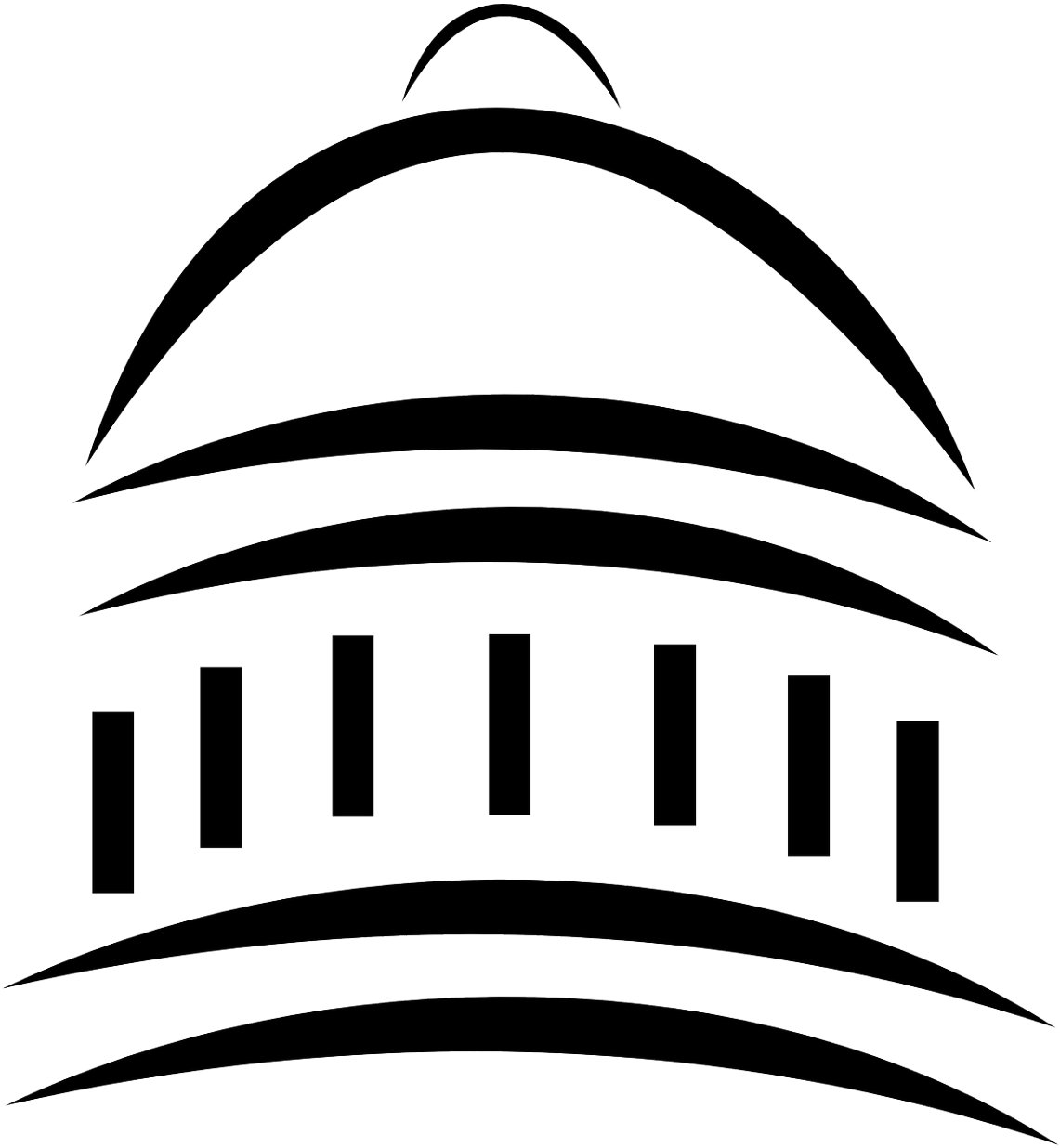
2023 LEGISLATIVE ISSUES



MENTAL HEALTH LEGISLATIVE NETWORK OF MINNESOTA

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MENTAL HEALTH LEGISLATIVE NETWORK 2023

The Mental Health Legislative Network (MHLN) is a broad coalition that advocates for a statewide mental health system that is of high quality, accessible and has stable funding. The organizations in the MHLN all work together to create visibility on mental health issues, act as a clearinghouse on public policy issues and to pool our knowledge, resources, and strengths to create change.

This booklet provides important information for legislators and other elected officials on how to improve the lives of children and adults with mental illnesses and their families and how to build Minnesota's mental health system.

The following organizations are members of the Mental Health Legislative Network:

ACCORD
Allina Health System
Amherst H. Wilder Foundation
Avivo
AspireMN
Barbara Schneider Foundation
Catholic Charities Twin Cities
Central Minnesota Mental Health Center
Children's Minnesota
East Metro Crisis Alliance
Epilepsy Foundation of Minnesota
Fraser
Guild
Hennepin Healthcare
Lutheran Social Service of Minnesota
Mental Health Minnesota
Mental Health Providers Association of Minnesota
Mental Health Resources
Mid-Minnesota Legal Assistance/Minnesota Disability Law Center
MARRCH - Minnesota Association of Resources for Recovery and Chemical Health
Minnesota Association of Black Psychologists
Minnesota Association for Children's Mental Health
Minnesota Association for Marriage and Family Therapy
Minnesota Association of Community Mental Health Programs
Minnesota Behavioral Health Network
MN Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Prenatal to Three Coalition
Minnesota Psychiatric Society
Minnesota Psychological Association
Minnesota School Social Workers Association
Minnesota Social Service Association
NAMI Minnesota
National Association of Social Workers, Minnesota Chapter
Nurse-Family Partnership
NUWAY
Nystrom
People Incorporated
Pregnancy Postpartum Support Minnesota
RISE, Inc.
State Advisory Council on Mental Health Subcommittee on Children's Mental Health
Touchstone Mental Health
Vail Place
Washburn Center for Children
Wellness in the Woods

If you have questions about the Mental Health Legislative Network or about policies related to the mental health system, please feel free to contact NAMI Minnesota at 651-645-2948 or Mental Health Minnesota at 651-493-6634. These two organizations co-chair the Mental Health Legislative Network.

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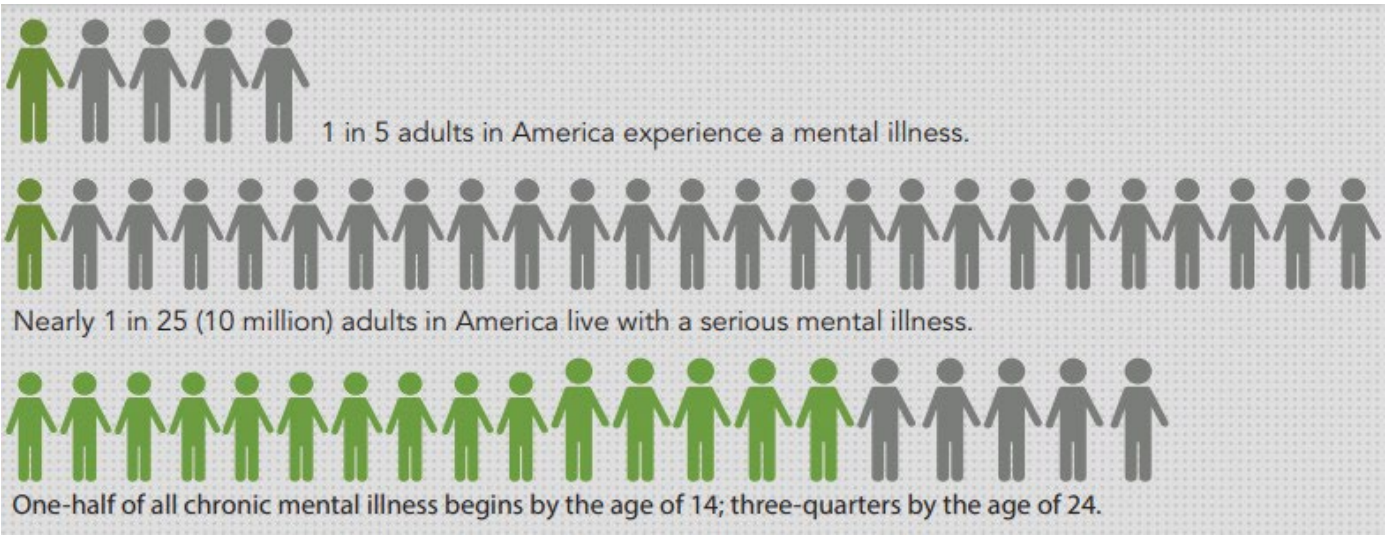
MENTAL ILLNESSES



Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Mental illnesses affect about one in five people in any given year. People affected more seriously by mental illnesses number about 1 in 25. Mental illnesses can affect persons of any age, race, religion, political party, or income.

Examples of mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), anxiety, panic disorder, post-traumatic stress disorder (PTSD), eating disorders and borderline personality disorder. There is a continuum, with good mental health on one end and serious mental illnesses on the other end.

