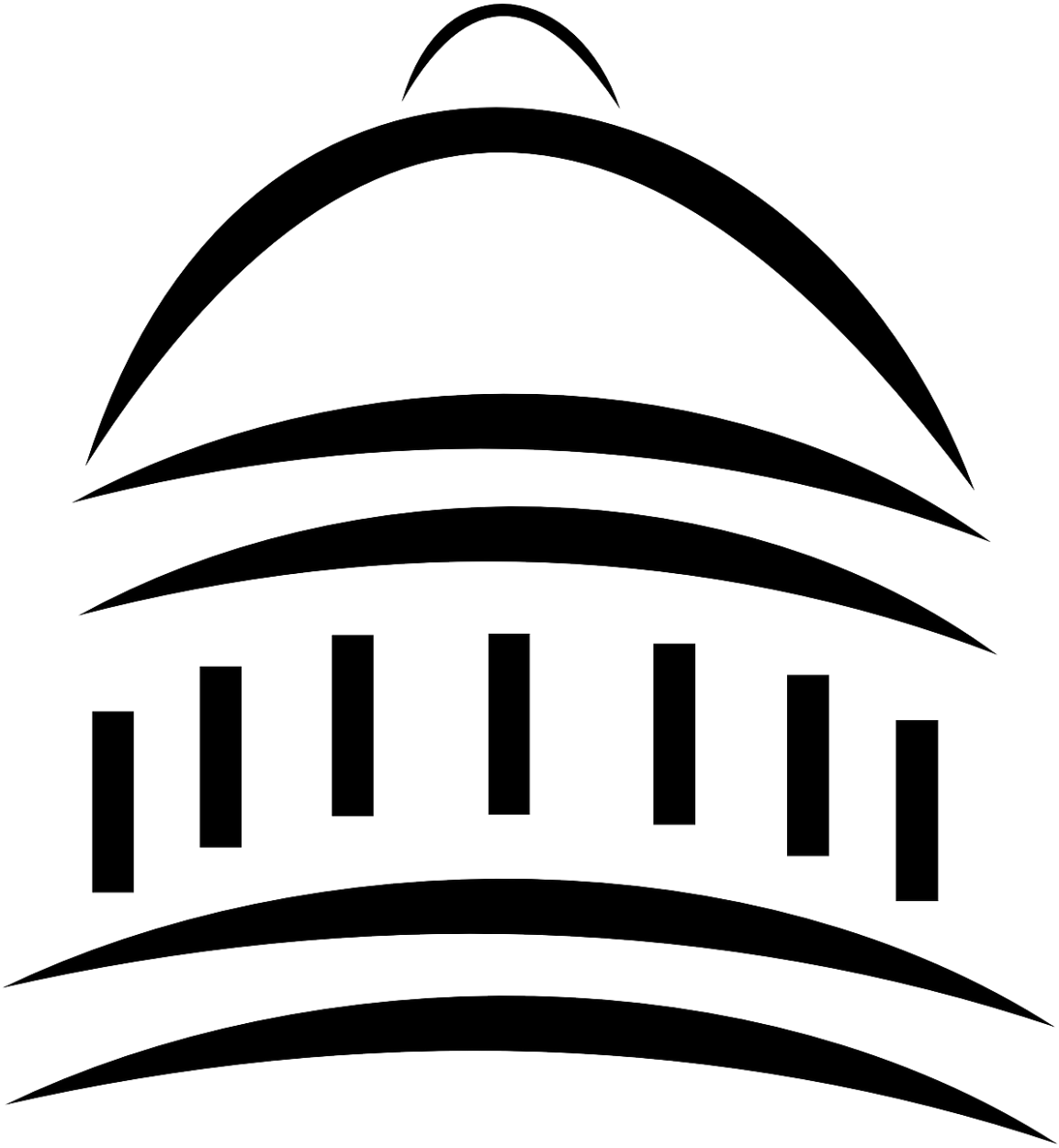
2019 LEGISLATIVE ISSUES



MENTAL HEALTH LEGISLATIVE NETWORK OF MINNESOTA

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MENTAL HEALTH LEGISLATIVE NETWORK 2019

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:

