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

2022 Report to the Governor and Legislature

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $475.00

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Contents

Land Acknowledgement and Declaration of Commitment

We, the members of the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health, acknowledge that the wealth of this country was built on stolen land and with enslaved and underpaid labor of African American, Native American, and Immigrant people.

We acknowledge that the recent global uprising, which was sparked by the murder of George Floyd here in Minnesota, paired with the COVID-19 pandemic, makes for a time of profound uncertainty, shame, fear, and distrust. We also recognize that despite those feelings, we all must actively challenge the impact of our own implicit biases and how they may influence our decisions as individuals and leaders.

Furthermore, we recognize that racism also expresses itself in policies and practices that either target or erase BIPOC communities and erect barriers to their prosperity.

Therefore, we pledge to be vigilant in monitoring the formulation of policies and practices that produce harm to vulnerable populations. We also commit to being open to other people's truths as we acknowledge the resilience, creativity and generosity of the human spirit and we hold firmly to the persistence of Hope.

With these issues in mind, we commit to dismantling systemic and structural racism by initiating and supporting policies, practices, and the allocation of resources that promote diversity, equity, inclusion, and shared power.

EXECUTIVE SUMMARY

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

Per statute, the Council and Subcommittee are charged with:

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

The 2022 Report to the Governor and Legislature provides recommendations from the members of the State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health. The Council and Subcommittee are dedicated to improving mental health services for **ALL** Minnesotans. Members considered current social, cultural, whole family, and person-centered needs when developing these important recommendations.

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

- Workforce development through enhanced Cultural and Ethnic Minority Infrastructure Grant {CEMIG) program
- Data and accountability
- Increase access to student loan forgiveness
- Continue to support community of practice and community-based wellness resources
- Leverage existing federal Medicaid funding to expand Individualized Education Program and Individualized Family Service Plan (IEP/IFSP) for school-based mental health services.
- Permanent per pupil allocation for specialized instructional support personnel and training
- Telehealth access for Minnesota students
- Parity law
- Improve DHS grant-making outreach
- Collaborative care model

- Update Minnesota Statutes 245.466 and 245.4875 pertaining to Local Advisory Councils
- Elimination of mandatory life without parole for juveniles and reduction of children being treated as teenagers
- Mental Health Services and Centralized Data Collection System for Juvenile Justice System
- Expand Access to Wraparound through the System of Care Initiative
- Expand family peer support opportunities
- Grow family support in schools
- Build Community Initiated Care to support young people and families
- Creation of one Minnesota board responsible for curriculum, certification and support of all Peer Support training, reporting, Continuing Education Units (CEU) management and quality compliance
- Increase access to affordable housing across Minnesota
- Increase employment support for individuals with mental health barriers to employment

RECOMMENDATIONS

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

Outreach for Cultural Diversity

Workgroup: Outreach to Cultural Diversity

Contact Person: BraVada Garrett-Akinsanya

Workforce Development through enhanced Cultural and Ethnic Minority Infrastructure Grant Program

Problem Statement: Minnesota has an increased need for mental health care that has been accentuated by the COVID19 Pandemic and the Murder of George Floyd (the Racism Pandemic). As early as the January 2015 report when Minnesota issued the Gearing Up for Action report (GearingUpForAction.pdf (healthforceminnesota.org), it has been clear that the current workforce is aging out and does not reflect the emerging diversity of the people being served. Therefore because of these factors, there is a great deal of pressure to quickly develop a responsive group of qualified mental health professionals. The shortage of mental health professionals in general, while significant, pales in the face of the even greater shortage of mental health services providers and professionals from diverse cultural backgrounds and rural communities. Nonetheless, funding for initiatives to support this growing problem has been inconsistent and anemic.

Background Information: To address the dearth of underrepresented ethnic minority providers, in 2007, Minnesota introduced two grant programs to address the issue. The two grants, the Cultural and Ethnic Minority Grant Program and the Cultural and Ethnic Minority Infrastructure Grant Program, were introduced as strategies to expand the workforce of licensed mental health professionals and practitioners from diverse cultural and ethnic backgrounds and rural communities by supporting professionals in obtaining clinical supervision and licensure support. These grants were designed to provide key foundational strategies in bridging the critical gap in access to mental health services and addressing the mental health workforce shortage in diverse and rural communities.

The Cultural and Ethnic Minority Grant Program has been resourced through ongoing state and federal funding and has been used primarily to support rural communities, with as much as $2.3 million dollars being shared among six grantees. On the other hand, the purpose of the Cultural and Ethnic Minority Infrastructure Grant Program has been to increase access to mental health services provided by racially and ethnically diverse mental health professionals who are proficient to provide culturally responsive and specific services to children, young people, and families from diverse

communities. The Cultural and Ethnic Minority Infrastructure Grant Program is a grant program that is also funded with ongoing state and federal monies. Nonetheless, the CEMIG Program has approximately supported 23 grantees who received funding that is historically approximately half of the amount (from $750, 000 to 1.2 million) granted to the CEMG program. While both of these grant programs are critical in our State's efforts to address the workforce shortage, increase the number of culturally specific providers and to increase the availability of mental health services that are culturally responsive and specific. Therefore, both the Cultural and Ethnic Minority Grant Programs need sustainable and ongoing funding that is equitably distributed.

Recommendations:

- Expand the availability of the Cultural and Ethnic Minority Grant Program by increasing funding for this grant program to $3M each biennium, while ensuring these funds are made available in an ongoing and sustainable manner.
- Expand the availability of the Cultural and Ethnic Minority Infrastructure Grant Program by increasing funding for this grant program to a one-time amount of $10 M and $SM each biennium.
- DHS ensures grants awarded through both programs focus on increasing access to mental health services that are culturally responsive and specific to adults, children, young people, and families from underserved cultural and ethnic communities and grows the mental health workforce.

Expected Outcomes & Who will benefit if this recommendation is implemented:

- Improved mental health access and well-being outcomes for diverse people.
- Reduced work shortages among participating providers.
- Increased family and young people's connection to their school and community. (E.g. An increase in the number and percentage of students who report in the Minnesota student survey that their community cares about them.)
- Increased access, services and funding to underserved communities through DHS grants and outreach provided for grants.

What is the impact on diversity of this recommendation? Communities will have access to more positive, cost-effective mental health services.

Data and accountability

Problem Statement: Many Minnesota entities fail to capture or accurately provide data that could lead to systems changes.

Background Information: BIPOC community mental health students, trainees, providers and agencies frequently complain that the availability of disaggregated, easy to find data is not required by notable entities. This lack of data serves to perpetuate inaction and a lack of accountability among systems. For example, data on Minnesota Student Survey data requires hours of data mining to gather comparative information across racial and ethnic groups. Licensing Boards do not capture data on the racial or ethnic backgrounds of examinees and therefore cannot be accountable for identifying who has failed or passed their licensing examples, which many examinees contend are culturally biased in the ways in which they are constructed, leaving examinees to believe that in order to pass the exam, cultural ways of knowing and engaging must be set aside and examinees must approach examination questions as if they are "older white men." Additional problems occur in other systems such as Juvenile Justice, where the existence of data on mental

health screenings is muddy and the outcomes based on those screening is not shared so that it is unclear if young people who are detected as having mental health concerns are ever referred for treatment.

Recommendations:

- Require any entities receiving state or federal dollars to report disaggregated data on services rendered by formulating comparative, disaggregated results based on ethnic/racial demographics as well as other key identifiers (i.e. urban or rural).
- Professional and government-based entities do not receive state or federal funds until they have reported key, disaggregated, data identifiers.
- State agencies provide disaggregated and comparative data across all systems where disparities are noted (especially areas such as criminal justice, schools, out of home placement, child protection).

Expected Outcomes & Who will benefit if this recommendation is implemented:

- Improvement in tracking evidence-based and practice-based outcomes especially regarding mental health access and well-being outcomes for diverse people.
- Increased awareness of where funds are needed for future statewide interventions and/or investments.
- We can currently measure the success of these recommendations based on how the data is currently handled (i.e., whether it is reported or not).

What is the impact on diversity of this recommendation? Communities will have access to more positive, cost-effective mental health services and targeted knowledge of where corrections are needed.

Increase access to student loan forgiveness

Problem Statement: Mental Health providers hold oppressive college loan debt that creates barriers to their full and timely entrance into mental health fields. The average college loan debt for practitioners of color is $56,000.