Mental illnesses are treatable. Most people diagnosed with a serious mental illness can get better with effective treatment and supports. Medication alone is not enough. Therapy, peer support, nutrition, exercise, stable housing, and meaningful activities (school, work, volunteering) all help people recover.

The Substance Abuse Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is characterized by continual growth and improvement in one's health and wellness that may also involve setbacks. Resilience becomes a key component of recovery.

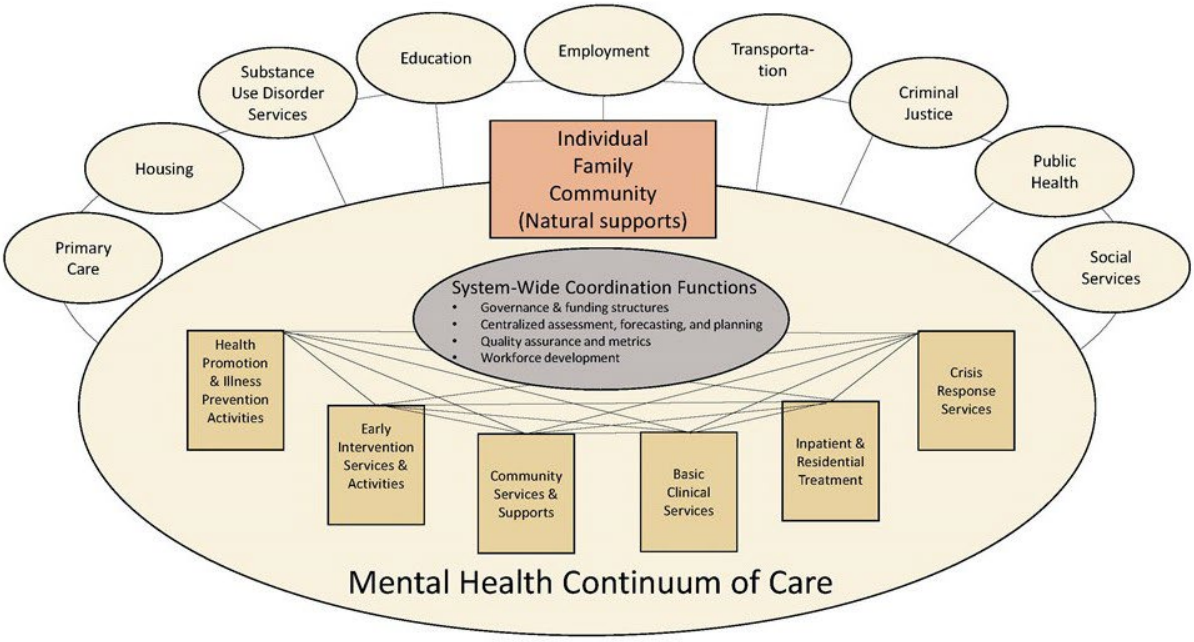
Some people need access to basic mental health treatment. Others need mental health support services such as case management (and/or care coordination) to assist in locating and maintaining mental health treatment and services. Still others need more intensive, flexible services to help them live in the community.

Depending on the severity of the mental illness and whether timely access to effective treatment and support services are available, mental illnesses may significantly impact all facets of living including learning, working, housing stability, living independently and relationships.

Although there are effective treatments and rehabilitation, the current mental health system fails to respond timely to the needs of too many children, adults, and their families. Timely access to the full array of necessary mental health benefits and services, whether treatment or rehabilitation, is often limited due to lack of insurance coverage, low payment rates, workforce shortages or geographical or cultural disparities. It should be noted that the pandemic had a negative impact on the mental health of people of all ages, with the rates of depression and anxiety increasing greatly, and the World Health Organization stated the increase worldwide was 25%.

Without access to treatment and supports, people with mental illnesses may cycle in and out of the criminal justice system or homelessness, drop out of school, be unemployed and be isolated from family, friends, and the community.

THE MENTAL HEALTH SYSTEM



The mental health system is not broken. It was never built. The old state hospitals were not a system and there were very good reasons that they were closed. Most of the beds closed by 1980 and since then we have identified what works and advocated for funding to build our mental health system. Barriers to fully building our mental health system exist and we hope to address them this session.

Access to Treatment and Services: Many people seeking mental health treatment or services struggle to access what they need, especially in rural areas and among Black, Indigenous, and People of Color (BIPOC). Telemedicine has opened doors to treatment, but there are still not enough options for treatment, support, and services in many areas of the state.

Insurance Coverage: The main access to the mental health system is through insurance – either private health plans or a state program such as Medical Assistance (MA) or MinnesotaCare. For those who have no insurance or limited coverage, access is then through the county or a community mental health center. Private health plans often do not cover the full array of mental health services. Mental health parity only requires plans to ensure parity *if* they cover mental health or substance use disorder treatment. Under the Affordable Care Act (ACA) individual policies and small group plans must cover mental health and substance use disorder treatment and follow mental health parity laws. Parity is not effectively enforced, and people continue to not be able to access care under private insurance or pay more out-of-pocket.

Community Services: Some people who have the most serious mental illnesses need additional services in the community such as affordable supportive housing, community supports, employment supports, educational services, respite care, waivered services, and in-home supports. These services are often funded by state grants, Medical Assistance, and county funds.

Workforce: Psychiatry, psychology, clinical social work, psychiatric nursing, marriage and family therapy and professional clinical counseling are considered the "core" mental health professions. For many years, Minnesota has experienced a shortage of mental health professionals. This shortage has been felt most profoundly in the rural areas of the state and within culturally specific communities.

Reimbursement Rates: Historically, poor reimbursement rates in public mental health programs and Medical Assistance have contributed to the problems of attracting and retaining mental health professionals. Improved payment to mental health providers allows providers to hire and supervise qualified workers to better meet the needs of people with mental illnesses in a timely way.

KEY ISSUES FOR THE 2023 LEGISLATIVE SESSION

As we look ahead to a "post-pandemic" future, we need to address the impact of the last several years. More people than ever are struggling with their mental health and more people than ever are seeking treatment and support. We must take action now to continue to build the mental health system and services we need, or it will only get worse for people living in Minnesota. Without sufficient access to the treatment and services people need, many people face a mental health crisis before they are able to get help. There is a significant human cost to this, as well as a financial one. It is imperative that we recognize mental health in Minnesota as a public health crisis that requires immediate action.

We know what works. Early intervention, evidence-based practices, and a wide array of mental health services and supports have created the foundation for a good mental health system in Minnesota. Unfortunately, workforce shortages, poor reimbursement rates, closure of programs and hospitals, health inequities, and lack of coverage by private plans have resulted in a fragile system that is not available statewide and is not able to meet the demand.

People often look for "quick fixes" such as more beds. While we need more inpatient beds, children and adults with mental illnesses spend the majority of their lives in the community. Thus, the "fix" is more complex in that we need to provide early identification and intervention, be able to address a mental health crisis, and provide ongoing supports in the community.

The Mental Health Legislative Network believes these challenges, though very significant, are not insurmountable. Again, we know what works. Let's build our mental health system.

Key Issues for the 2023 Legislative Session

- Permanently enact changes that allowed for telehealth in an audio-only format
- Stabilize and increase access to effective mental health care throughout the state by increasing rates and funding, eliminating barriers to development, streamlining regulatory systems, and enforcing mental health parity
- Expand access to intensive treatment and supports
- Create new services and expand current grant programs to support children and their families
- Implement key programs that address equity and disparities
- Help people living with mental illnesses obtain stable housing and employment
- Expand access to home and community supports through waivers and in-home services
- End the inappropriate use of the criminal and juvenile justice systems for children and adults with mental illnesses and provide adequate mental health care in these systems
- Expand and diversify the mental health workforce
- Ensure access to mental health crisis services and fund implementation of 988

SYSTEM ISSUES

Telehealth

Issue: In the 2021 session, the legislature took strong action to support Minnesotans in receiving telehealth care. The remaining issue is that of audio-only services which were only extended until July 2023.

Background: Audio only services are a crucial link in addressing the needs of the most vulnerable populations who have no access to audio-visual services, such as individuals in poverty, who are homeless, or who live in remote locations where adequate broadband service is not available. In November 2021, the Centers for Medicare and Medicaid took the important step to permanently support payment for audio-only mental health care in situations where the recipient of services either refuses to participate in audio-visual services or such services are not available.

It is important that Minnesota's public programs, Medical Assistance and MinnesotaCare, and third-party payers reflect the decision of CMS to adopt audio-only services. CMS noted that the reason for this inclusion was due to considerable public comment, indicating the high need for this service to address health disparities.

Policy Recommendations:

- Make coverage of audio-only services permanent, so that individuals can continue to receive needed care.
- Reimburse all telehealth visits at the same rate as in-person visits
- Ensure that these changes apply to both commercial and Medicaid plans

Reimbursement Rates

Issue: Reimbursement rates for mental health providers are unsustainable at a time when need has grown so greatly, and wages have been low. Providers are leaving the field and programs are closing because of unsustainable rates. While a rate development study is underway by DHS, funds are needed now, on an emergency basis, to meet the skyrocketing need and maintain critical services in place today.