Amherst H. Wilder Foundation
AspireMN
Barbara Schneider Foundation
Canvas Health
Catholic Charities of St. Paul and Minneapolis
Children's HealthCare Minnesota
Community Involvement Programs
Emily Program Foundation
Fraser
Goodwill Easter Seals
Guild Incorporated
Lutheran Social Service of Minnesota
Mental Health Minnesota
Mental Health Providers Association of Minnesota
Mental Health Resources
MMLA/Minnesota Disability Law Center
Minnesota Association for Children's Mental Health
Minnesota Association of Community Mental Health Programs
Minnesota Coalition of Licensed Social Workers
Minnesota Association of Marriage and Family Therapy
Minnesota Behavioral Health Network
Minnesota Department of Human Services
MN Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota PROOF Alliance, formerly MOFAS
Minnesota Psychiatric Society
Minnesota Psychological Association
Minnesota Recovery Connection
Minnesota Society for Clinical Social Work
Minnesota School Social Workers Association
NAMI Minnesota
National Association of Social Workers, Minnesota Chapter
MN Office of Ombudsman for Mental Health and Developmental Disabilities
People Incorporated
Resource, Inc.
Rise
State Advisory Council on Mental Health Subcommittee on Children's Mental Health
Touchstone Mental Health
Vail Place
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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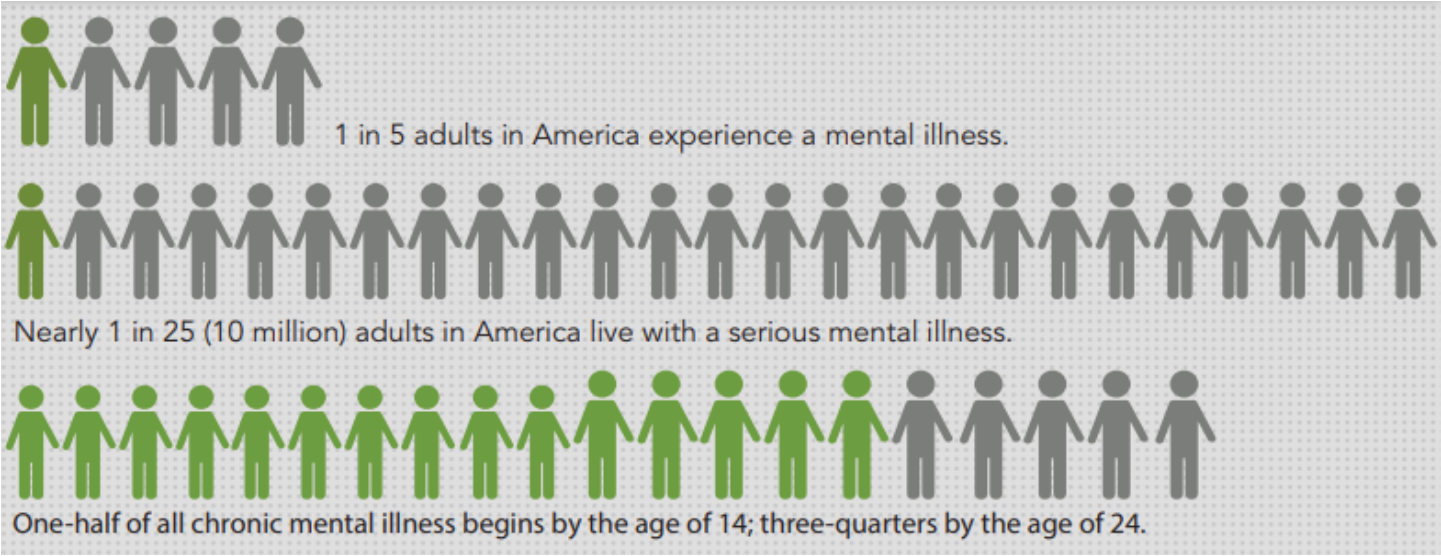
MENTAL ILLNESSES



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.