Background Information: The MN Loan forgiveness program is designed to recruit and retain health care professionals to needed areas and facilities in Minnesota. Loan Forgiveness is an important benefit for health care professionals as well as health care facilities and communities experiencing a shortage of access to primary care services. Eligible professionals include: Licensed Psychologist, Licensed Independent Clinical Social Workers (LICSW), Licensed Marriage & Family Therapists (LMFT), Licensed Professional Clinical Counselors (LPCC), and Licensed Alcohol and Drug Counselors (LADC). Psychiatric Nurse Practitioners apply as Advanced Practice Providers. Data on educational debt among medical school graduates indicate that American Indian, Blacks, and Latino graduates are more likely to have educational debt. Racial disparities in student debt have grown dramatically in recent decades. In one study, four years after earning a bachelor's degree, black graduates held $24,720 more student loan debt than white graduates ($52,726 versus $28,006), on average.

Recommendations:

- Increase funding for Loan Forgiveness for all mental health providers, with additional loan support and incentives targeting culturally diverse providers

Expected Outcomes & Who will benefit if this recommendation is implemented:

- Increased availability of providers in rural and urban settings as well as an increase of providers of color to address the current job shortage.

What is the impact on diversity of this recommendation? Minnesota will have access to more mental health providers in hard to serve communities and not lose providers to positions that will be more lucrative serving wealthier clients.

Continue to support community of practice and community-based wellness resources

Problem Statement: Mental Health providers often practice in silos and systems are not equipped to financially support consortia or alliances

Background Information: Most BIPOC communities hold communal value systems that require collaboration (vs. competition) as cultural strengths. Traditional ways of sharing knowledge and resources create systemic problems that detract from optimal success among multiple organizations. These practices lead to fractured community alliances, communication problems and the limited sharing of resources.

Recommendations:

- DHS create innovative paths that facilitate alliances that empower culturally diverse providers to name and legitimize cultural ways of engaging within their groups and with allied organizations.
- Add funding to support the culutrally-congruent measurement of outcomes of culturally diverse intervention models

Expected Outcomes & Who will benefit if this recommendation is implemented:

- Increased availability of culturally consistent support of traditional healing practices and ongoing research and establishment of shared knowledge and better practice-based evidence models.
- More resilient and formalized alliances among diverse groups of mental health professionals.

What is the impact on diversity of this recommendation? Culturally diverse providers will create innovative strategies of healing and supporting their communities.

Mental Health and Schools

Workgroup: Mental Health and Schools

Contact Person: Maleenia Mohabir

#1 Recommendation Title: Leverage existing federal Medicaid funding to expand Individualized Education Program and Individualized Family Service Plan (IEP/IFSP) for school-based mental health services.

Problem Statement: Although the need for school mental health services have continually increased, billing federal Medicaid reimbursements for IEP/IFSP mental health services have decreased for the last five years in Minnesota. Medicaid is the primary payer for IEP/IFSP health related and behavioral health services in the schools, not the Local Education Agencies (LEAs); however, schools are drawing down their educational funds to provide these services adding to the increasing cross subsidy.

There are two major factors contributing to school districts' inability to pursue federal Medicaid funding for IEP/IFSP mental health services:

1) Districts can only seek reimbursement for IEP/IFSP mental health services if they are certified under the Children's Therapeutic Services and Supports (CTSS) program, even though qualified mental health professionals and practitioners are providing the services

2) The duplicative paperwork required for districts to receive reimbursement. To seek federal Medicaid reimbursement for IEP/IFSP mental health services schools must conduct both CTSS and special education eligibility requirements that are completed by the same qualified professionals and often serve the same purpose

In a recent survey of 118 school social workers conducted by the Minnesota Department of Education, respondents reported that 88% of students receiving school social work services are not being billed. School social workers responded that if allowed to bill for school social work services without the constraints of Children's Therapeutic Services and Supports (CTSS), schools would have greater opportunities to access federal Medicaid reimbursements for the mental and behavioral health services being provided in our schools. All other health related services (transportation, speech/ language therapy, occupational therapy, nursing services, etc.) included in a child's IEP can be billed to Medicaid by documenting the need for the services in a special education evaluation and IEP/IFSP.

Background Information: Minnesota law requires school districts to seek federal reimbursement for health related and behavioral health special education services for students that are Medicaid recipients. Billing Medicaid for special education services allows schools to access federal funding already paid by Minnesota tax payers, is of no cost to the state and in no way effects the ability for outside mental health agencies to provide and seek reimbursement for their services.

Minnesota statute 256.0625 Subd. 26 already allows schools to seek federal Medicaid funds for clinical psychological services, school psychological services and school social work services and does not identify the need for separate certification. Nonetheless, schools are not able to access these funds outside of CTSS, like all other IEP/IFSP health related services provided in the schools.

Currently, the CTSS program is the only option for school districts to seek reimbursement of federal Medicaid funds for mental health services provided through a child's IEP/IFSP. Schools are providing the same evidence-based level of care to students by qualified mental health professionals who are often duly licensed by their licensing boards and Professional Educator Licensing and Standards Board (PELSB). However, to highlight the lack of CTSS participation, of the approximate 560 school districts across the state of Minnesota, only 8 districts are CTSS certified providers and 24 other districts contract with community CTSS providers.

In order for school districts to receive federal Medicaid reimbursement for IEP/IFSP mental health services, they are required to produce special education due process paperwork in addition to the documentation requirements of CTSS. The reimbursement received from Medicaid does not cover the cost of the additional paperwork, severely limiting a school districts' ability to bill and seek those federal funds for mental health services. For all other health related services provided through an IEP or IFSP, school districts are able to access federal Medicaid funds through the development of the special education due process paperwork, which identifies medical necessity and the need for the service, like other states.

There are many mental and behavioral health services reimbursable with federal Medicaid funds. Under the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, states are required to provide access to any Medicaid-coverable service in any amount that is medically necessary, regardless of whether the service is covered in the state plan. Even so, schools have limited access to these Medicaid funds by applying eligibility burdens, like CTSS, even though it is not required under the federal Medicaid benefit. The CTSS program is a state requirement and although schools are only accessing the federal share of the Medicaid payment, schools are limited in the benefits they

can access. School districts should be able to access federal Medicaid funds for IEP/IFSP mental health services without the constraints of CTSS.

Children and young people receiving Medicaid benefits are predominately from low-income families, who also disproportionally face a range of barriers in accessing mental health care and maintaining compliance with treatment. Some of these barriers include access to reliable transportation, parents' inability to take time off work, and a lack of service providers, especially in rural areas. Giving school districts more opportunities to access federal Medicaid funding can create greater equity in mental health care for vulnerable communities, as children and young people are more likely to receive consistent services at school.

Recommendation: Eliminate the Children's Therapeutic Services and Supports (CTSS) requirement for districts to access federal Medicaid reimbursement allowing the medical necessity and need for the services to be identified through the special education eligibility process.

Expected Outcomes: Accessing federal Medicaid funds will provide expanded comprehensive school-based mental health care services. Federal Medicaid funding offers a sustainable and reliable funding source to provide school-based mental health services at no cost to the state or community providers and potentially reducing that states cross subsidy. Finally, it gives schools the resources to build the internal capacity for school support services to meet the mental health needs of our students.

Work *group:* ***Schools and Mental Health Workgroup***

Contact Person: Lisa Hoogheem

#2 Recommendation Title: Permanent per pupil allocation for specialized instructional support personnel and training

Problem Statement: There is currently no permanent per pupil allocation for specialized instructional support personnel such as licensed school social workers, school psychologists, school counselors and school nurses) or funding to train said personnel on how to de-escalate and respond to a student experiencing a mental health crisis.

Background Information: Schools are often the first line of defense in addressing the mental health needs of students, but a lack of funding undermines and prevents schools from providing these crucial mental health services. Expanding our investment in mental health services in schools will help ensure greater student success. Approximately 80% of children and adolescents with mental health diagnoses have unmet mental health needs. Minnesota students increasingly report experiencing mental health problems that affect their lives.

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

Further, in his advisory entitled Protecting Young people Mental Health, the U.S Surgeon General writes that the negative impact of the pandemic "most heavily affects marginalized young people, such as disabled children, kids of

color, LGBTQ young people, children who are either homeless of in low-income households, kids in rural areas, young people in immigrant households and children in the juvenile justice system." This is also true in our great state.

