, jails, DOC, DHS, and community mental health providers would need to collaborate.

b.   Expand Pre-Crisis Services

Through federal block grant funding, Minnesota supports a "warmline," which provides a safe, accessible source of connection and information for people pursuing recovery from mental illness. As the name implies, it is not intended as a "hotline" capable of responding to individuals experiencing a mental health crisis. It fills an important gap between outpatient care and crisis response. Warmline operators are peers who have been trained as Certified Peer Specialists. The training provides people who have experienced mental illness the framework for supporting others by modeling healthy behaviors, asking the individual to recall previous tools or strategies that have been successful, and offering hope that recovery is possible.

The Minnesota Warmline is currently available statewide during evening hours (4 p.m. to 10 p.m.), Tuesday through Saturday. Individuals may call anonymously if they wish. Approximately half of the callers are experiencing significant stress or anxiety when they call, while the other half are reaching out to break isolation. Nearly 90% of callers report feeling calmer by the end of the call.[77]

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[76] Alter, Joel. "Mental Health Services in County Jails." Saint Paul: Office of the Legislative Auditor, 2016, 41. Available at: http://www.auditor.leg.state.mn.us/ped/2016/mhjails.htm

[77] Mulvihill, Shannah, Executive Director, Mental Health Minnesota. Grant report to DHS and correspondence on 10/10/16.

Minnesota should support and promote warmline services as an adjunct to crisis services to help individuals avoid experiencing a mental health crisis. This program handles nearly 500 calls/month during its open hours (30 hours per week), with the number of calls increasing every month. Adding hours and clinical supervision would increase the value of this service to Minnesotans who are frequently near crisis.

Appendix I: Governor's Executive Order

STATE OF MINNESOTA

EXECUTIVE DEPARTMENT

MARK DAYTON
GOVERNOR

Executive Order 16-02

Establishing the Governor's Task Force on Mental Health

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

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

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

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

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

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

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

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

Now, Therefore, I hereby order that:

1. The Governor's Task Force on Mental Health is created to advise the Governor and Legislature on mental health system improvements within the State of Minnesota.

2. The purpose of the Task Force is to develop comprehensive recommendations to design, implement, and sustain a full continuum of mental health services throughout Minnesota.

3. In addition, the Task Force will make recommendations on:
   a. Developing and sustaining a comprehensive and sustainable continuum of care for children and adults with mental illnesses in Minnesota, including policies, legislative changes, and funding;
   b. Clear definition for the roles and responsibilities for the state, counties, hospitals, community mental health service providers, and other responsible entities in designing, developing, delivering, and sustaining Minnesota's continuum of mental health care;
   c. Reforms needed to support timely and successful transition between levels of care, including early intervention services and substance abuse services; and
   d. Expanding the capacity of Minnesota's mental health system to responsively serve people of diverse cultures and backgrounds.

4. The task force shall consist of members appointed by the Governor, including:
   a. The Commissioner of the Department of Human Services;
   b. 4 individuals or family members of individuals with lived experience of mental health issues;
   c. 2 mental health advocates;
   d. 2 representatives of community mental health services;
   e. 2 representatives of hospital systems;
   f. 2 representatives from law enforcement;
   g. A representative from the counties; and
   h. A representative from the judicial branch.

5. The task force shall include four ex-officio leaders from state agencies, who shall be appointed by the Governor:
   a. The Commissioner of the Department of Health;
   b. The Commissioner of the Department of Corrections;
   c. The State Director to Prevent and End Homelessness; and
   d. The Ombudsperson for Mental Health and Developmental Disabilities.

6. The task force shall include four ex-officio legislative members, who shall be appointed by caucus leadership:
   a. A Member of the Majority Party in the Senate;
   b. A Member of the Minority Party in the Senate;
   c. A Member of the Majority Party in the House of Representatives; and
   d. A Member of the Minority Party in the House of Representatives.