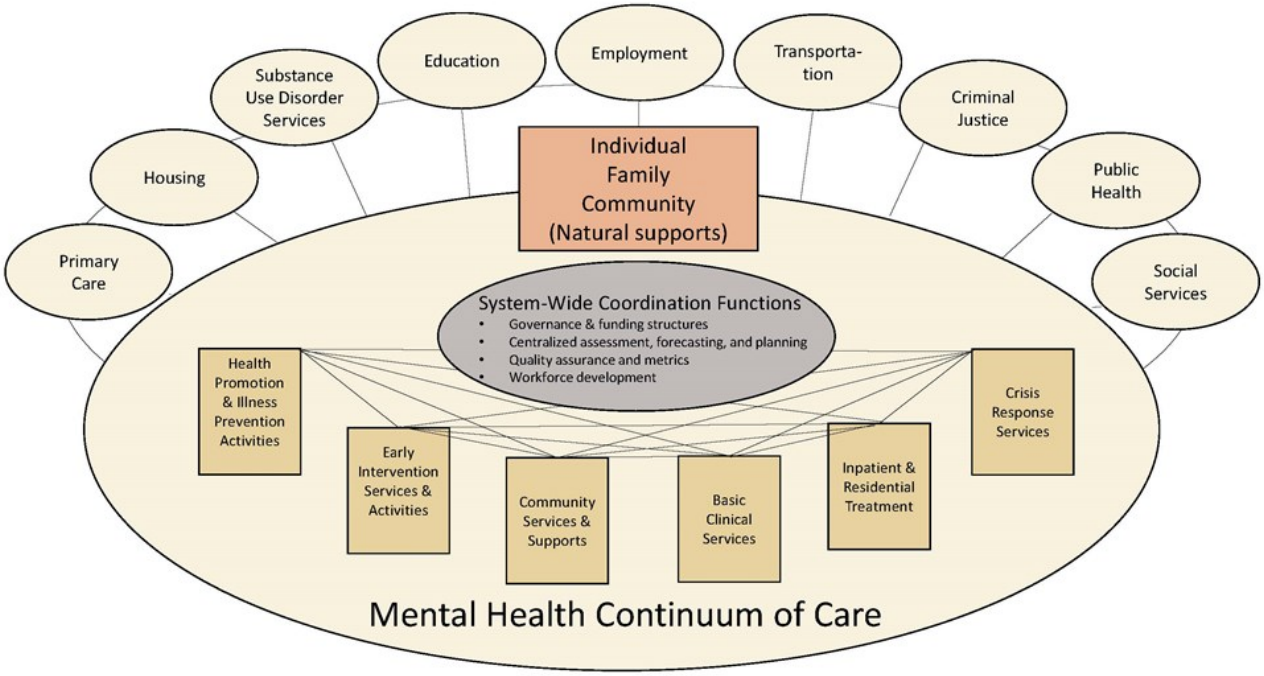
Some people need access to basic mental health treatment. Others need mental health support services such as case management (and/or care coordination) to assist them in locating and maintaining mental health and social services. Still others need more intensive, flexible services to help them live in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

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 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 progress exist and we hope to address them this session.

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 poor 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. Enforcement needs to be stronger.

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 and in-home supports. These services are often funded by state grants 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 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. Rates paid through managed care Medical Assistance are often lower than fee-for-service rates.

KEY ISSUES FOR THE 2019 LEGISLATIVE SESSION

More than ever before, we know what works. Early intervention, evidence-based practices and a wide array of mental health services has created the foundation for a good mental health system in Minnesota. Unfortunately, workforce shortages, poor reimbursement rates, 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. 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.

While the focus tends to be on the delivery of mental health treatment, other areas need attention as well. People with mental illnesses rely on the CADI Waiver (Community Alternatives for People with Disabilities) or on Community First Services and Supports (which will replace the old PCA program) for day-to-day help in their homes. Yet changes to both of these programs have resulted in them being less available to people with mental illnesses.

Affordable and supportive housing are very important to recovery. If you are homeless or have unstable or unsafe housing, it is difficult to focus on getting better. Everyone needs a reason to get up in the morning and yet people with serious mental illnesses have one of the highest unemployment rates.

Graduating from high school is important to future success. Many young people with serious mental illnesses drop out of school. Often, they lag behind their peers due to being in day or residential treatment and yet cannot access summer school. These students face the use of seclusion and restraints more frequently and schools are often at a loss as to what to do to keep the child safe.

Our juvenile justice and criminal justice system have been used for over 50 years to care for youth and adults with mental illnesses who have committed largely nonviolent crimes. Steps have been taken to address this including training of public safety officers, the development of mental health courts and the creation of mental health crisis teams _ but it isn't enough

Suicide rates are increasing in Minnesota. Nearly 800 people took their lives last year. Given the scale of this problem – exceeding even the opioid crisis – it is imperative that we recognize Minnesota's suicide rate as a public health crisis that requires immediate action.

Low rates and workforce shortages add to the stressors on the system. Providers are not paid for what they are required to do. Low rates make it difficult to attract new people to the field. Workforce shortages make it difficult to hire enough people to meet the needs.