Background: Reimbursement rates for mental health services under Medical Assistance have been problematic for many years. Rates are complicated by a myriad of one-off rules that makes payment issues confusing for providers and DHS. The Legislature, in 2021, charged DHS with developing a rate structure and report to the Legislature in 2024. Providers have cooperated with DHS in previous endeavors, such as a cost study that led nowhere.

Currently the need for providers is so acute that every effort must be made to address rate issues in the interim so needed services are available. Some potential fixes could be made to rates, independent of the development of a new rate system.

Policy Recommendations:

- Address PMAP inconsistencies.
- Address rates for Intensive Residential Treatment Services (IRTS), Assertive Community Treatment (ACT), Residential Crisis Services and Psychiatric Residential Treatment Services (PRTF) to ensure these cost-based rates are better structurally equipped to keep pace with inflationary pressures and service demands.
- Establish a single statewide reimbursement rate for behavioral health home services that meets the costs of the services
- Allow MN Care enrollees to have room and board through IRTS and Residential Crisis Services paid
- Adjust PRTF per diem rates to reflect changes in the CMS Psychiatric Facility Market Basket
- Increase Medicaid rates for community-based mental health services by 35% to bridge services to the new anticipated rate structure
- Annually adjust rates to better keep up with inflation

Regulatory Standards

Issue: Complicated and contradictory standards make it difficult for providers of community mental health services. We need to improve the ability of community mental health service providers to meet the immense need for quality mental health services in a time of a severe workforce shortage and inadequate reimbursement rates.

Policy Recommendations:

- Advance legislative changes that increase access to and quality of mental health services by clarifying and streamlining standards across mental health services where appropriate. While progress was made on this during the 2021 session, more opportunities remain.
- Establish consistent core provider entity application and certification process standards and expectations
- Continue to update, clarify, and streamline CTSS requirements, including a definition of children's care coordination
- Update USS changes and modifications to continue to refine standards with current workforce and care environment
- Simplify documentation requirements
- Simplify diagnostic assessments updates – removing duplications and requirements that do not add clinical value
- Streamline access to care for children by relying on clinical experts to identify the best assessments for each child, and eliminate requirements to use specific assessments
- Eliminate case reviews under treatment supervision
- Eliminate host county secondary certification for ARMHS programs
- Ensure MCO process consistency
- Remove duplicative requirements on clinical trainees

Network Adequacy

Issue: Minnesotans seeking mental health care face narrow networks, particularly in rural communities.

Background: Health plans contract with hospitals, doctors, and other providers to provide health and mental health care for their plan members. These providers constitute a health insurance plan's network and plan members pay more if they receive care out of their network.

Minnesota law requires health plan networks to offer mental health services with a maximum travel time of no more than 30 miles or 30 minutes to the nearest provider. For specialty services, the maximum travel time must be less than 60 minutes or 60 miles. These criteria are not adequate because they do not consider wait times or whether in-network mental health providers are even accepting new clients.

Plans can apply for a waiver from these network adequacy requirements. If the plan would like to renew their waiver after it expires, then new legislation passed in 2019 requires the Departments of Commerce and Health to consider the steps taken by Health Plans and HMOs to address network adequacy. HMO's and Health Plans must also update their website once a month to reflect providers being moved out-of-network and provide a list of available providers in an accessible format.

The process of health plans credentialing with providers can often take a long time. Health plans are allowed to be selective with providers, even those that fit their credentialing criteria, and are left with fewer available providers to meet the demand for mental health services.

The pandemic has had a negative impact on Minnesotans' mental health – of all ages. Over 750 Minnesotans died by suicide last year. To respond to this crisis and ensure that Minnesotan's have access to mental health services, the MHLN believes it is necessary to allow any willing mental health provider to offer in-network services if they are willing to abide by the same requirements and rate structure as other in-network providers.

Policy Recommendations:

- Acknowledge the crisis in access to care by requiring health plans to contract with any willing mental health provider to provide services in-network if they are willing to comply with the same standards and accept the same rates as other in-network providers.
- Require MDH and Commerce to recommend measures other than miles such as wait times and other criteria as a better predictor of network adequacy
- Require health plans to annually attest to the active status of providers within their network
- Require a public hearing on requested waivers to network adequacy
- Require licensing boards to share their lists with the MN Dept of Health
- Require PMAP to use timely filing timelines and prior authorization processes consistent with fee-for-service

Certified Community Behavioral Health Clinics

Issue: The state of Minnesota is walking back a previously made (unilateral) decision to withdraw from the National CCBHC Demonstration, extended for three more years by Congress through September 2025. As community stakeholders, CCBHCs and the state engage in discussion on possible reentry, Minnesota must ensure:

- Fidelity to the national CCBHC model is maintained
- Expanded federal resources are retained in Minnesota, allowing state funds to be invested across other critical mental health and SUD care needs
- Partnerships with community that built CCBHC in Minnesota continue with reciprocal trust and accountability

Additionally, we continue to streamline state requirements for CCBHC with the goal of creating a single licensure that recognizes CCBHC as a unified care model entity, not merely a compilation of separate services.

Background The Certified Community Behavioral Health Clinics (CCBHCs) are "one stop" shops that provide seamless behavioral health care to clients under a sustainable MN Medicaid model. The CCBHC model is an opportunity for laying a new foundation of mental and chemical health services delivery in Minnesota.

Thanks to the legislature's passage of 2019 through 2021 legislation, Minnesota's CCBHC model is a permanent Medicaid benefit. Additionally, Congress and the Federal Government continue to support CCBHC nationally with ongoing investments, model updates and extending and expansion of the National CCBHC Demonstration.

We are advocating to keep Minnesota in the National CCBHC Demo the entire time Congress supports and allows it. We also advocate to ensure Minnesota's CCBHC model maintains fidelity to the national CCBHC model as part of a nationwide network system and Minnesota retains all federal resources coming to the state under the National CCBHC Demo. In these efforts, we want to continue to further align the state regulations with the founding purposes of CCBHC.

Policy Recommendation:

- Return Minnesota to the National CCBHC Demonstration for its duration under Congress and the Federal Government
- Align Minnesota's CCBHC model to national standards, definitions, and criteria
- Streamline underlying state service standards – eliminate conflicting requirements of CCBHC's care components
- Transition the CCBHC model to a unified license under consistent oversight by the state

Direct Care and Treatment

Issue: DHS has become too large and challenging to manage, and the state of Minnesota should divest itself of programs that can be done in the community.

Background: The Mental Health Legislative Network has long supported removing Direct Care and Treatment (DCT) from DHS and making it a separate agency. Carving out DCT has been considered in the past by members of both parties and has the potential to significantly reduce the strain on DHS leadership without disrupting the core functions of DHS. This need has been

longstanding, but recent dysfunction makes simplifying DHS even more timely.

DHS Commissioners routinely spend an inordinate amount of time managing DCT, with problems at our state-operated programs distracting DHS Commissioners from agency-wide oversight and setting long-term goals. Carving out DCT will reduce administrative strain at DHS and allow leadership to prioritize managing their core roles including Medical Assistance and supporting the community-based mental health system.

Furthermore, it is a conflict of interest for DHS to license, operate, and fund the many services provided through DCT.

Policy Recommendation:

- Break apart Direct Care and Treatment and make it a separate agency within state government

Hospital Beds

Issue: There are not enough inpatient psychiatric beds, leading to emergency room boarding, traveling long distances to find a hospital bed, and out-of-state placements.

Background: It is always preferable for people with mental illnesses to receive community-based treatment. However, there will always be a need for inpatient mental health treatment to treat acute symptoms of a mental illness. Unfortunately, there is a significant shortage of hospital mental health beds for people with mental illnesses. This leads to emergency room boarding, where a patient is stuck in an emergency room for days, weeks, or months and are unable to access an inpatient bed or appropriate community services.

When someone is finally able to access an inpatient mental health bed, they are often forced to travel hundreds of miles or even out of state. This is an unacceptable situation that would never be tolerated for someone experiencing a heart attack or another acute health need. As the needs for mental health care are expected to increase, not decrease, it is essential that patients do not lose access to current inpatient beds, or we risk the unstable situation becoming a full-blown crisis.

With no extra slack in the mental health system, any decision to close inpatient mental health services creates a significant reduction in access to mental health inpatient services. If a mental health unit closes, other health systems will not be able to care for these additional individuals, which will likely make emergency room boarding and out-of-state placements more common.

There is never a good time to lose any mental health beds, but certainly not when the demand is on a steep incline because of the pandemic. What the community needs to know now is how acute mental health needs will be supported into the future. Any new beds should be within a regular hospital to ensure that Medicaid funds can be used and should have an emergency room. Note that there is a long-standing federal law that does not allow Medicaid to pay for mental health or substance use disorder treatment in any facility with more than 16 beds where more than half of the patients are being treated for mental health or substance use disorders. The way that people are admitted to a hospital is through an emergency room. Without one, people are unnecessarily being transported from another hospital and such a hospital could refuse to treat people with the most serious mental illnesses. Finally, our head is connected to the rest of our body and people can come into an inpatient psychiatric unit with other health conditions. Hospitals need to be able to treat the whole person.