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

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

Recommendation:

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

Expected Outcomes: Designating a per pupil allocation to hire additional specialized instructional support personnel will increase the ratio of specialized instruction support personnel to students which will translate into a ratio that is aligned with the national recommendations by the respective professional associations. This will also mean increased access to supports for students. Provide training to all school personnel so they may provide de-escalation and crisis response support to students who are in crisis will increase the capacity of schools across Minnesota to address student mental health concerns. By training all school personnel to address student mental health concerns, there will be a greater likelihood that students needs will be addressed in a timely manner and the situation will not escalate into a full blown mental health crisis.

Integrated Care and Access

Workgroup: Integrated Care and Access

Contact Person: Mary Kosling

Te/ehealth access for Minnesota students

Problem Statement: MN is experiencing unprecedented levels of mental health concerns in its population. Factors that play into this include increased community stress, the systemic impact of COVID, and a lack of available resources. One avenue used to increase access to mental health services has been to physically embed organizations into schools using school linked mental health services. This has been helpful, but not all schools have this resource. With the onset of

COVID and the stretching of resources, some schools have been accommodating to families by working with their established community mental health providers to allow students to have telehealth sessions during the school day. However, this collaboration is not consistent from school to school. Not all schools have been open to providing this space for their students.

Recommendation: It is in the best interest of children and our communities that access to mental health/substance abuse services are available as much as it is feasible.

- Establish legislation related to education requiring mental health access for students:
    - If a Minnesota school does not already have an embedded school linked mental health program available or if these services are unable to fully meet the mental health/substance abuse needs of their students that schools be open to collaborating with the student's established community provider to provide students the ability to access mental health/substance abuse services using a telehealth format if space, a student's regulation ability, and staffing allow.
- Provide uniform guidance to all Minnesota schools to ensure students have access to mental health supports while in school

Desired Outcome: Allowing young people to access to their mental health/substance abuse providers will support their healing and ability to address and ideally ameliorate mental health/substance abuse concerns. Providing more young people access to mental health/substance abuse services increases equity amongst schools. Accessing services at school will decrease stress upon family systems by parents not having to take off of work and potentially lose needed income. This opportunity for access may also benefit young people whose families may have limited transportation options outside of the school day or whose families are limiting community outings due to quarantine or immunocompromised family members.

Parity Law

Background: In December 2020 Congress passed the Strengthening Behavioral Health Parity Act as part of the Consolidated Appropriation Act (CAA). This required health plans to perform and document comparative analysis of their non-quantitative treatment limits (NQTLs) which are the elements of a health plans coverage that are not numerical such as prior authorizations and drug formulary designs and decisions.

The federal Departments of Health and Human Services, Labor, and Treasury recently reviewed the status parity enforcement nationally and issued a report in January 2022 which showed that:

- No health plans in the US adequately collected and sufficiently analyzed necessary information
- Proactive and rigorous enforcement is vital to ensuring meaningful MH/SUD parity.
- To ensure that participants and beneficiaries receive coverage of their benefits, DOL recommends that Congress amend ERISA to expressly provide that participants and beneficiaries, as well as DOL on their behalf, may recover amounts lost by participants and beneficiaries who wrongly had their claims denied in violation of MHPAEA, ensuring that participants and beneficiaries are made whole.
- Amending MHPAEA to ensure that MH/SUD benefits are defined in an objective and uniform manner pursuant to external benchmarks that are based in nationally recognized standards.

In the first 2-3 month CMS and the section of the Department of Labor that monitors compliance issued 45 determinations that NQTLs were out of compliance, received 25 corrective action plans, and been informed of another 26 plans that are in the process of changing their plans. Examples include plans paying for applied behavior analysis (ABA) for kids with autism, starting to pay for naltrexone and methadone for substance use disorders, and plans now paying for nutritional counselling for members with eating disorders.

Recently the American Psychiatric Association, specifically wrote edits to Minnesota's Parity Laws to bring them more into conformance with the Federal laws and best practices. See attachment below.

Recommendation:

- Minnesota enact the proposed changes as written to Minnesota Statutes 62Q.47. See Appendix A for language.

Expected Outcomes & Who will benefit if this recommendation is implemented: Members of our communities will have access to more positive, cost-effective mental health services provided by professionals who are BIPOC and other under-representative members of the community.

What is the impact on diversity of this recommendation? Communities will be able to hire and retain more total providers and BIPOC providers in communities that traditionally have had shortages

What is the impact of revising Minnesota's Parity Law? It will require the Commissioner of Commerce in consultation with the Commissioner of Health to require that each health plan submit comparative analyses for at least three distinct non-quantitative treatment limitations each year; conclude whether each health plan company demonstrated compliance, demonstrated noncompliance, or did not submit adequate information for the Commissioner to reach a conclusion. The Commissioner must report publically the number of (i) formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and non-quantitative treatment limitations; (iv.) detail any corrective action taken by either commissioner to ensure health plan company compliance. Prior to this there have been no requirements for health plans to submit data allowing for comparative analysis of mental health to medical/surgical data nor has there been a requirement for the Departments of Commerce/Health to analyze this, make conclusions, and publically report the results and any corrective action.

Improve OHS grant-making outreach

Mental health stakeholders, including individuals numerous individuals and mental health providers throughout Minnesota have shared how difficult it is to work with DHS' system to distribute grants and other sources of funding to Behavioral Health agencies and professionals. This is particularly true for minority and diverse individuals from other cultures and smaller agencies who have not historically received funding from DHS.

Recommendation:

- DHS utilize all available media and alternative outreach methods to publicly advertise upcoming proposals and grants early in the process - consideration should be given to include media and outreach methods serving diverse populations
- DHS revise its website operations to help candidates more successfully navigate its forms, rules, regulations which currently are difficult to understand and submit grant proposals.
- Make it easier for candidates to find a DHS staff person to help answer their questions and guide them through the application process

- Internally track, trend, and publically share the number of applications, percent that complete the application process, time to complete and submit applications, diversity statistics, as well as corrections/improvements that are made in instructions, internal resources, and processes
- Share information about other community resources that may be helpful

Collaborative Care Model

Issue: Residents in Minnesota with depression and anxiety have long had difficulties accessing care in a timely manner, outcomes have been poor and have not been improving, and individuals with insurance provided by Medical Assistance have an even harder time accessing mental health providers. The pandemic has increased the intensity of depression and anxiety, increased the numbers of Minnesotans needing treatment for depression and anxiety, and worsened access.

Background: With increased need for mental health and substance use disorder services, the Collaborative Care Model has been demonstrated to much more effectively use the constrained resources of psychiatry and psychotherapy. At this time more than 90 well designed, controlled studies show that Collaborative Care is the most effective model of care to treat these disorders.

The literature documents how integration with primary care, leveraging psychiatric and psychological expertise through a care manager, and systematically engaging and activating patients: improves access and allows far more patients to be seen; improves response and remission rates several fold; saves money. Currently Medical Assistance and MinnesotaCare only pay a few of the available payment (CPT) codes for Collaborative Care (Appendix B).

- A Cochrane Systematic Review of 79 randomized control trial studies shows abundant evidence that the Collaborative Care Model results in better outcomes, faster; diverting people from crisis and resulting in cost savings.[2]
- For example, Mayo's experience when implementing this model showed significantly better response at three- and six months compared to usual practice.[3]
- Another study showed that for every $1 spent on care delivered in the Collaborative Care Model, there is a $6.50 ROI in improved health and productivity.[4]

Recommendation:

- Implement Evidence Based Solution to have Minnesota Medical Assistance and MinnesotaCare pay for the suite of collaborative Care codes at sustainable rates
- Broadly publicize this payment plan and the details of the sustainable rate.
- For all future DHS RFPs to manage PMAP contracts, include that the health plans pay for the full suite of Collaborative care codes, measure utilization, and improve utilization during the contract.

Expected Outcomes: Integration with primary care, leveraging psychiatric and psychological expertise through a care manager, and systematically engaging and activating patients: improves access and allows far more patients to be seen; improves response and remission rates several fold; saves money.

How does the Collaborative Care Model differ from other services covered by MN Medicaid in primary care where mental health and substance use disorder care is (or may be) addressed? (Such as team-based models or services including coordination or case management, like Behavioral Health Home, ACT, Health Care Home, Integrated Health Partnerships, and others)

The Collaborative Care Model provides the following, different from other services:

a) ongoing psychiatry consultation to ensure people get treatment adjustments as needed over time to get to target / remission
b) direct interventions provided by the behavioral health care manager, who has a clinical/educational role that both the PCP and the psychiatrist rely on to help the patient in skill-building; and
c) proactive use of a registry to ensure patients aren't lost to follow-up and progress to target/remission

What services are covered by Collaborative Care Model (CoCM) codes for mental health and substance use disorder in primary care that are not already covered by Medicaid in Minnesota?