7. The chair of the Task Force will be the Commissioner of the Department of Human Services.

8. The Task Force will report to the Governor's Office, the Legislature, and the public by November 15, 2016.

9. The Commissioner of the Department of Human Services will provide general administrative and technical support to the Task Force.

10. The Task Force will make its meetings open to the public and provide opportunities for public comment.

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

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

Mark Dayton
Governor

Filed According to Law:

Steve Simon
Secretary of State

Appendix II: Task Force Members

Emily Johnson Piper
Department of Human Services, Chair

Sue Abderholden – Minneapolis, MN
NAMI Minnesota

Jaime Anderson – Minneapolis, MN
Fourth Judicial District

Melissa Balitz – Hastings, MN
Representative with Personal or Family
Experience with Mental Illness

Paul Goering – St. Paul, MN
Allina Health

Brantley Johnson – Minneapolis, MN
Representative with Personal or Family
Experience with Mental Illness

Jim McDonough – St. Paul, MN
Ramsey County Commissioner

Shauna Reitmeier – Crookston, MN
Northwest Mental Health Center

Rodney Seurer – Savage, MN
Savage Police Department

Kim Stokes – Britt, MN
Representative with Personal or Family
Experience with Mental Illness

Sara Suerth – Brooklyn Park, MN
Brooklyn Park Police Department

Bruce Sutor – Rochester, MN
Mayo Clinic

Liliana Torres-Nordahl – Bloomington, MN
Women's Alliance Minnesota

Crystal Weckert – Brainerd, MN
Representative with Personal or Family
Experience with Mental Illness

Pahoua Yang – St. Paul, MN
Amherst H. Wilder Foundation

Brenda Cassellius – Saint Paul, MN
Department of Education, Ex-Officio Member

Edward Ehlinger
Department of Health, Ex-Officio Member

Clark Johnson
Minnesota House of Representatives, Ex-Officio
Member

Tony Lourey
Minnesota Senate, Ex-Officio Member

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

Roz Peterson
Minnesota House of Representatives, Ex-Officio
Member

Julie Rosen
Minnesota Senate, Ex-Officio Member

Tom Roy
Department of Corrections, Ex-Officio Member

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

Appendix III: Acronyms Used in this Report

ACT: Assertive Community Treatment

AMRTC: Anoka Metro Regional Treatment Center

APS: Acute Psychiatric Services

CAH: Critical Access Hospital

CHIPS: Child in Need of Protection

CMS: Center for Medicare and Medicaid Services

CPS: Certified Peer Specialist

DHS: Minnesota Department of Human Services

DOC: Department of Corrections

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

ED: Emergency Department

EMS: Emergency Medical Service

FACT: Forensic Assertive Community Treatment

HCMC: Hennepin County Medical Center

HIPPA: Health Insurance Portability and Accountability Act

IRTS: Intensive Residential Treatment Services

LGBTQ: Lesbian, gay, bisexual, transgender, queer

MDH: Minnesota Department of Health

MN.IT: State of Minnesota information technology agency

MnSCU: Minnesota State Colleges and Universities

NAMI: National Alliance on Mental Illness

PRTF: Psychiatric residential treatment facilities

PTSD: Post-traumatic stress disorder

RARE: Reducing Avoidable Readmissions Effectively

RCS: Residential Crisis Stabilization

SAMHSA: Substance Abuse and Mental Health Services Administration (federal agency)

Appendix IV: Acute Care Capacity Issue Background

Inpatient Psychiatric Hospitalization

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

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

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

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

Providers, law enforcement, and community members have focused particular attention on this sub-population in recent years because Minnesota's mental health system does not currently have the capacity to meet their complex needs. This is similarly the case for children and youth living with serious emotional disturbance and co-occurring conditions. These conditions include but are not limited to Autism Spectrum Disorders, self-injury or aggression, brain trauma, and complex medical issues.[78]

Psychiatric Hospital Statistics

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

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[78] "Mental Health Acute Care Needs Report." St. Paul: Minnesota Department of Human Services, March 2009, 13.