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 2019 Legislative Session

- Stabilizing and increasing access to effective mental health care throughout the state by increasing rates and funding and eliminating barriers to development
- Enforcing Mental Health Parity laws
- Expanding access to intensive treatment and supports
- Providing supports and education that support children to live with their families
- Helping people living with mental illnesses obtain stable housing and employment
- Expanding access to home and community supports through waivers and in-home services
- Ending the inappropriate use of the criminal and juvenile justice systems for children and adults with mental illnesses and providing adequate mental health care in these systems
- Expanding the mental health workforce

SYSTEM ISSUES

Reimbursement Rates

Issue: There is not a sustainable reimbursement rate for mental health providers.

Background: Reimbursements for mental health services under Medical Assistance have been a concern for many years. We are now at a critical time in which demand for more access is catalyzing increased investments to build more services on top of a very unstable foundation. Many providers are paid less than the fee-for-service rate.

Providers serving the most vulnerable face additional pressure because they cannot gap-fill losses with commercial payments and do not refuse services to clients for any reason.

Sustainable reimbursements for services are key to addressing workforce shortage, program cuts/ flattening, and safety net services.

Policy Recommendations:
The MHLN propose a three (3) part reformed mental health service delivery and payment system to address the immediate need and long-term solutions to solvency, including:

- Addressing mental health services' payments under managed care by requiring that mental health services payments must be at least equal to the published fee-for-service schedule
- Providing a rate increase for community mental health services
- Revise payments so that there is a sustainable payment methodology for mental health services under Medical Assistance

Mental Health Parity

Issue: Mental health services are not covered by insurance in the same way as medical health services.

Background: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law aimed at requiring health insurance to cover mental health or substance use disorder services in the same way plans cover other medical services. Minnesota statutes require plans to follow the federal law.

The three pillars of mental health parity are:

Out of Pocket Costs: Mental health parity requires that copayments cannot be higher for mental health care than other medical surgical benefits, nor can there be a different deductible or higher out-of-pocket maximums for mental health care.

Treatment Limits: Health plans cannot establish different quantitative limits for mental health care than other medical benefits.

Non-Quantitative Treatment Limit (NQTL): Requires plans to make the scope or duration of benefits for treatments the same. An NQTL can take the form of step-therapy for a medication, different standards for a provider to enter a network including reimbursement rates, or other limits based on facility type or provider specialty that limit the scope or duration of health plan benefits. Mental health parity stipulates that the standards that a health plan uses when making an NQTL cannot be any more stringent or restrictive for mental health and substance use dis order treatment than it is for other categories of health care.

Violations still occur in all three areas, but the most common one is the NQTLs.

Policy Recommendations:

- Require private health plans to demonstrate that their plans are in compliance with parity regulations, including non-quantitative treatment limits such as network adequacy, wait times, formularies, etc. before they are certified by the Department of Commerce
- Require the Departments of Commerce and Health to monitor the implementation of mental health parity, including market conduct examinations
- Require the Departments of Commerce and Health to provide a report to the legislature every year regarding their efforts to enforce the parity law

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 its 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, the Department of Commerce must take into consideration steps taken by the plan to expand their network when reviewing this waiver request.

Over 800 Minnesotan's died by suicide last year. To respond to this crisis and ensure that Minnesotan's have access to mental health services, NAMI Minnesota 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:

- Measure 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
- 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. And require training for health care and mental health care providers on how to treat

Certified Community Behavioral Health Clinics

Issue: Minnesota needs to sustain and expand the CCBHCs.

Background: The Certified Community Behavioral Health Clinics (CCBHC) model is a federal pilot of the Excellence in Mental Health Act. Minnesota is one of eight states selected for the pilot. CCBHCs are "one stop" shops that provide more seamless care.

To date, we found the model provides great service flexibility, innovation and efficacies.

These include: aligned intake assessments, implementing new tools, enhanced care coordination, models for addressing the opioid epidemic and a sustainable payment system for delivering mental health services.

The CCBHC model is an opportunity for laying a new foundation in mental health services delivery in Minnesota.

Policy Recommendation:

- Expand and continue development of the CCBHC model beyond the FY 2019 demonstration end date and authorize sustainable funding options

Telemedicine

Issue: Current statute limits the frequency and type of providers who can use telemedicine to serve people experiencing mental illness.