Policy Recommendations:

- Increase reimbursement rates for inpatient psychiatric care to make it more sustainable for hospitals to offer this level of care.
- If a hospital closes its inpatient mental health and substance use disorder beds, it will not be allowed to “bank” the beds. The bed licenses will be reallocated to the commissioner of health to distribute to entities wishing to expand their hospital beds to treat people for mental health or substance use disorders.
- The state must use bonding dollars to increase the mental health beds in other hospitals.
- Not approve new beds unless they are in a regular hospital with an emergency room.

Life Insurance

Issue: Survivors of people who die by suicide are unable to get their life insurance benefits if the policy was started within two years of dying.

Background: Minnesota's life insurance clauses have antiquated language that marginalize people with mental illnesses. The suicide clause also says that when someone completes suicide less than two years after starting a life insurance policy, their beneficiaries can only receive a refund of the premiums paid. We know that suicide is largely impulsive and that people who complete suicide don't do so for an insurance payout, and their families deserve the financial support that other beneficiaries receive.

Policy Recommendations:

- Amend these clauses to delete discriminatory language and allow payment of benefits if the person dies by suicide after three months of taking out the policy rather than two years.

ADULT MENTAL HEALTH SERVICES AND SUPPORTS

Continuum of Care

Issue: There is a significant need to strengthen the continuum of care available for mental health in Minnesota to avoid unnecessary use of both hospitals and the criminal justice system, and to ensure that people who do need hospital level of care are able to find the right level of care in their communities when they are ready for discharge.

Background: Many people across Minnesota, including children, wait in emergency rooms for a hospital bed. Still others wait in hospital psychiatric beds, an Intensive Residential Treatment Services (IRTS) facility, and in jail for an opening at Anoka Metro Regional Treatment Center (AMRTC). People who are at ARMTC are waiting for community services.

Policy Recommendations:

- Provide funding and increase standards for mental health treatment in jails
- Expand the Transition to Community Initiative to serve people over age 65, people in Community Behavioral Health Hospitals (CBHHs), and people in community hospitals seeking admission to AMRTC
- Pay for IRTS room and board costs under MinnesotaCare.
- Ensure IRTS and Residential Crisis Stabilization (RCS) service facilities are equipped to meet standards like accessibility by funding facility upgrades.
- Increase the number of Forensic Assertive Community Treatment Teams
- Expand the Elderly Waiver to meet the mental health needs of older adults

Housing

Issue: There is limited access to affordable and supportive housing.

Background: 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. People with mental illnesses cannot achieve recovery without stable housing.

Homelessness has been getting worse in Minnesota. Before the start of the COVID-19 pandemic, the most recent Wilder Homeless Count found a 10% increase in the number of people experiencing homelessness between 2015-2018, with a higher rate of growth in Greater Minnesota. Just as concerning, there was a 62% increase in the number of people that are not staying in a formal shelter setting. Most homeless adults also have a chronic health condition, with 64% of respondents having a serious mental illness and 24% living with a substance use disorder. The eviction moratorium that kept so many out of

homelessness during the pandemic expired on June 1, 2022, and renters immediately felt the effects, as the rate of eviction filings jumped nearly 140% in June compared to May.

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. In one study, 95% of the costs of supportive housing were offset by lower treatment costs.

The grant program called Housing with Supports for Adults with Serious Mental Illness provides grants to housing developers, 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. The 2019 bonding bill doubled this funding to $60 million, and a 2020 bill allocated $100 million in housing infrastructure bonds for supportive housing, affordable housing, and land banks.

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.

Policy Recommendations:

- Increase funding for the Bridges Program
- Increase funding for Housing with Supports for Adults with Serious Mental Illnesses
- Any bonding bill must include a significant investment in the development of affordable housing
- Expand the landlord risk mitigation fund and provide the funds to agencies serving people who are homeless

Clubhouses and Community Support Programs

Issue: Increase access to Community Support Programs and Clubhouse Model programs across the state.

Background: Community Support programs and Clubhouse Model programs help people with mental illnesses stay out of the hospital while achieving social, financial, housing, educational and vocational goals. People are referred to as members not clients.

The Clubhouse Model is an Evidence–Based Practice for employment, quality of life, and mental health recovery. It provides a uniquely integrated approach to recovery, combining peer support with a full array of services. Studies have shown that Clubhouse Programs decrease isolation, reduce incarceration and hospitalizations, and increase employment opportunities.

Community Support Programs/Clubhouse Programs rely on a limited funding stream: Community Support Grants (part of the State Adult Mental Health grants) and local county dollars. Reliance on this often-at-risk funding restricts the further expansion of community support and Clubhouse programs across the State of Minnesota, despite the fact that they are among the most cost-efficient community support services available and have been proven effective.

Policy Recommendations:

- Ensure state funding to counties is used to support Community Support Programs and Clubhouse Model Programs
- Explore alternate sustainable funding options to ensure access to Clubhouse services.
- Fund Community Support Programs and Clubhouses to carry out employment programming

First Episode

Issue: There are limited programs and services available for people experiencing their first psychotic or mood episode. The results are adverse outcomes and disability caused by their untreated or undertreated mental illness.

Background: Individuals experiencing their first psychotic or mood disorder episode are not receiving the intensive treatment they need to foster recovery. On average a person waits 74 weeks to receive treatment. Our mental health system has relied on a “fail-first” model of care that essentially requires people experiencing psychosis or serious mood disorder to be

hospitalized or committed multiple times before they can access intensive treatment and supports. With schizophrenia being one of the most disabling conditions in the world, it is crucial that we intervene early with intensive services. Waiting costs our system a great deal in terms of hospitalizations, homelessness, and involvement with the criminal justice system. It costs the individual even more.

First Episode Projects, focusing on psychosis and mood disorders, offer coordinated specialty care including case management, psycho- therapy, psychoeducation, support for families, cognitive remediation, and supported employment and/or education. These programs provide intensive treatment right away. They have been researched by the National Institute of Mental Health and found to be very effective.

In rural areas the catchment area would need to cover many miles, which means that housing must be made available for the young person and their family to access this outpatient treatment program. Currently there are only four programs in Minnesota, three in Hennepin County and one in Duluth.

While 10% of the federal mental health block grant must be used for first psychotic episode programs, state funding is needed to develop enough programs around the state to meet the need - which we calculate to be at least eight programs.

Policy Recommendations:

- Increase the number of first episode psychosis (FEP) programs so that young people experiencing their first psychotic episode receive intensive treatment
- Fund the first early episode of mood disorder program to provide treatment for young people with bipolar disorder or depression
- Require a report from DHS on how the federal and state dollars are being used

Employment

Issue: People with mental illnesses have the highest unemployment rate and yet employment is an evidence-based practice, meaning it helps people recover. Programs that are designed specifically for persons with mental illnesses are underfunded and serve a limited amount of people.

Background: People living with mental illnesses face a number of barriers to finding and keeping a job. They often face discrimination when applying for jobs and may face other obstacles such as losing health insurance coverage for their mental health treatment and medications or have a lack of transportation. In addition, few receive the supported employment opportunities shown to be effective for people with mental illnesses and few employers know about accommodations for a mental illness.

Individual Placement and Support (IPS) is an evidence-based employment program for people with serious mental illnesses. There are only eight in the state. In 2019, the Legislature appropriated an additional $1.8 million in one-time state funds. However, because federal VR funds can no longer be used for grants to IPS projects, the additional funds will only sustain existing programs, not add new IPS projects.

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 follow the requirement to use some of their state mental health funds for IPS.

Vocational Rehabilitation Services (VRS) continues to have three out of four service categories closed. This makes it hard for people with mental illnesses to access help through VRS. With hardly any programs to help people with mental illnesses find and retain employment, most do not have jobs.

Policy Recommendations:

- Require the commissioner of DEED, in consultation with stakeholders, to identify barriers that people with mental illnesses face in obtaining employment, identify all current programs that could assist people with mental illnesses in obtaining employment and submit a detailed plan to the legislature how to expand the numbers of people with mental illnesses working

- Increase funding for the IPS program for both expansion and infrastructure, explore the use of Medicaid for IPS, require a memorandum of understanding between DEED and DHS
- Require workforce centers to have training on accommodations for a mental illness
- Fund community support programs to assist people with mental illnesses to find and keep employment
- Require DHS and DEED to consider racial and geographic disparities in their efforts to help people with disabilities obtain competitive, integrated employment

Voluntary Engagement

Issue: Mental health professionals who try to engage people in treatment typically stop their efforts if the person refuses, which can often lead to worsening symptoms without treatment.

Background: In the 2020 session, the legislature passed a comprehensive update of the civil commitment statute. One key change was replacing court-ordered early intervention with new language to promote early intervention by working to engage a person in treatment voluntarily. The goal is to engage someone to accept treatment, services and supports early on, when symptoms are appearing and to prevent someone from being hospitalized, committed, or going to jail. Under current law, counties can opt-in to providing engagement services, but there is no financial support to do so. While we believe many counties have the existing capacity to offer this level of support now, using case managers, peer specialists or mobile crisis teams and providing funding to start and sustain the program is the best route long-term.

Policy Recommendations:

- Use state funding dollars to pilot engagement in service programs and track outcomes.

Protected Transport

Issue: Mental health crises can be exacerbated by ambulances or police cars responding, especially if there are sirens, flashing lights, or people being physically restrained. Rates are too low for many providers to provide this service.