- 35 community hospitals

- 7 Community Behavioral Health Hospitals, state-operated

- Anoka Metro Regional Treatment Center (AMRTC), state-operated

- Children and Adolescent Behavioral Health Services , state-operated

- 2 Veterans Administration hospitals, federally-operated

Including all 46 hospitals and their licensed beds reported for inpatient psychiatric capacity, there are 1,436 licensed beds for inpatient mental health treatment for adults and children/adolescents.[79] In reality, there are fewer than this available. AMRTC is licensed for 175 beds, but it operates at 110. The Community Behavioral Health Hospitals are licensed for 16 beds but currently operate at about 10 beds each. Children and Adolescent Behavioral Health Services, also licensed for 16 beds, currently operates at less than 5. In addition, community hospitals report instances of taking beds offline for security or treatment purposes.

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

The Minnesota Hospital Association released a white paper in 2015 that included statistics showing average inpatient mental health occupancy rates.[80] The Association found average occupancy rates of 80 percent statewide, with 87.4 percent in the Twin Cities and 76.6 percent in Greater Minnesota. In contrast, the average occupancy rate for all conditions statewide was 40 percent. The contrast was particularly apparent for children and youth. Mood disorders like depression were the top reason for all inpatient admissions for children and adolescents, including non-psychiatric conditions. The average length of stay for mood disorders was 6 days.

Minnesota hospital emergency department visits for mental health and substance use disorders have increased substantially from 2007-2014. Minnesota hospital EDs experienced a 49 percent increase in all mental health and substance use disorder visits during that period. For all conditions, the increase was 20 percent. Emergency department visits increased 34 percent in the metro and 40 percent in Greater Minnesota.[81]

Inpatient Psychiatric Bed Shortage

There has been a great deal of attention paid to the shortage of psychiatric inpatient hospital beds in Minnesota, as evidenced by long waiting lists and other "patient flow" problems that result in people

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

[80] *"Mental and Behavioral Health: Options and Opportunities for Minnesota."* St. Paul: Minnesota Hospital Association, December 2015, 9.

[81] Ibid., 12-14.

not getting access to the treatment they need at the right time and place. According to the 2009 Acute Care Needs Report, a review of the empirical research literature showed that there are not yet population-based standards for determining the right number of psychiatric inpatient beds needed to serve a certain population size, nor is there an accepted methodology for setting such standards.

> "Several reports have identified specific community-based mental health services that can directly impact the utilization of inpatient psychiatric capacity. The 2008 Treatment Advocacy Center report on the shortage of public psychiatric hospital beds recommends 50 public psychiatric beds per 100,000 population. However, the report also states that the use of assertive community treatment teams, club houses and other community supports would directly decrease the number of beds needed (Torrey, et al., 2008). A 2007 National Health Policy Forum issue brief also reported that comprehensive intensive outpatient services such as assertive community treatment, mobile crisis response teams and partial hospitalization produce lower rates of hospitalizations (Salinsky, 2007). A 2006 national focus group convened by the National Association of State Mental Health Program Directors concluded that the need for public and private inpatient psychiatric beds must be evaluated in the context of the full array of care rather than an absolute "per capita" indicator independent of the rest of a state or community mental health system. (Emery, 2006)." [82]

A 2008 Minnesota Medical Association report offers a number of factors contributing to the "absolute and functional shortage of psychiatric beds." These are staff shortages, high patient acuity levels and a lack of facilities to serve individuals with both mental health and medical needs and discharge barriers such as a lack of housing with supportive services, delays in the commitment process and lack of timely access to outpatient services for medication management.[83]

Minnesota's mental health system includes and is expanding the use of ACT teams, mobile crisis services, permanent supportive housing, and other community-based services intended to help prevent hospitalization. These services, as well as the workforce necessary to deliver them, are important to keep in mind as discussion of inpatient bed capacity progresses.