Collaborative Care Model (CoCM) codes support non-visit time for ongoing psychiatric consultation, including between care manager and psychiatrist, and panel management.

Service	MN Medicaid	Collaborative Care Model
Psychiatric consultation for primary care	I	I
Care manager time, providing psychiatric care coordination and management		I
Consultation between care manager and psychiatrist (key for med adjustments)		I

How are CoCM codes different from Behavioral Health Home codes?

Behavioral health home (BHH) is for people with serious mental illness, while CoCM is for any mental health condition, including substance use disorders. BHH codes also don't reimburse for ongoing psychiatric consultation and management.

Population/Service	Behavioral Health Home	Collaborative Care Model
For people with Serious Mental Illness		
For all mental health conditions and SUD		I
Psychiatric Consultation for primary care	I	I
Care manager time, providing psychiatric care coordination and management		I
Consultation between care manager and psychiatrist (key for med adjustments)		I

Yellow highlighted areas indicate primary care gaps in services for the Medicaid population.

Collaborative Care Model	General Behavioral Health	Psychiatric Consultation	Behavioral Health Home
Evidenced Based Components of the Collaborative Care Model (Codes 99492, 99493,99494)	Code 99484 (Other clinical staff)	Code 99499 (Licensed professionals)	PMPM
Psychiatric consultation, ongoing			
Care manager/BHC, ongoing	X		X (only for patients enrolled in program)
Psychiatric consultation, initial/one		X	
Care manager/BHC, initial	X		X (only for patients enrolled in program)
Psychiatric consultation to primary care provider		X	
Facilitating and coordinating treatment such as psychotherapy, pharmacology, counseling and/or psychiatric consultation			X (only for patients enrolled in program)
Registry and panel management			X (only for patients enrolled in program)
Continuity of care	X		X (only for patients enrolled in program)
Validated measurement-based care	X		
Provision of brief interventions using evidence-based techniques	X		

From the University of Washington AIMS Center: Collaborative Care Model, Evidence, Financing, etc

From the American Psychiatric Association: Payment for CoCM, including Medicaid

Local Advisory Council

Update Minnesota Statutes 245.466, Subd. 5: Local Advisory Council and 245.4875, Subd. 5: Local Children's Advisory Council

Problem Statement: The Legislative language used in regards to Local Advisory Council is outdated and does not include strong efforts to include diverse communities.

Background Information: The legislative language regarding local service delivery system, Minnesota Statutes 245.466, Subd. 5. Local Advisory Council, uses the term regional treatment center. Not every region has this facility. Instead, they have a Community Behavioral Health Hospital.

Recommendations:

1.) The Local Advisory Council Workgroup recommends changing the language to include the different types of facilities that may serve individuals in their community.
2.) In addition, the LAC Workgroup recommends updating language regarding the representatives who should serve on the LAC to be more inclusive of the diversity of communities and ensure that BIPOC and other underserved individuals are represented on the LAC.
3.) The workgroup also recommends updating Minnesota Statutes 245.4875, Subd. 5 Local Children's Advisory Council to include language related to coordinating efforts with the Subcommittee on Children's Mental Health.
4.) Funding (of a minimum of $1000. Per adult **and children's** LAC) is requested to conduct surveys, advertise, provide stipends to support those who cannot financially participate without losing money from their jobs, etc.

- See Appendix C. for statutory language changes.

Expected Outcomes and Who Will Benefit if this recommendation is implemented: It is believed that Local Advisory Councils will be financially able to fulfill its mandates and include a broad range of community interests in order to better inform local government on the needs of those who utilize the mental health system of care.

What is the impact on diversity from this recommendation: Implementation of these recommendations will ensure that each Local Advisory Council represents the diversity of the community being served.

Below are some ways Local Advisory Councils can recruit participants.

1. Asking special teachers at schools to reach out to BIPOC parents by sharing a flyer that lists contact information and has information about participating in the group.
2. Look at duplicating that process through churches and social service organizations, grocery stores, medical facilities and asking people from various populations (who may not qualify to sit on the LAC if they can help you to recruit.
3. Offer a listening session (it can be virtual and in person) clearly requesting to discuss the topic of accessing mental health/wellness support for themselves and their loved ones.

4. Have multicultural speakers to present mini-trainings at the LAC and open those meetings to the public. This will help pull in multicultural community members who may be of service (and who may also need support).

Mental Health and Juvenile Justice

Workgroup: Mental Health and Juvenile Justice

Contact Person: Cici Hughes

Elimination of mandatory life without parole for juveniles and reduction of children being treated as teenagers

Problem Statement: Minnesota still has a mandatory life without parole sentence for juveniles and outdated laws that treat young children the same as teenagers.

Background Information: In 2012, the Supreme Court ruled mandatory life without parole unconstitutional for juveniles. Having a mandatory life without parole as an option in the state of Minnesota does not show good faith in the findings of the Supreme Court or Mental Health providers and advocates.

Recommendation:

- Remove the mandatory life without parole for juveniles allowing for accountability of criminal acts but also recognizing a juvenile's brain development does not reach maturity until mid-20s; this does not account for young people with intellectual and developmental disabilities.
- Establish more meaningful attempts of rehabilitation of a young people whose brain maturity has not yet reached full potential in place of mandatory life without parole
- Provide mental health services to evaluate and address the underlying cause(s) of the criminal behavior allowing for a greater potential of a more productive and law abiding life.
- Recognize that young children's brain development is vastly different than that of juveniles and recognize that criminal behavior should not be treated as the same for the two age groups.
- Children involved in the legal system should be referred to community based mental health services for appropriate evaluation and treatment. This earlier intervention process will reduce the likelihood of delinquent/criminal behavior later in life while obtaining the most appropriate interventions that do not include the need of the legal system.
- Special consideration should be given to young people with a known history of or signs of potential intellectual disability requiring the use of Rule 20s or other mental health assessments to be administered and utilized in a young people's criminal review.

Expected Outcomes & Who will benefit if this recommendation is implemented: Expected outcomes would include more support and assistance for at-risk and BIPOC young people by having more referrals sent into the community for mental health evaluations and services. Increased assistance to families unaware of alternative services to address delinquent and criminal behavior. Protection of young people as a whole while promoting the justice system to be more just, fair and balanced.

What is the impact on diversity of this recommendation? Young people benefit holistically from culturally relevant strategies that are based in rehabilitation and restorative practices. These approaches support and strengthen the BIPOC populations when services can be provided in the community of the justice involved young people. This community engagement provides more support and opportunity to the young people and family allowing for a more just and equitable way of life that can significantly disrupt and end the school to prison pipeline, and intergenerational incarceration for the BIPOC population.

Mental Health Services and Centralized Data Collection System for Juvenile Justice System

Problem Statement: Recent data from the Department of Justice shows that around 70% of juveniles have a diagnosable mental health condition. While we work to build our mental health system, juveniles with mental illnesses remain disproportionately vulnerable to harmful law enforcement encounters and involvement in the criminal legal system. Minnesota juveniles need more access to adequate mental health treatment at every point in the justice system, and trauma-informed professionals from law enforcement and jails to courts. Decriminalizing mental illnesses not only save resources in the long term, but it saves lives and promotes safety and justice for all Minnesotans.

Meaningful system change must be led by measurable, reliable and current date. Minnesota has no statewide data system that gathers data consistently, using the same definitions, data points and measurers.

Background Information: The juvenile justice system needs significant reforms, and the legislature must address the impacts of incarceration on children and families. Recently released data from The Sentencing Project the racial disparities of young people that are detained or committed in a juvenile facility are four times higher than their white peers according to the nationwide date collected in October 2019. (This same data shows Minnesota in 2019 to have an 8.5% disparity). Minnesota needs to implement strategies aimed at reducing the number of young people of color in correctional facilities as disparity reduction efforts and reforms happening statewide are not sufficient. More support for young people in our communities is needed. Recent research from the University of Minnesota showed that over half of all adults incarcerated in Minnesota jails and prisons are caretakers of minor children. Further research has shown that children with incarcerated parents are more likely to be involved in the juvenile justice system and face negative outcomes in health, education, and social life down the road. Children and families need resources to connect with their loved ones and prevent generational cycles of incarceration.