Background: Protected transport is a mode of nonemergency medical transportation (NEMT) allowing a person experiencing a mental health crisis to ride in a car that is not a police car or ambulance. The unmarked vehicle is equipped with safety locks, a video recorder, and specially trained drivers. Providers who supply protected transport services get people to the appropriate care setting safely in a dignified manner without needing to be handcuffed or strapped down.

Policy Recommendations:

- Increase rates for protected transport so that more providers can provide the service

CHILDREN'S MENTAL HEALTH

Early Childhood Consultation

Issue: Childcare providers and educators do not have the necessary training or skills to adequately support children with mental health needs. Children are getting kicked out of childcare instead of receiving the supports and treatment they need.

Background: Since 2007, Minnesota has invested in building infrastructure to address early childhood mental health through grants to support and develop the availability of and access to developmentally and culturally appropriate services for young children.

Early childhood mental health consultation grants support having a mental health professional, with knowledge and experience in early childhood, provide training and regular onsite consultation to staff serving high-risk and low-income

families, as well as referrals to clinical services for parents and children struggling with mental health conditions. Early childhood mental health consultation has three main components:

- On-site mental health consultation and support for childcare agency staff. Mental health agencies will also work directly with families as appropriate
- Referrals for children and their families who need mental health services
- Training for childcare staff in child development; trauma/resilience; working with families who have their own mental health issues; and skills to better support the emotional health and development of children they work with. These trainings would be built into the Parent Aware ratings of participating childcare agencies

Policy Recommendation:

- Increase funds to expand early childhood mental health consultation grants

School-Linked Mental Health Services

Issue: There is a need to increase funding investments in the School-linked Mental Health program

Background: Since 2008, grants have been made to community mental health providers to collaborate with schools to provide mental health treatment to children. This program has reduced barriers to access such as transportation, insurance coverage, and finding providers.

This program works collaboratively with school support personnel such as school nurses, school psychologists, school social workers and school counselors. The providers bill private and public insurance and use grant funds to pay for students who are un/underinsured and for services for which you can't bill insurance. Grants are used to build the capacity of the school to support all children.

Data show that of the children served in this program, 50% of the children had never been seen before, and 50% had a serious mental illness. In 2020 (Pre-COVID), 20,957 children were served in 328 districts and 1,116 school buildings.

The COVID-19 pandemic has negatively impacted the mental health of our children. Distance learning has been difficult and the isolation even more so. Children returned to in-person learning after experiencing the trauma of COVID-19, food insecurity, and more. The need for mental health services is even greater than before. COVID-19 also exposed standing problems with the underlying payment/ delivery model of providers billing private/ public insurance and based on the number of appointments provided (fee for service). Grants cover some, but not all of the costs invested into providing the care, which go uncompensated for providers.

Policy Recommendations:

- Increase funding for school- linked mental health grants so it is in every school building
- Fold in and increase existing grants for co-locating mental health professionals in Intermediate Districts, special education cooperatives and at level four settings and allow these grants to support developing innovative therapeutic teaching models in addition to other school-linked priorities
- Add a grant option for providers serving culturally specific populations in multiple schools

Children's Mental Health Supports

Issue: When a child is facing significant mental health challenges, there are not enough options for the child and their family to obtain the level of support they need. Extensive wait lists to access all levels of mental health coupled with lengthy assessment requirements significantly delay the delivery of critical treatment and services. Without adequate support in the community, children and youth will develop more serious mental illnesses and require more intensive treatment.

Background: While some progress has been made there are still significant gaps in our children's mental health continuum of care. Effective services are responsive to child and family needs, leverage the expertise of the full care team, and support transitions between treatment services . Respite care is a very successful program where the parents of children with a mental illness are given a break to recharge. There are currently no crisis homes for youth or crisis respite care. We also need to support parents who are living with a mental illness so that they can raise healthy children. Building on these efforts and providing more community-based supports will allow children with mental illnesses to get the level of care they need in the

community where they live.

Policy Recommendations:

- Replace the term “emotional disturbance” with “mental illness” in state statute
- Allow teens ages 16 and older to consent to outpatient treatment
- Increase funding for shelter-linked mental health
- Allow youth ages 21-26 to remain with the providers of their Youth ACT team
- Create a child-focused response for Nonemergency Medical Transportation
- Fund respite care services and expand to children who have used crisis services, ER services, or experienced a loss of in-home supports
- Fund an enhanced rate for PCAs working with children who exhibit high aggression
- Allow up to 20 hours per week of childcare for children under MFIP whose parent has a mental illness
- Require crisis intervention and stabilization service providers to have at least 6 hours of training with children, and establish a pilot program for rural family response and stabilization services
- Add children to the Transition to Community Initiative
- Create and fund after care services for children transitioning from a Qualified Residential Treatment Programs (QRTPs) to community settings.
- Expand training for family peer specialists and increase rates for family peer specialist services
- Increase rates for in-home services
- Fund training for staff providing in-home services
- Create and fund children’s care coordination
- Direct the commissioner to maximize Medicaid benefits for family focused children’s mental health care
- Fund Collaborative Bridging Services

Education K-12 and College

Issue: Schools have an important role to play in supporting students with mental illnesses, but they don’t have the resources to do this work effectively.

Background: While some students with significant mental health needs will require more intensive treatment from a mental health professional, most youth can greatly benefit from mental health supports provided by school staff. Academic counselors, school social workers, nurses, school psychologists and other student support personnel all have a very important role to play in the continuum of care for students having some mental health challenges.

School support personnel have incredibly high caseloads, making it difficult to meet the needs of students.
Minnesota students are often unable to access even basic information about what mental illnesses are, what the symptoms are of mental illnesses, and what they need to do if they are worried about themselves, a friend, or someone in their family.

Policy Recommendations:

- Increase funding in order to increase number of student support personnel
- Expand and continue Positive Behavioral Interventions and Supports (PBIS)
- Fund social emotional learning programs
- Eliminate use of suspensions in grades K-3 and focus on nonexclusionary policies for all grades
- Provide year-round education and summer school to students who miss out on school due to being in the juvenile justice system or residential mental health treatment or day treatment
- Increase funding for substance use disorder services in the schools
- Create a designated office of mental health within the Department of Education and a mental health lead
- Fund trauma informed schools
- Fund training for paraprofessionals to ensure they can work effectively with students
- Fund programs to reduce the use of seclusion and restraints
- Encourage districts to engage in restorative practices and create guidelines through the Dept of Education
- Fund the evidence-based suicide prevention training tool Kognito to reach all Minnesota school staff
- Fund college-linked mental health services at community and technical colleges

Conversion Therapy

Issue: Conversion therapy to alter or change an individual's sexual orientation is not supported by rigorous scientific research and is proven to increase levels of depression, suicidal thoughts, suicide attempts, and substance use disorder.

Background: Conversion therapy is usually defended by proponents because of their belief that same sex romantic orientation is a mental illness or developmental disability to be cured. Scientific evidence, in contrast, has found same-sex attraction and gender non-conformity are healthy aspects of human diversity.

Conversion therapy practitioners base their treatments on unscientific and inaccurate understandings of sexual orientation, gender identity, and gender expression. Being LGBTQ is not a mental illness and therefore therapy is not needed. There is no scientifically rigorous evidence demonstrating the effectiveness of conversion therapy. Scientific studies have found negative effects associated with conversion therapy, however, including increased levels of depression, suicidal thoughts, suicide attempts, and substance abuse in adults.

Recent research has found adolescents surviving conversion therapy to have less educational attainment in addition to the increased depression and suicide risk adult survivors of conversion therapy experience. All the major health and mental health organizations support banning conversion therapy.

Policy Recommendation:

- Ban conversion therapy as a harmful and ineffective practice

Child First

Issue: Growing up in a challenging environment can be damaging to children's mental health.

Background: Child First is a national evidence-based model of care that works with children and their families to provide intensive mental health and home visiting services.

Policy Recommendation:

- Fund grants to start up, expand, or sustain Child First programs in metropolitan and rural areas of the state for community based mental health organizations, family service organizations, hospital systems and pediatric providers, early care and education providers, and university-based family or mental health programs.

Boarding in the ER

Issue: Children are stuck in emergency rooms without appropriate mental health services or places to go.

Background: Children are being assessed in the ER but often there are no appropriate or available services to meet the needs of the children. At times, when a parent cannot bring the child home, they are referred to Child Protective Services.

Policy Recommendation:

- Change the definition of neglect to specify that a child in need of child protective services does not include one whose parent or guardian cannot bring them home because appropriate services are not available to keep the family safe. It's not the parent that has neglected the child, it's the mental health system.
- Provide start-up funding to new PRTFs and allow such facilities to specialize or target the children they serve. Improve rate setting by including the CMS Market Basket Rate Adjustment and incorporating future cost projections into the rate tool.
- Create rate exceptions for providers serving children with challenging behavioral disorders
- Increase funds in order to add staff at the State Medical Review Team (SMRT)
- Create specialized settings for children boarding in the ER so they can receive care specific to their mental illness
- Mandate coverage of PRTFs by private insurance

Third Path

Issue: Children who try to access residential services are often forced to go through child protection.