Patient Flow – the Front and Back Doors

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

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[82] "Mental Health Acute Care Needs Report." St. Paul: Minnesota Department of Human Services, March 2009, 2. See also Torrey, E. Fuller., and K. Entsminger, J. Geller, J. Stanley, and D. Jaffee. "The Shortage of Public Hospital Beds for Mentally Ill Persons." Arlington, VA: Treatment Advocacy Center, 2008; Salinsky, Eileen and Christopher Loftis. "Shrinking Inpatient Psychiatric Capacity: Cause for Celebration or Concern? Issue Brief #82. Washington, DC: National Health Policy Forum, George Washington University, 2007; Emery, Bruce. "The Crisis in Acute Psychiatric Care: Report of a National Focus Group Meeting." Washington, DC: National Association of State Mental Health Program Directors, 2006.

[83] "Mental Health Acute Care Needs Report." St. Paul: Minnesota Department of Human Services, March 2009, 3. See also Roger Kathol and S. Sterner, et.al. "Psychiatric Bed/ER Diversion Task Force Report." Minneapolis: Minnesota Medical Association, 2008.

refers to getting into a treatment setting; "back door" refers to when, how, and where they are discharged.

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

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

> "The factors that force people to wait for access to inpatient psychiatric beds are called *front door* issues, and the factors that prevent a patient from leaving AMRTC or a community hospital at the appropriate time are called *back door* issues. Both front door and back door problems prevent people from making smooth transitions to the right care in the right place at the right time. The lack of community services underlies the failure to prevent people from needing a hospital level of care and too much demand forces people to wait (front door). The (back door) problem of people "stuck" at AMRTC and other hospitals exacerbates the front door problems and forms a serious barrier to recovery. Both problems waste scarce resources that could be better spent on appropriate care and prevention programs. Both problems are further exacerbated by inefficient legal processes, complicated eligibility and funding processes, and inadequate coordination among agencies."[84]

A recently-released study from Wilder Research on behalf of the Minnesota Hospital Association shows nearly 20 percent of inpatient psychiatric bed days in 20 community hospitals were potentially avoidable. In other words, a person on an inpatient mental or behavioral health unit who reached stability and no longer needed treatment in a hospital was not able to be discharged from the hospital because of a lack of appropriate treatment capacity. According to this pilot study, 14 percent of these potentially avoidable days were due to a patient waiting for transfer to a state-operated Community Behavioral Health Hospital. Eleven percent were waiting for substance use disorder treatment. Ten percent awaited IRTS.[85]

Roles and Responsibilities

Underlying the patient flow problems is confusion between the state, providers, counties, law enforcement, and the judiciary, among others, about the roles each plays. In particular, the question of

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[84] "*Plan for the Anoka Metro Regional Treatment Center*." Saint Paul: Minnesota Department of Human Services, 2014, 43.

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

who is responsible for the "safety net"—the provision of services for a person whom other providers have declined to treat—is consistently raised. While the State has historically been the safety net provider, deinstitutionalization, financial incentives, and the Olmstead decision have been driving Minnesota to a community-based care model for decades. As these changes have occurred, roles have not been clarified and confusion continues about who has the ultimate responsibility for treating individuals with the most complex and serious mental illnesses and substance use disorders.

Appendix V: Additional Models for Crisis Response

This Appendix presents some additional models for crisis response programs that the task force did not have enough background to recommend, but that could be considered in the future for implementation or replication.

Healthcare System-based Telehealth Pools

Minnesota could support the development of telehealth resources for hospitals and urgent care settings that would be operated by the healthcare systems for their affiliates. When a person with a mental illness comes to a hospital or clinic that does not have the necessary mental health providers on staff, telehealth would be used to support the local ED in providing appropriate intervention and stabilization.