Without proper data collection and analysis across jurisdictions we cannot understand the scope of disparities in the juvenile justice system or find adequate solutions. **NAMI** supports the creation of a statewide data hub that requires stakeholders to report regularly and for accurate real time tracking of the number and demographics of kids in the system, so that meaningful changes and improvements can be made.

Recommendation:

- Acknowledge and address the racial disparities of young people in the juvenile justice system by updating the juvenile justice process to be more person-centered including more opportunities for diversion, mental health services, and engagement in voluntary treatment.
- Increase funding for mental health and substance use disorder services at corrections facilities and programs to provide on-site services.
- Create a centralized database for the juvenile justice system to include reports to allow real time tracking of numbers and demographics of young people in detention facilities and correctional out of home placements. Support data transparency by mandating stakeholders to report data on a regular basis.

Expected Outcomes & Who will benefit if this recommendation is implemented: Expected outcomes would include more support and assistance for at-risk and BIPOC young people by having more referrals sent into the community for mental health evaluations and services. Increased assistance to families unaware of alternative services to address delinquent and criminal behavior. Protection of young people as a whole while promoting the justice system to be more just, fair and balanced.

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Family Systems, Prevention, Intervention, and Supports

Workgroup: Family Systems, Prevention, Intervention and Supports

Contact person: Anna Lynn

Expand Access to High-fidelity Wraparound through the System of Care Initiative

Problem Statement: Families need help navigating the many different systems that are essential to provide their children needed support. This is especially true for families with:

- Children who may have social needs and risk factors but not necessarily a specific mental health diagnosis.
- Children with atypical or lower priority needs from a particular system perspective (E.g., a high performing student with anxiety), and/or
- Children who are not officially in the mental health system currently but are beginning to exhibit symptoms.

Background Information: High-fidelity Wraparound is an evidence-based practice. If structured to support the identified families above, wraparound can provide early intervention and access to supports when they are needed, it may help prevent the need for clinical care or prevent the further decline and utilization of higher levels of care.

The Minnesota System of Care grant has included wraparound supports for many children and families at different points in their journey in mental health system, including those who are not connected to resources. For example, the SOC grant has enabled Intermediate District 916 to provide connections to families for children who had no pre-existing condition but who experienced risk factors such as high number of school absences. Local MN counties have been involved in the system of care and support this effort.

Recommendation:

- Develop grant funding for county and school partnerships to expand High-fidelity Wraparound services, building on the system of care model and initiative. Per wraparound models, local partnerships should include school, local public health, mental health providers, and especially organizations that provide natural supports (young people centers, faith communities, etc.)
- Local partnerships will coordinate with others doing the same work through the system of care grant initiative.

- State resources should support a learning community to continue to have opportunities for local partners to share best practices with each other after the System of Care grant expires.

Expected Outcomes & Who will benefit if this recommendation is implemented:

- Improved mental health and well-being outcomes for young people.
- Reduced stress among participating families.
- Increased family and young people's connection to their school and community. (E.g. An increase in the number and percentage of students who report in the Minnesota student survey that their community cares about them.)

What is the impact on diversity of this recommendation? The system of care grant prioritized children and families from black, indigenous and communities of color (BIPOC); this priority population could continue with additional resources. BIPOC families have often cited distrust of systems because of historical trauma and personal experiences. A wraparound approach with the family at the center could help identify people and organizations that are most trustworthy and valuable to the family.

Expand family peer support opportunities

Problem Statement: Families need support to help manage their stressors and create a more nurturing environment for their children. This is especially true for families who are just beginning to navigate the mental health system and those with increased risk factors (e.g., families with an incarcerated parent, children in foster care, and children with a special health care need).

Background Information: The CTSS Family Peer Support has a certificate training program for family peer support. This service is only available to families with a child who is in CTSS. Families who are just beginning to navigate the mental health system or other related systems, such as foster care and special education, need this type of support. The structured training program that has been developed is valuable based on reports from parents who have participated. However, there is limited opportunity for those peers to be employed and a limited number of people that they can offer support. There are other family peer supports have been available to select populations such as children and young people with special health care needs intermittently through grant funding.

If we could build on these resources and offer peer support to families as early as possible to help reduce family stress, avoid common system pitfalls, and potentially avoid more intensive services, it may also help build sustainability for existing family peer support specialists. County social workers and other navigators may not have the capacity to provide the *family* support (because of caseloads, etc.)

Evidence shows that the pile up of toxic stress for children and families impacts the mental health and well-being of children and that of their caregivers. When parents are unable to manage their emotions and behaviors, they are unable to effectively nature and support their children. Having an opportunity to connect with peers and share common experiences can help reduce that stress and provides valuable skills and information from those who have navigated the same systems.

Recommendation:

- Develop family peer support program for families earlier in their journey through the mental health system and for families with other risk factors, such as those with a child in foster care or with an incarcerated parent.

- Through this program, offer families 1:1 and/or group support, opportunities to share different experiences and information about relevant systems.
- Develop outreach mechanisms through which families can engage with a family peer support specialist, or family peer support groups. Schools, foster care, local public health, and other county systems (e.g. county jails) could refer families to peer support specialists.
- Expand the capacity of the CTSS training program or coordinate with the program to train additional family peer support specialists who will offer support to newly eligible families.
- Ensure that foster care parents are included and recruited in the training, as well as a focus on families from black, indigenous and communities of color (BIPOC), LGBTQ families and those who have children who are transgender.
- Create opportunities for family peer support specialists to learn from each other and continue to develop skills, through regional and topic specific groups to sustain the resource.

Expected Outcomes & Who will benefit if this recommendation is implemented:

- Improved mental health and well-being outcomes for young people.
- Reduced stress among participating families.
- Improved parent-child relationships.
- Reduced social isolation among participating families.
- Increased family and young people's connection to their school and community. (E.g. An increase in the number and percentage of students who report in the Minnesota student survey that their community cares about them.)

What is the impact on diversity of this recommendation? With a focus on recruiting parents from marginalized communities more families will have an opportunity to connect with someone who have similar backgrounds and experiences.

Grow family support in schools

Problem Statement: Families need support to help manage their stressors and create a more nurturing environment for their children. This is especially true for families who are just beginning to navigate the mental health system and those with increased risk factors (e.g., families with an incarcerated parent, children in foster care, and children with a special health care need).

Background Information: Schools are natural supports for children and families. School do not have sufficient resources to provide significant outreach to families to build community and connect them to additional supports if needed. Models such as FAST- Families and Schools Together, an evidence-based program, have demonstrated feasibility and impact. For example, District 622 implemented FAST years ago through grant funding. Family outreach included a variety of strategies, such as providing meals for families where families cooked together. This offered opportunities to develop skills for children and families. The program helped to get families connected to school, practice skills together, and build communities. The school was able to provide referrals to other agencies, based on needs of the family.

Family connection to schools improves educational outcomes. Many families from marginalized communities do not have a deep trust and connection to schools because of past experiences of trauma, discrimination and/or inequities in schools.

Recommendation:

- Provide grant funding to schools to develop family outreach programs to engage families with specific risk factors.
- Schools should partner with local public health and school health clinics if a school clinic is available.
- Engage families through social activities, self-care practices, provide opportunities to develop relevant skills and information and connect family to supports based on specific family needs. The outreach will include culturally specific practices and opportunities as defined by the community population.

Expected Outcomes & Who will benefit if this recommendation is implemented: Utilizing evidence-based practices derived from social, behavioral, and physiological science, FAST builds protective factors focusing on:

- The child's interpersonal bonds,
- The family system,
- Parent-to-parent support,
- Parent peer social network,
- Parent empowerment training, and
- School/community affiliation.

Other expected outcomes include:

- Increased social connection among participating families.
- Reduced stress among participating families.
- Improved mental health and well-being outcomes for young people.
- Increased family and young people's connection to their school and community. (E.g. An increase in the number and percentage of students who report in the Minnesota student survey that their community cares about them.)
- Increased early access to care among participating families.

What is the impact on diversity of this recommendation? FAST is implemented by trained 4-10 person FAST Teams comprised of local parents, teachers (or other school representatives), and community-based professionals. At the Middle School and High School levels, young people are also provided with leadership opportunities within the team. Each FAST Team is representative of the population served - that is, consistent with the race, ethnicity, culture, and language of the participating families.

Many BIPOC families have had negative experiences with school systems. Intentionally building a community of support with schools could help to mitigate some of trauma and stress that remains for many BIPOC families, especially if the outreach and engagement is inclusive of cultural traditions and openly acknowledges past harms.