Background: Congress passed the Family First Act to keep families and kinship networks together when a child enters the child protection system. The Mental Health Legislative Network shares the priority of keeping families together, particularly because of the significant racial disparities in the child protection system. However, Family First also impacts voluntary placements in children's residential programs because the state uses Title IV-E funding to pay for room and board. This means that a family with a child voluntarily seeking residential mental health treatment would have to undergo an invasive relative search and screening team before they can access medically necessary treatment for a serious mental illness. This places unnecessary roadblocks and delays to obtaining care. The Children's Mental Health Residential Service Path is how children and youth with mental illnesses should access residential treatment services. Through this "third path", families don't go through child protection. While legislation passed to make this possible, funding is needed to pay for room and board.

Policy Recommendation:

- Include Third Path residential option cost of room and board under Behavioral Health Fund

ACCESS TO MENTAL HEALTH TREATMENT

Equity and Disparities

Issue: Access to mental health care by BIPOC communities can be difficult.

Background: Social determinants of health have a huge impact on the mental health of children and adults. This includes economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

The state of Minnesota has the second biggest income inequality gap between Black and white people in the entire nation. Compared to white Minnesotans, Asian people earn 94 cents on the dollar, Black people earn 71 cents, Latino people earn 70 cents and Indigenous people earn 68 cents (Minnesota House of Representatives, 2020).

We know that BIPOC youth, particularly indigenous students, are more likely to be expelled or suspended. They also graduate at lower rates. People from BIPOC communities experience trauma, both historical, and due to racism.

It can be hard to find a culturally responsive mental health professional or to obtain an interpreter. And culturally appropriate mental health services are virtuially non-existent for BIPOC people in rural Minnesota. Over 80% of mental health professionals in Minnesota are white.

Policy Recommendations:

- Fund the Cultural and Ethnic Minority Infrastructure Grant program and put it in statute
- Fund culturally specific provider consultation
- Fund cultural healers from different communities
- Create fund to provide interpreters in child or adult residential settings

Workforce Shortages

Issue: Minnesota has longstanding significant deficits in the mental health workforce. Not only do we need a larger mental health workforce, but we also need one that can be responsive to the needs of our diverse communities.

Background: For many years Minnesota has experienced a shortage of providers for mental health services. This shortage is felt most acutely in rural areas and for culturally specific providers. Nine of eleven geographic regions in Minnesota are designated as mental health shortage areas by the Health Resources and Services Administration. As more people will need to seek mental health treatment, there is an urgency to the need to increase the supply of community mental health professionals, especially those able to meet the needs of our diverse community. In the wake of the recent unrest, it is anticipated that there will be a greater need for diverse providers.

The 2015 Mental Health Workforce Task Force made a number of recommendations to address shortages by increasing the number of qualified people working at all levels of our mental health system. Several of these recommendations were passed during the 2021 Legislative Session including requiring mental health professionals to have at least 4 of their 40 hours of continuing education on cultural awareness, racism, and cultural humility; allowing Licensed Alcohol and Drug Counselors to access the health professional education loan forgiveness program; and funding CEUs for BIPOC mental health professionals to become supervisors. A Culturally Informed and Culturally Responsive Mental Health Task Force (CICRMHTF) was also established to evaluate and make recommendations on improving the provision of culturally informed and culturally responsive mental health services throughout Minnesota.

In 2022, the Legislature increased the funding for the loan forgiveness program for mental health professionals; allowed a student who is in the process of completing a practicum or internship as part of a formal undergraduate or graduate training program in social work, psychology, or counseling to be a mental health practitioner; created a grant program for mental health providers to pay for direct supervision hours for interns or clinical trainees; and allowed mental health trainees to meet their supervisory requirements using real-time two-way interactive audio and visual communication.

We have made progress, but more must be done due to the critical workforce shortage. We also need to invest in traditional healing models that incorporate multigenerational and multidisciplinary approaches. People of color and new immigrants face additional hurdles when trying to become licensed as a mental health professional.

Policy Recommendations:

- Fund providers largely serving Medicaid clients or diverse populations to provide supervisory hours for free for mental health certification and licensure
- Increase funding to train more peer and family peer specialists
- Increase funding for health professional education loan forgiveness program
- Require private health insurance to cover treatment provided by a clinical trainee
- Provide grant funding to every Tribal Nation and Indian Community in Minnesota as well as the five urban Indian communities to support a full-time traditional healer
- Fund and reimburse cultural healers in different communities
- Charge DHS to work with mental health licensing boards to create alternative pathways to licensure for mental health professionals from diverse backgrounds and work with the licensing boards to encourage people to provide demographic/ethnic information in order to measure progress.
- Fund fellowships for people seeking careers in addiction medicine and treatment.
- Establish a mental health and substance use disorder education center at the Minnesota Department of Health to increase the workforce and diversity, and target training to have a culturally informed and responsive workforce
- Fund the Grow Your Own program to create opportunities for people to move up the ladder in their mental health field, such as paying for tuition
- Pay for psychiatry residential slots
- Create an interstate compact to allow LPCs in other states to practice in Minnesota
- Ensure that medical education includes training taking place in community-based and non-hospital or facility settings
- Train pediatric providers on mental health care alongside child psychiatrists
- Create and fund a Youth Care Professional training program for people working in direct care with youth in residential settings

- Create a governing board for Certified Peer Support Specialists
- Increase funds for culturally diverse mental health professionals to become supervisors

Suicide Prevention

Issue: Suicide is one of the leading causes of death for Minnesotans and has become a public health crisis with nearly 800 people dying by suicide this past year.

Background: Suicide is a public health crisis and must be tackled like the opioid crisis with improved coordination and additional resources. Minnesota has made slow progress to address the significant increase in death by suicide. In addition to increasing access to care increased suicide prevention efforts must take place.

Policy Recommendations:

- Increase funding for suicide prevention training
- Provide targeted support to communities experiencing high rates of violence, trauma, and suicides
- Increase suicide prevention outreach to farm communities
- Include means restriction education and safe storage information in firearm education programs
- Treat risk of suicide and risk of violence differently under Red Flag legislation

988 Implementation

Issue: With the implementation of 988 as the new three-digit number for the National Suicide Prevention Lifeline, Minnesota must build the capacity needed to respond to incoming calls, texts, and chats 24/7.

Background: A federal law in 2020 designated 988 as the new nationwide three-digit number for the National Suicide Prevention Lifeline to replace the former 10-digit number (800-273-8255). Since July 16, 2022, anyone can dial or text 988 to reach the Lifeline. All states, including Minnesota, are expected to handle 988 calls, chats, and texts within their states 24 hours a day, seven days a week.

Suicide is the eighth leading cause of death in Minnesota. It is the second leading cause of death among youth ages 10–19 and young adults ages 20–34. This funding will ensure the lifeline centers in Minnesota can continue to provide localized support under 988 and expand services to include text and chat. The new 988 number will also direct callers to mental health services and supports, making 988 a comprehensive system for those seeking mental health support.

If calls are not answered in Minnesota, they roll into a national system and are answered by back-up calls centers in other states that do not have information or understanding of Minnesota's system of crisis services if a caller needs in-person help. It is essential that Minnesota build capacity to respond to all incoming calls, texts, and chats in-state.

Policy Recommendations:

- Implement a 988-telecom surcharge on all wired lines, wireless, prepaid and VOIP lines to support 988
- Provide funding in the interim before the telecom fee is enacted to ensure that Lifeline centers can meet current needs

Crisis Response

Issue: Minnesota residents do not have the appropriate level of mental health crisis services available to them in an appropriate or effective time frame.

Background: Research has shown that mobile crisis services are:

- Effective at diverting people in crisis from psychiatric hospitalization
- Effective at linking suicidal individuals discharged from the emergency department to services
- Better than hospitalization at linking people in crisis to outpatient services and
- Effective in finding hard-to-reach individuals.

- Providing a mental health response also limits interactions with police.

In 2016 MMB reported the cost savings for crisis services is $102 per person avoiding hospitalization, and $1,080 per person avoiding the criminal justice system. Mobile crisis interventions are face- to-face, short-term, intensive mental health services provided during a mental health crisis or emergency. These services help the recipient to:

- Cope with immediate stressors to lessen suffering
- Identify and use available resources and recipient's strengths
- Avoid unnecessary hospitalization and loss of independent living
- Develop action plans
- Begin to return to their baseline level of functioning

Mobile crisis services are available throughout Minnesota for both adults and children. Hours of coverage vary as does ability to respond. Other components of the crisis system should include urgent care or walk in clinics, direct referral from 911, psychiatric emergency rooms and crisis homes.

Policy Recommendations:

- Increase state funding for crisis teams and homes
- Allow flexibility with funding in order to meet demands at key times
- Require training on children's mental health and working with families
- Keep strengthening collaboration between crisis teams, 988 and 911.

Behavioral Health Homes

Issue: There is a need to improve service access through sustainability of Behavioral Health Homes (BHH) investment.