CentraCare is establishing telehealth for psychiatric consultation to the emergency rooms of the smaller hospitals in its system. Mental health staff will be based at St. Cloud. Hiring the needed workforce has been a challenge, especially to get 24/7 coverage. CentraCare participates in a regional planning effort that includes law enforcement, county health and human services, and Central Minnesota Mental Health, the local community mental health center. They are exploring further improvements, including urgent care for mental health that would be co-located with physical urgent care.[86]

A key advantage of the system-based model is the increased familiarity between host and remote staff than might be expected in a general statewide system. A host provider with a set territory can better learn local referral resources and collaborate better with other providers in the same health system. Moreover, it could be easier to set up a single system-based program than to coordinate a multi-system network. However, the system-based model could increase regional disparities in the availability of services if some systems implement programs and others don't. There could also be variability within a single system, depending on how closely the host and remote staff are connected with county based services in some areas and on the level of buy-in at the host and remote sites. Finally, although telehealth programs are one possible solution to the lack of mental health staff at remote locations, workforce shortages could make them difficult to implement. Additional funding to target student loan forgiveness could be offered. Grant support for physical and information technology infrastructure might be required.

Psychiatric Emergency Rooms

Minnesota could support the development of more psychiatric emergency rooms to serve people with acute mental illnesses. The psychiatric emergency rooms would provide specialized response to mental health needs and collaborate well with law enforcement, social services, and community-based mental health providers.

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[86] Hartford, Dave, Behavioral Health Section Director, CentraCare. Correspondence on 9/1/16.

Since 1971, Hennepin County Medical Center (HCMC) has operated the Acute Psychiatric Services (APS) unit. Initially designed to handle walk-in appointments and referrals from other parts of the hospital, APS has expanded services and operates a dedicated psychiatric emergency room with 14 rooms. The waiting room was recently remodeled and is a more calming environment than a general ED. People without appointments present with a variety of needs, and they are assessed by a psychiatrist or other prescribing provider. Many people come to the psychiatric emergency room with a particular problem, especially the need for medication refills, but more complex needs emerge as they talk with the provider during the assessment process. HCMC has made the deliberate choice to use psychiatrists and other prescribing providers to perform the psychiatric evaluations although this is a relatively expensive approach. They see a lower rate of inpatient admission because they are able to address more potential concerns during the assessment process.

APS serves people with acute mental illnesses, including those with complex medical conditions in addition to their mental illness and those whose symptoms have recently included assaultive behavior. APS has security personnel on site, the rooms are designed to ensure the safety of the people being served and staff, and a portion of the APS unit is secured. This means that APS can respond quickly to the range of needs and circumstances of the people it serves and police officers who bring people to APS know that they can expect a 7-9 minute transition time.

Other collaborations help address related needs. While APS can serve people with some aggressive behaviors, HCMC staff serve people in the Hennepin County jail to provide mental health treatment when a jail setting is required for safety. HCMC staff also work with nursing homes and other community settings to quickly readmit people who were discharged to those settings but whose needs have escalated. This helps build trust with community providers and create more discharge options to be considered when a person is ready to leave HCMC. Building trust and communication among departments and programs makes it possible to harness the right resources at the right time to deliver the best outcomes for people being served.[87]

Operating a psychiatric emergency room requires significant patient volume and on-going operational funding, which likely restricts the model to urban areas. HCMC recoups about two-thirds of their operating costs through billing insurers, leaving a shortfall of approximately $1 million per year. The model provides non-quantified benefits, however, including helping HCMC's ED ensure that people with mental illnesses are served appropriately and that law enforcement officers don't spend valuable time waiting in the ED while appropriate services are located for the person they have transported to HCMC.