Build Community Initiated Care to support young people and families

Problem Statement: The pandemic and resulting layers of stress have highlighted and exacerbated poor mental well-being throughout the community, especially among those who experience the greatest social inequities. The current system of supports does not adequately promote mental well-being across the population and cannot meet the depth of need and current interest in promoting well-being. Children and families need a range of opportunities to build skills, mental health awareness, and social supports. Minnesota does not have adequate community-based infrastructure for mental health promotion and prevention to offer evidence-based programs that can augment the current system of care.

Background Information: Community Initiated Care can include community services that are not clinical. This model has been successfully used internationally to offer support through trained non-specialized health care providers and lay community members. This could include: a support or skills group, programs to develop mental well-being awareness and skills among community members (e.g. barbers, hair dressers, baristas), and culturally specific healing practices offered in community.

There are current Minnesota examples. For example, Wellshare International is using COVID resources to train community health workers from the Somali, LatinX and Orama communities in Living Life to the Full, an evidence-based program that has been broadly implemented in Scotland, Wales, Ireland, Australia and Canada. Similarly, Wellness in the Woods has been offering Wellness Recovery Action Planning to different populations such as seniors and families through school partnerships. WRAP is also an evidence-based program, which has been offered broadly to families in some states such California. WRAP has traditional been implemented in Minnesota with a limited population through ARMHS or grant funding. Kente Circle launched a program to equip barbers with knowledge and awareness of mental health and well-being, so they can offer general support and accurate information to customers. Many different organizations have offered culturally specific healing circles throughout COVID and the civil unrest after the George Floyd murder and related incidents.

There is growing national interest in this scope and direction for promoting mental well-being. See Community Initiated Care: Building Skills to Improve Mental Health - Well Being Trust for more information. This was also a focus area of recommendations included in the Children's Summit, Prevention/Promotion workgroup.

Recommendation:

- Grant funds to community-based organizations to train community members in evidence-based or culturally informed programs.
- Conduct an evaluation of the impact of community-initiated care on mental well-being.
- Establish a network or community of practice to build sustainability and quality improvement.
- Develop an advisory council to outline best practices and build the infrastructure needed to sustain this work. Infrastructure includes things such as: an inventory of current informal support models, a utilization assessment, established guidelines for implementation (e.g., how to connect to higher levels of care), formal linkages to existing programs (e.g., FHV, ECFE), and an assessment of sustainable funding sources (e.g., MA billing).

Expected Outcomes & Who will benefit if this recommendation is implemented:

- Improved mental well-being among participants.
- Improved mental well-being among families of participants.
- Reduced social isolation among participating families.
- Improved awareness and understanding about mental health and well-being.
- Reduced barriers to higher clinical levels of care for those who need it.

What is the impact on diversity of this recommendation? Building the infrastructure and expanding access to community-initiated care will allow BIPOC communities greater opportunity to get mental well-being support directly from BIPOC people. It can help center culturally specific practices and it can facilitate access to clinical care when needed among populations with historical distrust of health care systems. Community care can help BIPOC address collective trauma and continuous trauma from ongoing social and health inequities in community.

Recovery Supports

Workgroup: Recovery Supports

Contact Person: Angie Schmitz

Creation of one Minnesota board responsible for curriculum/ certification and support of all Peer Support training/ reporting/ CEU management and quality compliance

Background Information: Peer-to-peer services are services rendered by professionals who have received training on how to utilize their own personal experiences in supporting individuals currently on the journey towards wellness. Peer-to-peer services have been proven to improve an individual's use of skills in practical environments thereby reducing their use of crisis mental health services including and not limited to accessing crisis response services and mental health hospitalization services. Overall, peer-to-peer services are a cost effective, evidence-based prevention method for saving systems money.

Problem Statement: The certification of the existing programs is currently a confusing maze that is different for each discipline. The certification process of a peer professional trained in mental health peer support is vastly different to the process of a peer professional trained in substance use peer support. The certification process for family peer support specialists and forensic peer support specialists is still different, again. These differences, in addition to being unnecessarily confusing, inhibit the networking of peers across disciplines which stagnates the profession as a whole.

Recommendation:

- Create one board that will be responsible for the certification process for all peer professionals in the state. This includes the initial training, reporting and management of CEUs, and the reception of complaints from service users.
- Establish a peer-created, Minnesota-owned training curriculum to help ensure that all peers receive fair and equitable training prior to their provision of peer professional services.

Expected Outcomes & Who will benefit if this recommendation is implemented: Currently in Minnesota, certification programs exist for individuals with lived experiences within the mental health, substance use, and criminal justice systems. Research shows that these services are proven effective in any number of formats, including individuals experiencing chronic illnesses, Veterans of military service, and students at all grade levels.

Increase access to affordable housing across Minnesota

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

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

The grant program called Housing with Supports for Adults with Serious Mental Illness provides grants to housing developers/agencies, counties, and tribes to increase the availability of supportive housing options. In the 2017 Legislative Session, supportive housing funding was increased by $2.15 million dollars in one-time funding. The 2018

bonding bill also included $30 million dollars to develop or renovate supportive housing for people with mental illnesses. As of October 2018, over 5,280 Minnesotans with mental illnesses were on a waiting list to receive supportive housing, including 2,390 outside of Ramsey and Hennepin Counties. Bridges provides housing subsidies to people living with serious mental illnesses while they are on the waiting list for federal Section 8 housing assistance. There are long waiting lists for this program. The 2018 Minnesota Homeless Study by Wilder Research identifies that the percentage and number of adults and young people with Serious Mental Illness (SMI) who are homeless continues to rise, while federal and state funding for homeless outreach services to persons with SMI has remained flat for 10 years.

Recommendation:

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

Increase employment support for individuals with mental health barriers to employment

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

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

Individual Placement and Support (IPS) is an evidence-based employment program for people with serious mental illness. IPS grant projects are available in only about 50% of Minnesota. Statewide expansion would require new funding for direct service (grants to providers) and infrastructure to support training, technical assistance, data collection, program monitoring, and evaluation. Not all counties use state mental health funds for IPS and there are no consequences for counties or Adult Mental Health Initiatives that continue to use their resources to fund employment services that are not evidence based (IPS). Access to effective evidence based employment services to most people with serious mental illness remains quite limited in Minnesota.

Recommendation:

- Increase funding for the IPS state grant program for expansion and infrastructure

- OHS Behavioral Health Division explore the use of Medicaid for IPS
- Require a memorandum of understanding (MOU) between DEED-VRS (Vocational Rehabilitation Services) and DHS-BHD (Behavioral Health Division) regarding employment services for people with mental illness.*
- Require DHS-BHD and DEED-VRS to consider racial, ethnic, and geographic disparities in their efforts to help people with disabilities obtain competitive, integrated employment

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

Appendix A

Proposed changes to Minnesota Statutes 62Q.47

A bill for an act relating to insurance;

requiring health plan transparency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2020, Section 62Q.47 is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(a) All health plans, as defined in section 62Q.01, that provide coverage for alcoholism, mental health, or chemical dependency services, must comply with the requirements of this section.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

(c) Cost-sharing requirements and benefit or service limitations for inpatient hospital mental health and inpatient hospital and residential chemical dependency and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for inpatient hospital medical services.

(d) A health plan company must not impose an NQTL with respect to mental health and substance use disorders in any classification of benefits unless, under the terms of the health plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health and substance use disorders in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL with respect to medical and surgical benefits in the same classification.

(e) All health plans must meet the requirements of the federal Mental Health Parity Act of 1996, Public Law 104-204; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; the Affordable Care Act; and any amendments to, and federal guidance or regulations issued under, those acts.

(f) The commissioner may shall require information from health plan companies to confirm that mental health parity is being implemented by the health plan company on an annual basis by February 1 each year, beginning in 2023. Information required may shall include the comparative analyses and other information regarding the design and application of nonquantitative treatment limitations required of the health plan company by 42 U.S.C. 300gg-26(a)(8)(A) and may include any additional comparisons between mental health and substance use disorder treatment and other medical conditions the commissioner deems necessary, including a comparison of prior authorization requirements, drug formulary design, claim denials, rehabilitation services, and other information the commissioner deems appropriate. The commissioner may specify which nonquantitative treatment limitations for which a health plan company shall submit comparative analyses each year. The commissioner shall not be required to request that the health plan company submit comparative analyses for all nonquantitative treatment limitations each year, provided that the commissioner shall request that the health plan company submit comparative analyses for at least three distinct nonquantitative treatment limitations each year.