Background: BHH is a newer Medicaid service, beginning in 2016. As we move the whole mental health system forward, we believe our system is enriched by the broad spectrum of services, including BHH, that are available to our community of individuals who have a wide variety of needs. BHHs are serving individuals in over 60 counties across the state, including community mental health providers and primary care providers. Since beginning in July 2016, over 2,700 individuals received BHH services. We thank the Legislature for updating and strengthening the framework of Behavioral Health Home services in 2019. The BHH is a program that can dramatically improve people's lives by treating the whole person in the community. BHH provide a mechanism to address clients' physical and mental health symptoms. Most importantly, they provide a mechanism to coordinate care and address clients' social determinants of health risk factors in conjunction with their mental and physical health symptoms.

Policy Recommendations:

- Update reimbursement rates for BHH services to ensure the rates are more reflective of the actual cost of providing this critical service, to increase access.
- The Commissioner for the Department of Human Services should implement a single statewide reimbursement rate for behavioral health homes that shall be adjusted annually by CPI for medical care services. Allow broader eligibility to fill key roles in the BHH team while maintaining quality standards to ensure programs and access are viable

Community Mental Health Treatment

Issue: Minnesotans continue to lack access to adequate mental health treatment in the community where they live.

Background: While we have come a long way in Minnesota in the development of our community based mental health services system, we must continue to grow our community based mental health service system in order to meet the critical mental health needs present in our communities. We know what works in the area of community based mental health services: earlier intervention services provided where Minnesotans with need for services are located and a continuum of care with transitions allowing individuals to move to levels of care that meet their changing levels and kinds of need.

Policy Recommendations:

- Increase funding for the community mental health system, including grant programs that support Assertive Community Treatment (ACT) teams, First Episode Psychosis programs, mental health crisis teams, and more

- Review the role of the county as the mental health authority
- Expand transportation options so that more people can be involved in the community
- Increase funding for tools like Fast-Tracker that connect people with resources for mental health and substance use disorder services in their communities

Collaborative Care Management

Issue: Residents in MN with depression and anxiety have long had difficulties accessing care in a timely manner, outcomes have been poor and have not been improving, and folks with MA insurance have even a harder time getting in. The pandemic has increased the intensity of depression and anxiety, the numbers of Minnesotans needing treatment for depression and anxiety, and worsened access. Meanwhile, patient outcomes on MN Community Measurement's Depression Suite of Measures have failed to improve significantly.

Background: The Collaborative Care Model (CoCM) is the only behavioral health integration model with a clear base of evidence of more than 80 randomized control trials. CoCM has been proven to deliver better patient outcomes faster, diverting people from crisis and resulting in cost savings. It has also been proven to reduce health inequities. In addition, the model delivers improved physician satisfaction and improved patient satisfaction.

Medicare, commercial, and employer markets in MN reimburse for this high-value care, and Medicaid in 22 states also pays for CoCM. However, MN Medicaid does not. Specifically, in the majority of practice settings, Minnesota MA (and MNCare) only pays for a few of the necessary collaborative care services. A group of more than two dozen mental health leaders, medical leaders, and employers from across MN were convened by the Institute for Clinical Systems Improvement (ICSI) in 2021. The group resoundingly expressed that integrated behavioral health care in primary care, specifically CoCM, is a solution that must be expanded. Because payer alignment is necessary to ensure economic viability for providers and patient access to care, one of the key findings of the multi-stakeholder group was: *"CoCM codes need to be covered by Medicaid in Minnesota."*

Policy Recommendation:

- Mandate that Minnesota Medical Assistance and MN Care pay for all necessary collaborative care services in all settings with a sustainable rate.
- Require that managed care plans use timely filing timelines and prior authorizations consistent with the medical assistance fee for service for all Medical Assistance services covered under Chapter 256B.

CRIMINAL JUSTICE

Juvenile Justice

Issue: Children with mental illnesses are severely overrepresented in the juvenile justice system. The federal Office of Juvenile Justice Delinquency and Prevention (OJJDP) estimates around 70% of juveniles have a diagnosable mental health condition. On top of this, data and first-hand experience in Minnesota show deep racial disparities in the juvenile justice system – Black and Brown children are more likely to be put in the legal system and are punished more severely than their white counterparts.

Background: When children and their families cannot access mental health care in the community, often a crisis can lead to involvement in the legal system. Other factors are also proven to be risk factors for legal involvement including housing insecurity, parental incarceration, and school suspensions. The first solution to disparities in the juvenile justice system will always be building an equitable children's mental health system. This includes prevention, school-linked services, a continuum of care in the community, and sufficient crisis and inpatient settings.

Yet, we also need many interventions for youth who have already entered the system. Minnesota has specifically seen a

growing crisis with children with very complex needs who cannot find placements around the state. Some board in emergency rooms, some are taken out of state. Many of these children are not involved with the justice system, but for those who are, finding placements can be even harder and the children can be placed in juvenile detention facilities.

While the crisis is daunting, we do know what works for these children. Individualized care settings, with 1:1 and even 1:2 staff to child ratios. While these services require a lot of resources, the truth is that the number of very serious juvenile cases in the state are relatively few. Most children in the juvenile system are not accused of violent crimes, so while we continue to provide prevention and interventions, we can also focus resources on the children with the highest immediate needs.

There is growing agreement in the public safety community that all children deserve a rehabilitative and restorative response when they have committed a crime. This comes with the acknowledgement that corrections and detention centers are not designed or intended for such a response. We know that children in the juvenile justice system are overwhelmingly survivors of trauma, yet many corrections practices are not trauma-informed, and worse yet, can be retraumatizing. We need to work together to actualize the values of rehabilitation by increasing the resources and uses of diversion programs and restorative justice, providing adequate care for children across a continuum including detention, reducing, and eliminating harmful practices and collateral consequences.

Policy Recommendations:

- Raise the age of delinquency and detention from 10 to 13.
- Ban strip searches in detention facilities.
- Ban solitary confinement and mirror "restrictive procedures" in treatment environments with good data collection
- Address the issues when a juvenile is found incompetent to stand trial
- Fund restorative justice programs in schools and through court diversion
- Fund pretrial diversion programs
- Fund safe alternatives to police responses in communities
- Fund Youth Intervention Programs
- Ban "life without parole" sentences for juveniles and provide restorative options for juveniles currently serving life.
- Address collateral consequences through criminal records.
- Create an office for juvenile justice that focuses on restoration and wellness.
- Invest in data collection infrastructure.
- Require minimum standards for juvenile court examiners
- Create stronger protections and oversight for interrogation of juveniles

Public Safety

Issue: People with mental illnesses and BIPOC communities are disproportionately impacted by our public safety and criminal legal systems. We need more and equitable resources to divert people away from the legal system, restore those who are in the legal system, and support public safety and legal professionals who work in these environments.

Background: Whenever we talk about public safety we are also talking about mental health. It follows that to have good mental health we must feel and be safe, and when we have good mental health, we are able to experience more safety and respond better when safety is threatened.

Mental health impacts everyone – victims of crimes, first responders, lawyers, judges, the accused, corrections officers, incarcerated people, and the families and loved ones of every one of these people. While the issues across these systems can be very complex, we can operate from the simple principle that everyone deserves to be safe. This means that whenever we are talking about public safety, we are talking about adequate mental health supports for victims and families, job-specific supports for first responders, mental health care in our jails, support for corrections officers, trauma-informed courts, court officials who partner with the mental health system, robust rehabilitative services in our prisons, and sufficient resources for probation officers and people reentering the community.

Many times, symptoms and untreated mental illnesses can result in criminalization, whether it is called trespassing or disorderly conduct, the underlying issue is not criminal behavior, but unmet needs. We know that when we respond to the

underlying issues, the criminal concerns often resolve themselves, and in many cases, responding to root social issues costs less to taxpayers and human beings than a criminal legal response. In cases where a person has committed a serious crime, it is also important that adequate mental health supports are in place throughout the legal system so that a person can be held accountable for their harm and that everyone in the community can be safe.

Finally, when we talk about public safety we are also talking about systemic racism. In the United States many of our laws and corrections practices were created out of the notion that Black, Indigenous, and people of color (BIPOC) are inherently more dangerous than white people. When we work to correct and improve our systems, we must address systemic racism head on and take action to allow communities of color to heal from the significant trauma that has been inflicted and continues to harm them today.

Policy Recommendations:

- Make calls from jail to family or for mental health free for prisoners
- Require the Department of Corrections to update a model discharge plan for all jails
- Fund jail reentry services
- Ensure and expand access to mental health care in jails
- Create incentives to contract with local community mental health providers to offer mental health services in jail and continuum of care upon release
- Provide resources for first responder wellness programs following best practice for the profession
- Review critical incident debriefing practices for first responders to follow trauma-informed best practices
- Reform sentencing and record keeping laws to reduce harmful collateral consequences
- Provide resources for families with incarcerated loved ones including increased quality visitation for children
- Require minimum training on mental illnesses for court officials
- Require minimum standards and certification for forensic and juvenile examiners

Prison and Probation

Issue: People with mental illnesses need support and treatment while in prison and serving sentences under community supervision. 95% of incarcerated people in Minnesota will reenter the community. Prisons need more mental health professionals and trauma informed practices to ensure that people can live safely while incarcerated and reenter the community with stability and safety. Additionally, maintaining meaningful connections is essential for the mental health of incarcerated people and their loved ones. However, phone, video, and email correspondence can be very cost-prohibitive, and visitation practices and policies are confusing and punitive. The Department of Corrections needs resources to support family connections.