Background: Internet-based telepresence offers broad applications to assist in rapid innovation and statewide service implementation. Increasingly, different telepresence platforms are being used by different sectors and disciplines, making it difficult to efficiently and effectively connect with critical partnerships, providers and individuals that depend on access. Limits on the type of provides and number of visits limits access.

Policy Recommendation:

- Eliminate the cap on the number of encounters permitted in a week
- Create a Telepresence Task Force to evaluate leveraging the State of Minnesota's telepresence network to connect providers of critical mental health services and to better serve individuals that lack access due to geography, lack of transportation or incarcerated

ADULT MENTAL HEALTH SERVICES AND SUPPORTS

Flow Issues

Issue: People are waiting in the emergency room for a bed and in community hospitals to get into Anoka Metro Regional Treatment Center (AMRTC) or an Intensive Residential Treatment Services (IRTS) facility and people are waiting at ARMTC for community services.

Background: The "48 hour rule" gives jail inmates who are committed priority to access state facilities, in particular AMRTC. The number of people found incompetent to stand trial has increased greatly resulting in most of the people at AMRTC coming from jails. It went from 44 people a year from jails in 2013 to 227 in 2017. As a result, patients in the community who may be more ill and need to continue their care at AMRTC are unable to transition out of community inpatient beds and into AMRTC. This has created a significant bed flow problem for community psychiatric units. To make the situation worse, over 20% of people at AMRTC do not need that level of care and are waiting to transition into the community and the state is not using all of the beds that are licensed or funded. The Minnesota Hospital Association reports that roughly 20% of the people in an inpatient unit are waiting for another level of service.

Policy Recommendation: Address the "flow issues" by:

- Provide funding for mental health treatment to inmates in jail
- Expanding 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
- Fund projects that offer high intensity, secure facilities for people with complex mental health needs
- Increase the number of Forensic Assertive Community Treatment Teams
- Expand the Elderly Waiver to meet the mental health needs of older adults at AMRTC or MSH
- Fund community competency restoration programs
- Break off State Operated Services from DHS to become its own agency

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.

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.

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.

Recommendations:

- Increase funding for the Bridges Program
- Increase funding for housing supports for adults with serious mental illnesses
- Expand the landlord risk mitigation fund and provide the funds to agencies serving people who are homeless
- Block DHS's efforts to limit the number of people in a building on a home and community-based waiver to 25%

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: Mobile crisis teams reduce psychiatric hospitalizations. 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.

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 and lessen his/her 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 his/her 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
- Continue to move to have one (not 44) crisis numbers

Peer Respite

Issue: Adults with serious mental illnesses seeking help through local hospital emergency rooms and/or experiencing interventions via local law enforcement, often learn that there are no community services that can assist them until they are experiencing marked increases in symptoms or even a mental health crisis. Then, many are deemed "eligible" to access more acute or subacute treatments in hospitals, intensive residential treatment services, or face incarceration within jails and prisons. The purpose of Peer Respite Services (PRS) is to alleviate situations such as these.

Background: With a lack of ***early***, preventative community-based alternatives, such as PRS, unnecessary and damaging trauma is experienced by the person and their family and friends. Often, there are unwarranted losses of housing, education, employment, community engagement, and established mental health services and supports.

Peer respites are voluntary, short-term, services provided in a home-like setting designed to support individuals experiencing, or at-risk of, a psychiatric crisis. "Most peer respites work to mitigate psychiatric emergencies by addressing the underlying cause of a crisis before the need for traditional crisis services arise."

Ostrow, Laysha & Croft, Bevin**. (2015).** Peer Respites: A Research and Practice Agenda. *Psychiatric Services,* 66(6), 638-640.

The foundation of PRS is the Peer Support model itself. Peer Support is rooted in the empathic understanding of shared experiences of psychological and/or emotional distress, rather than the medical treatment model. PRS differs from present crisis response and stabilization programs due to the holistic support of the guests learning and growing during their stay rather than a focus on medication, diagnosis and therapy. Peer respite promotes empowerment, self-advocacy, and personal responsibility for one's recovery while using supports of the person's own choosing.

An August 2018 study compared costs of service by analyzing the month of crisis respite use and the 11 subsequent months. Medicaid expenditures were on average $2,138 lower per Medicaid-enrolled month with 2.9 fewer hospitalizations for crisis respite clients than would have been expected with absence of the intervention.