The HCMC model could be replicated and refined as an expansion of services in high-volume EDs for people with acute mental illnesses and symptoms that include aggressive behaviors. Physical spaces would need remodeling (or construction) to make them more conducive to recovery. Funding would need to be secured, and staff hired and trained. This program would have some costs that are not directly billable to health insurance (for example, security personnel needed to ensure staff and patient safety). Depending on the people served, some portion of the services could be billed to public health programs. Key partners would include the hospital and/or health care system, counties, tribes, MDH,

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[87] Coyne, Megen, Senior Director, Department of Psychiatry, Hennepin County Medical Center. Correspondence on 9/29/16.

and DHS, and community providers. Partnerships with law enforcement could help define plans for addressing security needs.

Zero Suicide Model

The Zero-Suicide Model links physical and behavioral health to support young people with mental health challenges.[88] It creates a leadership-driven, safety-oriented culture committed to dramatically reduce suicide among people under care. Survivors of suicide attempts and suicide loss are included in leadership and planning roles. Zero suicide programs relentlessly pursue a reduction in suicide and improve the care for those who seek help. The model comprises:

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

2. Systematically identifying and assessing suicide risk among people receiving care.

3. Ensuring that every individual has a pathway to care that is both timely and adequate to meet his or her needs. This includes collaborative safety planning and means restriction.

4. Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors.

Range Mental Health Wellstone Center for Recovery

The Range Mental Health Center's Wellstone Center for Recovery is a community-based program designed to assist adults experiencing a mental health crisis or emergency.[89] The program offers individualized services that meet the unique needs of those being served and is staffed around the clock by highly trained mental health practitioners and skilled nursing staff. Each resident has a private room. Most insurance is accepted, including Medicaid. Admissions are taken 24 hours a day, 7 days a week, 365 days a year.

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

- Individualized Assessment and Treatment

- Psychiatry Medication Management

- Onsite Diagnostic Assessment

- Onsite Alcohol and Drug Assessments (Rule 25)

- Illness Management and Recovery

- Integrated Mental Health and Substance Abuse Program

- Family Psychoeducation

- Holistic Skills Training focusing on Prevention, Wellness and Self-Care

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[88] "What is Zero Suicide?" Washington, DC: Suicide Prevention Resource Center, 2015. Available at http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/zero_suicide_final6.pdf
[89] "Services." Range Mental Health Center website. Accessed 10/12/16 at http://rangementalhealth.org/services/.

- Discharge Planning and Referrals to ongoing/follow-up services and resources

Beltrami County Jail Diversion Program

Funded with $2 million in one-time startup grants in 2015, Beltrami County is designing programs to address the mental health needs of individuals who come into contact with law enforcement. The county is required to show sustainability for the services and provide integrated care. This funding has supported the development of an ACT team and the hiring of a project coordinator to represent the interests of tribal nations in the development of new services. This project may also include the development of IRTS services.

Connect Suicide Postvention

Minnesota is implementing a post-suicide intervention, or "postvention" based on the *Connect* model developed by NAMI-New Hampshire.[90] This is a nationally recognized best practice by SAMSHA and the Suicide Prevention Resource Center.

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

Since knowing someone who has died by suicide is one of the highest risk factors for suicide, postvention becomes an integral part of suicide prevention efforts. *Connect* has developed postvention protocols for educators, emergency medical services, faith leaders, funeral directors, law enforcement, mental health/substance abuse providers, medical examiners, coroners, military, and social service providers. The training can be customized with consultation with tribal organization.[91]

Training Highlights:

- Best practices on how to coordinate a comprehensive and safe response to a suicide

- Strategies for reducing the risk of contagion

- Review of the complexity of suicide-related grief, especially for different age groups

- Recommendations for funerals and memorial activities

- Suggestions of how to talk to survivors of suicide loss to promote their healing

- Best practices for safe messaging about suicide and responding to the media

- Identification of community resources to promote healing

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[90] "Suicide Prevention Program." Minnesota Department of Health website. Accessed 10/12/16 at: http://www.health.state.mn.us/injury/topic/suicide/.

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