(g) Regardless of the health care provider's professional license, if the service provided is consistent with the provider's scope of practice and the health plan company's credentialing and contracting provisions, mental health therapy visits and medication maintenance visits shall be considered primary care visits for the purpose of applying

any enrollee cost-sharing requirements imposed under the enrollee's health plan.

(h) By June 1 of each year, beginning June 1, 2021, the commissioner of commerce, in consultation with the commissioner of health, shall submit a report on compliance and oversight to the chairs and ranking minority members of the legislative committees with jurisdiction over health and commerce. The report must:

(1) describe the commissioner's process for reviewing health plan company compliance with United States Code, title 42, section 180310) 300gg-26, any federal regulations or guidance relating to compliance and oversight, and compliance with this section and section 62Q.53;

(2) describe the commissioner's conclusions as to the sufficiency of the comparative analyses and other information regarding the design and application of nonquantitative treatment limitations submitted by each health plan company, as required under subsection (f), and whether the commissioner concluded that each health plan company demonstrated compliance, demonstrated noncompliance, or did not submit adequate information for the commissioner to reach a conclusion. If the commissioner determines that a health plan company did not submit adequate information demonstrating whether there was or was not compliance, the commissioner shall find the health plan company out of compliance with 42 U.S.C. 300gg-26(a)(8)(A).

ill identify any enforcement actions taken by either commissioner during the preceding 12-month period regarding compliance with parity for mental health and substance use disorders benefits under state and federal law, summarizing the results of any market conduct examinations. The summary must include: (i) the number of formal enforcement actions taken; (ii) the benefit classifications examined in each enforcement action; and (iii) the subject matter of each enforcement action, including quantitative and nonquantitative treatment limitations;

Bl detail any corrective action taken by either commissioner to ensure health plan company compliance with this section, section 62Q.53, and United States Code, title 42, section 180310); and

(5) describe the information provided by either commissioner to the public about alcoholism, mental health, or chemical dependency parity protections under state and federal law.

The report must be written in nontechnical, readily understandable language and must be made available to the public by, among other means as the commissioners find appropriate, posting the report on department websites. Individually identifiable information must be excluded from the report, consistent with state and federal privacy protections.

Appendix B

Crosswalk of the Collaborative Care Model and Minnesota Medicaid Services for Mental Health in Primary Care

How does the Collaborative Care Model differ from other services covered by MN Medicaid in primary care where mental health and substance use disorder care is {or may be) addressed? (Such as team-based models or services including coordination or case management, like Behavioral Health Home, ACT, Health Care Home, Integrated Health Partnerships, and others)

The Collaborative Care Model provides the following, different from other services:

d) ongoing psychiatry consultation to ensure people get treatment adjustments as needed over time to get to target/ remission
e) direct interventions provided by the behavioral health care manager, who has a clinical/educational role that both the PCP and the psychiatrist rely on to help the patient in skill-building; and
f) proactive use of a registry to ensure patients aren't lost to follow-up and progress to target/remission

What services are covered by Collaborative Care Model {CoCM) codes for mental health and substance use disorder in primary care that are not already covered by Medicaid in Minnesota?

Collaborative Care Model (CoCM) codes support non-visit time for ongoing psychiatric consultation, including between care manager and psychiatrist, and panel management.

Service	MN Medicaid	Collaborative Care Model
Psychiatric consultation for primary care	I	I
Care manager time, providing psychiatric care coordination and management		I
Consultation between care manager and psychiatrist (key for med adjustments)		I

How are CoCM codes different from Behavioral Health Home codes?

Behavioral health home (BHH) is for people with serious mental illness, while CoCM is for any mental health condition, including substance use disorders. BHH codes also don't reimburse for ongoing psychiatric consultation and management.

	I	I
		I
	I	I
		I
		I

Yellow highlighted areas indicate primary care gaps in services for the Medicaid population.

Collaborative Care Model	General Behavioral Health	Psychiatric Consultation	Behavioral Health Home
Evidenced Based Components of the Collaborative Care Model (Codes 99492, 99493, 99494}	Code 99484 (Other clinical staff)	Code 99499 (Licensed professionals)	PMPM
Psychiatric consultation, ongoing			
Care manager/BHC, ongoing	X		X (only for patients enrolled in program)
Psychiatric consultation, initial/one		X	

Care manager/BHC, initial	**X**		X (only for patients enrolled in program)
Psychiatric consultation to primary care provider		**X**	
Facilitating and coordinating treatment such as psychotherapy, pharmacology, counseling and/or psychiatric consultation			X (only for patients enrolled in program)
Registry and panel management			X (only for patients enrolled in program)
Continuity of care	**X**		X (only for patients enrolled in program)
Validated measurement-based care	X		
Provision of brief interventions using evidence-based techniques	**X**		

From the University of Washington AIMS Center: Collaborative Care Model, Evidence, Financing, etc.

From the American Psychiatric Association: Payment for CoCM, including Medicaid

Appendix C

Proposed changes to Minnesota Statutes 245.466, Subd. 5, please see strikethrough below for omissions and underlining for additions.

245.466 LOCAL SERVICE DELIVERY SYSTEM.

Subdivision. 5. Local advisory council.

The county board, individually or in conjunction with other county boards, shall establish a local adult mental health advisory council or mental health subcommittee of an existing advisory council. The council's members must reflect a broad range of community interests. To the greatest extent possible, counties shall ensure membership of the LAC is representative of the diverse demographics in the county or counties served by the LAC. They must The membership shall include, and not be limited to: at least one consumer individual with lived experience of mental illness;, at least one family member of an adult with mental illness,; at least one representative from each of the following communities Black, Indigenous, and Persons of Color (BIPOC) who understand the mental health needs of BIPOC communities in the county or counties served; representatives knowledgeable about the mental health needs of other minority populations including but not limited to LGBTQ+, immigrants, and non-English speakers; at least one mental health professional; ,-a-A-El-one community support services program representative, at least one mental health advocate; and at least one community-based provider of mental health services. The local adult mental health advisory council or mental health subcommittee of an existing advisory council shall meet at least quarterly to review, evaluate, and make recommendations regarding the local mental health system. Annually, the local adult mental health advisory council or mental health subcommittee of an existing advisory council shall:

(1) arrange for input from the regional treatment center's mental illness program unit, Community Behavioral Health Hospital, community mental health center, treatment centers for individuals with dual diagnosis of substance use and mental health disorders, or any state facility or program serving their community regarding coordination of care between the regional treatment center facility and community-based services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.462, subdivision 10;

(3) provide to the county board a report of unmet mental health needs of adults residing in the county to be included in the county's mental health plan, and participate in developing the mental health plan, Adult Mental Health Initiative Grant application, Community Support Program Grant application, Mental Health Crisis Services Grant application, and any other grant applications for mental health services; and

(4) coordinate its review, evaluation, and recommendations regarding the local mental health system with the state advisory council on mental health.

The county board shall consider the advice of its local mental health advisory council or mental health subcommittee of an existing advisory council in carrying out its authorities and responsibilities including but not limited to submissions of mental health grant applications.

Proposed changes to Minnesota Statutes 245.4875, Subd. 5

245.4875 LOCAL SERVICE DELIVERY SYSTEM. Subd. 5. Local children's advisory council.

(a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with severe emotional disturbance; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with emotional disturbance in the local area and services needed by families of these children, and shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2); and

(3) provide to the county board a report of unmet mental health needs of children residing in the county.

(4) coordinate its review, evaluation, and recommendations regarding the local mental health system with the State Advisory Council on Mental Health's Subcommittee on Children's Mental Health

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities including, but not limited to, submissions of mental health grant application.

5.) Funding (of a minimum of $1000 per adult LAC) is requested to conduct surveys, advertise, provide stipends to support those who cannot financially participate without losing money from their jobs etc.

Appendix D.