E Bouchery (2018 Aug 3) The Effectiveness of a Peer Staffed Respite Program as an Alternative to Hospitalization. *Psychiatric Services*. 68(10) 1069-1073.

Policy Recommendations:

- Approve development of standards for and implementation of a minimum of two (2) consumer-run peer respite services administered through DHS
- Provide annual funding of $370,000 beginning in fiscal year 2019-2020 with an additional $60,000 being to evaluate the new services during year one and two

Clubhouse or 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 Clubhouse Programs decrease isolation, reduce incarceration and hospitalizations, and increase employment opportunities.

Funding: 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 dispersion 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 that State funding to counties is used to support Community Support Programs and Clubhouse Model Programs.
- 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 mental illness.

Background: Individuals experiencing their first psychotic or manic 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 be 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, will offer coordinated specialty care including case management, psychotherapy, 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

Employment

Issue: Persons 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.

IPS is an evidence-based employment program for people with serious mental illnesses. There are only eight in the state. IPS State grant projects have received no cost of living increases. In SFY 2015 all IPS grantees experienced cuts of 8.6 percent that have not been restored.

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 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

Farmers

Issue: People in farming communities are experiencing high rates of stress and distress.

Background: Men in the farming, forestry and fishing industries have the highest rate of suicide. A recent CDC report found that suicides in rural areas were higher and the increased rate has been higher than other communities. In Minnesota, counties with the highest percentages of suicide per population between 2012 and 2016 include counties that have a high percentage of farmers. The suicide rate in Greater Minnesota increased from 13.1 to 15.9 in this same period, while the rate for the seven county metro area went from 11.2 to 11.1.

Researchers are examining why the rate is higher in rural areas and have found that isolation, substance use disorders, an aging population with poor physical health and financial issues are some of the contributing factors.

Policy Recommendations:

- Increase funding for counselors through the Department of Agriculture
- Fund efforts to increase awareness about stress and mental health and suicide prevention

Behavioral Health Homes

Issue: There is a need to make changes to Behavioral Health Homes.

Background: This proposal aims to strengthen the existing framework of BHH services to support the capacity of providers delivering BHH services and to increase access for individuals with mental illness and co-occurring medical conditions. These changes are expected to result in approximately 300 additional individuals accessing BHH services each year.

Policy Recommendations:

- Update eligibility requirements, service standards, provider requirements, and reimbursement rates
- Include four elements: Certification process and standards, Streamlined BHH rate structure, Improved access to BHH services, New/ added staff qualifications

CHILDREN'S MENTAL HEALTH

Early Childhood Consultation

Issue: Child care 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 child care 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:

1) On-site mental health consultation and support for child care agency staff. Mental health agencies will also work directly with families as appropriate
2) Referral for children and their families who need mental health services
3) Training for child care 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 child care agencies

Policy Recommendation:

- Appropriate funds to expand early childhood mental health consultation grants

School-Linked Mental Health Grants

Issue: Expand School-linked Mental Health (SLMH) Grants.

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 grant funds 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.

We know that 50% of the children had never been seen before & 50% had a serious mental illness. In 2017, 16,284 children were served in 288 districts and 953 school buildings.

Last year the Intermediates and cooperatives received funding to support their students.

Policy Recommendations:

- Increase funding for school-linked mental health grants so it is in every school building
- Ensure that grant funds are used to build the capacity of schools to meet the needs of students with mental illnesses such as staff development
- Utilize telemedicine to increase access in Greater Minnesota
- Fold in and increase existing grants for co-locating mental health professionals in Intermediate Districts, special ed cooperatives and at level four settings and allow these grants to support developing innovative therapeutic teaching models in addition to other school-linked priorities
- Require DHS to work with stakeholders to assess the school -linked mental health program and develop recommendations on how to improve it including promoting sustainability among grant attendees, determining the staffing necessary for a successful program, reviewing what data is collected, and analyzing outcomes when school buildings have access to a school-linked mental health program, sufficient school support personnel and Positive Behavioral Intervention and Supports

Residential Treatment

Issue: Since 2001, with approval from the Center for Medicaid and Medicare (CMS,) Minnesota has used Medical Assistance to pay for the treatment portion of the per diem for children's residential treatment services. Last year CMS decided that most of the residential facilities in Minnesota meet the definition of Institutes of Mental Disease (IMDs) which makes them ineligible for federal Medicaid funding.