Minnesota also faces a dire need for resources in community supervision, from workforce to adequate treatment options to ensure that people are successful as they serve their sentences. Startling data from the Department of Corrections last year showed thousands of people are being released from prison into unsheltered homelessness each year.

Background: Minnesota prisons do not have enough resources to meet the mental health treatment needs of prisoners. On top of this shortage of resources, many people are returned to prison for less than 90 days for technical probation violations, where they will not be engaged in programming for such a short sentence. Thus, many people are removed from their community where they may be working, engaging treatment, and supporting families and are returned to prison on small violations with no support, risking loss of treatment, employment, and housing. Minnesota must prioritize resources for community supervision to support people and relieve the strain on the needs of the prison population.

Minnesota has determinate sentencing, which means criminal sentences are set by the legislature and the Minnesota Sentencing Guidelines Commission. While a judge may “depart” from a recommended sentence, there is no “good time” in Minnesota prisons. If a person is sentenced to incarceration, they must serve 2/3 of their sentence in prison and 1/3 on community supervision. Both the Department of Corrections and formerly and currently incarcerated people have expressed the negative impact this has on everyone involved. An incarcerated person may work very hard to improve themselves and prepare to give back to their community, but they will still be released on the same day even if they did nothing while incarcerated. Moreover, a person may exhaust all the programming and education resources available to them and still have

years left on a sentence. If Minnesota created an earned incentive plan for early release, incarcerated people would have more motivation to engage in programming and the Department of Corrections could reinvest the money they would spend on incarceration on increased programming and community supports.

Policy Recommendations:

- Increase staffing levels for mental health and substance use disorder treatment staff
- Make calls and video communication from prisons to family members free
- Increase funding for mental health services
- Fund a family support unit in the Department of Corrections
- Place fewer conditions on eligibility for mental health services in prison
- Fund reentry specialists
- Create and fund transitional and affordable housing for people leaving prison
- Create an equitable funding formula for community corrections
- Increase diversion of technical-violators, lower-risk-level, non-violent offenders out of the prison and jail systems and into community-based alternatives to incarceration
- Increase of evidence-based practices for criminal justice involved persons in community programs and services
- Expand release options like work release and compassionate medical release
- Provide transitional services to these target populations so that they are eligible for benefits, are assessed for treatment needs, and connected with community providers and supports before and upon release
- Create personalized incentive plans for *all* prisoners to earn early release and reinvest the money saved into community services (the Minnesota Rehabilitation and Reinvestment Act [MRRA])
- Reduce the use of solitary confinement and promote rehabilitative safety measures in prisons
- Convene a working group to review safety and discipline policies in prisons and work to increase physical and psychological safety to prisoners and corrections officers
- Retain good corrections officers with salary increases, trauma-informed supports, and crisis intervention training

OTHER ISSUES

Coordinated Care in Integrated and Culturally Diverse Health Settings

Issue: Better information at the point of care leads to better healthcare outcomes. Individuals with mental illness often receive poorly integrated care because they receive services in multiple settings. Widespread use of the Encounter Alert Service by community providers would improve access to information and improve care coordination.

Background: Hospitals and community providers have the capacity to communicate safely and securely about changes to patient status using the Encounter Alert Service (admissions, discharges, transfers.) This service can improve care for individuals with mental illness by drawing on the most up-to-date information. Use of this system can improve care coordination and reduce costs, especially related to re-hospitalizations.

If community providers are included to the fullest extent in this service, case managers and other mental health providers can get an alert when someone is about to be discharged so that immediate follow up can occur. Unfortunately, few community providers have been brought into this system. While all of the major health systems have electronic health records, most of the systems do not communicate with one another, nor do they communicate with community providers. Some of the ensuing problems can be alleviated by robust use of the Encounter Alert Service. We need to require health systems to participate in the Alert Service and for them to share that information with community providers.

Policy recommendations:

- Require health systems to share encounter alerts with community providers
- Direct DHS to extend the Encounter Alert Service to all community providers

Cannabis Legalization

Issue: There are significant risks with the legalization of recreational cannabis.

Background: Minnesota recently legalized the recreational use of hemp-derived THC products, and full legalization of recreational cannabis is being discussed in the Minnesota Legislature with increasing frequency. Many enticing fiscal and ideological incentives are also pushing a national trend toward full legalization. Not least among these is the important work to decriminalize cannabis and right the wrongs of the past by expunging cannabis related convictions. While the MHLN believes cannabis use should be decriminalized, when it comes to full blown legalization of recreational cannabis, Minnesota must move forward cautiously. The MHLN has significant concerns about legalizing recreational cannabis.

The MHLN is particularly concerned about the connection between cannabis use and psychosis among young people, the impact of cannabis use on the developing adolescent brain, memory and cognitive impairment, and the risks to fetal development when the parent is using cannabis.

While the MHLN has many concerns with the legalization of recreational cannabis, we acknowledge the significant racial disparities associated with the war on drugs. The burden of a felony conviction affects people long after their involvement in the criminal justice system through discrimination in employment, housing, and civic involvement. Incarceration for such low-level drug offenses comes at great cost to individuals, families, and taxpayers.

Policy Recommendations:

- Increase investments in our mental health and substance abuse treatment system
- Increase investments in first episode psychosis programs.
- Invest in research and data collection on the effects of cannabis use prior to legalization
- Invest in systems to monitor the effects of legalization on education, car accidents, homelessness, pregnancy, and other psychosocial factors
- Raise the age of purchase to 25, due to the adverse effects of cannabis use on the developing adolescent brain
- Invest in providing education to youth and families on the possible adverse effects of cannabis use, especially for families with histories of serious mental illnesses
- Restrict and regulate marketing strategies that target vulnerable people
- Invest in public health labels warning about potency and the risks involved in using cannabis
- Increase investments in cultural competency and implicit bias education, particularly around cannabis use and criminal justice

Establishment of License for Behavior Analysts

Issue: There is a significant shortage of Behavior Analysts in Minnesota. Currently there are 250, while over 1,500 are needed just to serve people with autism (let alone people with other disabilities).

Background: While Board Certified Behavior Analysts are mentioned in Minnesota Statute in eight places, they are currently practicing without a licensing board to oversee them. Behavior Analysts serve individuals in their homes, clinical settings, adult residential settings, and schools. Proposed legislation establishes a license for professionals in Applied Behavior Analysis (ABA) under the Board of Psychology. This will ensure that the credential is used by licensed professionals meeting rigorous standards, and licensing reduces the likelihood of misuse of behavioral principles and practices by people with insufficient training

Licensing Behavior Analysts in Minnesota will have the effect of increasing the number of Behavior Analysts providing services here, as it has in the 31 other states who have already licensed this profession. More Behavior Analysts will increase access to services and lead to better outcomes for people seeking ABA services.

Policy Recommendation:

- Establishes a license for professionals in Applied Behavior Analysis (ABA) under the Board of Psychology.

Voter Registration

Issue: Patients in residential treatment programs sometimes run into obstacles trying to vote.

Background: Current Minnesota election law allows for employees of residential treatment programs to vouch for the client's residency to cast a ballot.

Policy recommendations:

- Clarify that the definition of residential program includes residential mental health treatment programs.
- Partner with the Second Chance Coalition to continue to advocate for voter rights.

Access to Tobacco Dependence Treatment

Issue: There are barriers to accessing tobacco dependence treatment for Medical Assistance and MinnesotaCare enrollees.

Background: : Individuals living with mental illness and substance use disorders are disproportionately impacted by the harms of commercial tobacco. They are more dependent on tobacco, smoke more heavily and are more likely to die from tobacco-related illness than from their mental health or substance use conditions. Seventy-five percent of adults living with serious mental illness and substance use disorders want to quit smoking, but only 40 percent of Minnesota's mental health treatment facilities and 31 percent of substance use disorder treatment programs offer tobacco treatment. This lack of treatment availability is due, in part, to inadequate insurance coverage for treatment and lack of reimbursement for providers.

Medical Assistance and MinnesotaCare coverage for tobacco dependence counseling and medications includes barriers such as prior authorization requirements. Coverage also changes from year to year and has, in the past, included other barriers such as requirements to try one medication before another will be covered and annual limits on the number of medication-supported quit attempts. Additionally, many qualified providers (e.g., mental health professionals and alcohol and drug counselors) are not able to be reimbursed for delivering tobacco dependence counseling.

Barrier-free coverage and adequate reimbursement policies are necessary to ensure commercial tobacco users can access the treatment they need**.**

Policy Recommendations:

- Require Medical Assistance and MinnesotaCare to cover, without barriers, all FDA-approved tobacco dependence medications, and all types of counseling (individual, group, and phone).
- Require Medical Assistance and MinnesotaCare reimbursement of tobacco dependence counseling services if they are provided by a health care practitioner whose scope of practice encompasses tobacco dependence education and counseling. This includes, but is not limited to, mental health practitioners, mental health professionals, mental health certified peer specialists, licensed alcohol and drug counselors, and recovery peers.