STATE ADVISORY COUNCIL ON MENTAL HEALTH MEMBERSHIP LIST

Shanna Langston	1. Department of Corrections Representative	shanna.langston@state.mn.us	6/15/2025
Anna Lynn	2. MN Department of Health Representative	Anna.lynn@state.mn.us	5/21/2025
Claire Courtney	3. Department of Employee & Economic Dev Rehab Service Division	Claire.Courtney@state.mn.us	1/4/2023
Eric Grumdahl	4. OHS Assistant Commissioner	Eric.Grumdahl@state.mn.us	6/18/2025
Kristine Preston	5. OHS Assistant Deputy Commissioner	Kristine.Preston@State.mn.us	6/18/2025
Mikki Maruska	6. Staff Ex-officio	Michele.Maruska@state.mn.us	6/18/2025
posted	Department of Human Services, Medical Assistance Program Rep		
Ellie Miller	7. MN Housing Finance Agency Rep	Ellie.Miller@state.mn.us	6/18/2023
Posted	8. American Indian Mental Health Advisory Council Representative		
Reverend Rozenia Fuller	9. Consumer 1	Rozeniafullergoodnews@gmail.com	1/1/2024
Allison Wobeck	10. Consumer 2	a.wol beck@yahoo.com	1/2/2023
Pa Lee	11. Consumer 3	pakonglee@gmail.com	1/2/2023

Jamaica Del Mar	12. Consumer 4	delmar13@gmail.com	1/2/2023
Jennifer Springer	13. Consumer 5	jenspringer19@gmail.com	1/2/2023
Al Levin	14. Consumer 6	allevin18@yahoo.com	1/1/2024
Jade Freyholtz-London	15. Consumer-Run Mental Health Advocacy Group Representative	jode@mnwitw.org	1/1/2023
Mandy Meisner	16. County Commissioner #1 (Metro)	Mandy.Meisner@co.anoka.mn.us	1/1/2024
Rodney Peterson	17. County Commissioner #2 (Rural)	rodneyrpeterson@gmail.com	1/1/2024
Dave Lee	18. County Social Service Director	dglee777@yahoo.com	1/2/2023
Angela Bartolomero	19. Family Member #1	angiebart17@gmail.com	1/1/2024
Amy Jones	20. Family Member #2	abjeducationalconsulting@gmail.com	1/1/2024
Kenneth Moorman	21. Family Member #3	kenmoorman@centurytel.net	1/2/2023

Amanda Larson	22. Family Member of an Adult with Mental Illness	amanda.larson@co.sherburne.mn.us	**1/1/2024**
Posted	23. Family Physician Member		
Posted	24. Legislator Member (Senate)		
Ashwak Hassan	25. Marriage And Family Therapy Practitioner	ashwak.hassan@gmail.com	**1/1/2024**
Claudia Dami	26. Mental Health Provider	claudiadaml1@gmail.com	1/1/2023
Mx. Eren Sutherland	27. MN Disability Law Center Rep	esutherland@mylegalaid.org	1/1/2024
Mary Kjosling	28. Parent #1	float@charter.net	1/1/2024
Posted Jennifer Pedersen	29. Parent #2	jped1005@netscape.net	1/2/2023
Posted	30. Parent #3	bweckmanbrekke@co.scott.mn.us	1/2/2023
Beth Prewett	31. Professional Clinical Counselor	bethprewett@gmail.com	1/1/2024
Michael Trangle	32. Psychiatrist	mbtrangle@gmail.com	1/1/2024

David Nathan	33. Psychologist	gdavid.nathan@gmail.com	1/1/2024
Cynthie Christensen	34. Registered Nurse	oakridgeteletherapy@gmail.com	1/1/2024
Posted	35. Rep National Alliance On Mental Illness - Minnesota		
Posted	36. Rep. Of MN Mental Health Association		
Claudette Larson	37. Social Worker	clarson@willowcreekcounselingnl.com	1/2/2023
Dave Lislegard	38. State Representative (House)	rep.dave.lislegard@house.mn	1/2/2023
Posted	39. Legislative Member (Senate)		

SUBCOMMITTEE ON CHILDREN'S MENTAL HEALTH MEMBERSHIP LIST

Past term end Sherri Mortensen Brown	Department Of Commerce	open/past term end	sherri.mortensen-brown@state.mn.us	Jan-15
Michelle Schmid-Egleston	Department Of Corrections Rep	filled	michelle.schmid-egleston@state.mn.us	8/29/2022

Thomas Delaney	Department Of Education Rep	filled	Thomas.Delaney@state.mn.us	8/12/2023
Sarah Dunne	Department Of Health Rep	filled	sarah.dunne@state.mn.us	7/7/2025
Mikki Maruska	Ex-officio - contact	filled	michele.maruska@state.mn.us	
Maleenia Mohabir	Children's Mental Health Advocacy Groups #1	filled	mohabir.maleenia@gmail.com	1/2/2023
Jennifer Bertram	Children's Mental Health Advocacy Groups #2	filled	jbertram@childrensdefense.org	1/1/2024
Kim Stokes	Children's Mental Health Advocacy Groups #3	filled	kimberlystokes@me.com	1/6/2025
Honorable Nicole Frethem	County Commissioner (Metro)	filled	nicole.frethem@co.ramsey.mn.us	1/6/2025
Stephanie Podulke	County Commissioner (Rural)	filled	podulke.stephanie@co.olmsted.mn.us	1/1/2024
Danna Trebesch	County Social Services Rep #1	filled	danna.trebesch@co.brown.mn.us	1/1/2024
Jeffrey Lind	County Social Service Agency Rep #2	filled	jeffrey.lind@co.beltrami.mn.us	1/1/2024
Debra Peterson	Educator With Emotionally Disturbed Children	filled	petersondebraann@gmail.com	1/6/2025

Addyson Moore	Former Consumer Of Children's Or Adolescent Serv.	filled	14Addyson.Moore@gmail.com	1/1/2024
Michael Gallagher	Hosp-based Prov Mh Services To Children W/E.D.	filled	Michael.j.gallagher@state.mn.us	1/1/2024
Linda Hansen	Local Corrections Dept.	filled	linda.hansen@co.dakota.mn.us	1/6/2024
Erin Marrone	Local Corrections Dept.	filled	erin.marrone@co.ramsey.mn.us	1/1/2024
Ed Morales	Parent Of A Child W/E.D. - Minority		edjmorales@gmail.com	9/1/2023
Donna Lekander	Parent Of A Child W/E.D. #1	filled	Donna.lekander@co.carlton.mn.us	1/2/2023
Lisa Hoogheem	Parent Of Child W/E.D. #3	filled	hoogheemlisa@yahoo.com	1/1/2024
Dan Porter	Parent Of Child W/E.D. #4	filled	danpporter@msn.com	1/6/2025
Kimberly Baker	Parent Of Child W/E.D. #5	filled	kbaker12_29@yahoo.com	1/1/2024
Bra VADA Garrett-Akinsanya	People Exp Work W/Child Who Committed Status Offen	Filled	bravadaakinsanya@hotmail.com	1/1/2024

Cecilia Hughes	People Exp. In Working W/E.D. Minority Children		CHughes@optionsminnesota.com	1/6/2025
David Johnson	People Know Needs Of E.D. Of Minorities & Cultures	filled	swede828@hotmail.com	1/1/2024
Success Suehne	Present/Former Consumer Child's/Adoles **M.H.** Serv	filled	ssuehne@gmail.com	1/6/2025
Sarah Fuerst	Provider Mh Services To Preadolescent Children	filled	Sarah.Fuerst.55125@example.com	1/2/2023
Corey Harland	Provider Of Children's Mh Services To Adolescent#4	Filled	harlandcj@gmail.com	1/6/2025
Posted	State Advisory Council On Mental Health Rep.			
Posted	State Legislator			

Appendix E.

RECOMMENDATIONS

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

- Outreach to Cultural Diversity
- Mental Health and Schools
- Integrated Care and Access
- Local Advisory Council
- Mental Health and Juvenile Justice
- Family Systems Prevention, Intervention, and Supports
- Recovery Supports

REFERENCES

1. Minnesota Statute 245.697 State Advisory Council on Mental Health. https://www.reviser.mn.gov/statutes/cite/245.697

2. Archer J, Bower P, Gilbody S, et al. Collaborative care for depression and anxiety problems. Cochrane Database Syst Rev. 2012 Oct 17;10:CD006525. doi: 10.1002/14651858.CD006525. pub2. PMID: 23076925.

3. Shippee ND, Shah ND, Angstman KB, et al. Impact of collaborative care for depression on clinical, functional, and work outcomes: a practice-based evaluation. J Ambul Care Manage 2013 Jan-Mar;36(1):13-23. doi: 10.1097/JAC.0b013e318276dc10. PMID: 23222009.

4. UnUtzer J, Harbin H, Schoenbaum M, Druss B. The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes. Health Home Info Resource Center Brief. 2013