Background: Programs that are larger than 16 beds that provide mental health treatment are considered an IMD and not only does Medicaid not pay for the treatment, but children residing in IMDs lose their Medical Assistance eligibility. Minnesota has over 800 beds in the continuum of care that would be affected by this loss of funding.

In 2017, the legislature appropriated bridge funding to cover the lost federal share. However, this funding is set to expire on April 30, 2019, before the end of the biennium. Without funding, counties will have to bear 100% of the costs of this vital part of our continuum of care.

Psychiatric Residential Treatment Facilities (PRTF) provide active treatment rather than rehabilitation and must have a psychiatrist or physician as a medical director, and require 24 hour nursing. The rates include room and board under MA and PRTFs are exempted from the Institute for Mental Disease (IMD) exclusion. The legislature authorized 150 beds in 2015. Only one PRTF is operating in the state.

Policy Recommendation:

- Immediately pass legislation to cover the loss of federal funding until June 30, 2019
- Fund the loss of federal funding for the next two years
- Increase the number of PRTF beds
- Implement the recommendations from the residential treatment report that will be released in late February

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. 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. 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. Youth in shelters also need access to more intensive mental health 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:

- Fund training for crisis teams to understand the unique needs of children and their families experiencing a mental health crisis
- Clarify that a child does not need a case manager in order to receive respite care
- Increase funding for respite care.
- Fund crisis respite services
- Develop and fund crisis homes for children and youth
- Move funding for Evidence Based Practices out of school-linked grants and other grants and concentrate all in one grant to an agency to increase training and their use of Evidence Based Practices.
- Explore developing intensive in-home services for children with a mental illness
- Expand Youth ACT teams to a younger age
- Fund shelter-linked mental health providers
- Fund child care for mothers with mental illnesses who have MFIP child only grants when it is recommended by a mental health professional
- Fund multi-generational treatment teams
- Fund community and technical college mental health programs.
- Fund transition age programs

CHILDREN'S MENTAL HEALTH

Education

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 pyschologists 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 number of student support personnel
- Require schools to include mental health and recognizing the symptoms of a mental illness in their health curriculum
- Increase funding for school-based mental health providers such as licensed PreK-12 school social workers, so that every buildings student's have lower barrier access to evidence-based education, behavior, and mental health services
- Expand and continue Positive Behavioral Interventions and Supports (PBIS)
- Fund social emotional learning programs to reduce use of suspensions in grades K-3
- Provide year round education to students who miss out on school due to being in the juvenile justice system or intensive mental health treatment
- Fund an online training for all teachers on suicide prevention
- Increase funding for substance use disorder services in the schools

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

ACCESS TO MENTAL HEALTH TREATMENT

Workforce

Issue: There are not enough mental health practitioners and professionals to meet the needs of the children and adults requiring mental health treatment and services.

Background: 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 providers of mental health services. This shortage has been felt most profoundly in the rural areas of the state. There is also an ongoing-shortage of culturally competent and culturally specific providers.

Nine of eleven geographic regions in Minnesota are designated mental health shortage areas by the Health Resources and Services Administration (HRSA). As more people seek mental health treatment and as we work to expand access to mental health services across the state, there is a great urgency to increase the supply of community mental health professionals.

In 2015 the Mental Health Workforce Task Force released the report with recommendations to address workforce shortages by increasing the number of qualified people working at all levels of our mental health system, ensure appropriate coursework and training for mental health professionals and create a more culturally diverse mental health workforce.

Policy Recommendations:

- Ensure access to affordable supervisory hours for mental health certification and licensure
- Increase funding for the rural health professional education loan forgiveness program and set aside funds for people working in metro area programs where more than 50% of the patients are on Medicaid or uninsured
- Require insurance to cover treatment and services provided by a clinical trainee
- Add LMFTs and LPCCs to the MERC program
- Provide grant funding to every Tribal Nation and Indian Community in the state of Minnesota and (5) urban Indian communities to support a full-time traditional healer
- Fund a program to train pediatricians on how to treat mental illnesses in children
- Extend the state funded primary residency program from three years to four for psychiatrists
- Create an alternative pathway to licensure for mental health professionals from diverse backgrounds

Duty to Warn

Issue: Current Minnesota statute covers only certain mental health professional or practitioner trainees under duty to warn protection and liability.

Background: Minnesota statute defines duty to warn as the duty to predict, warn of, or take reasonable precautions to provide protection from violent behavior when a client or other person has communicated to the provider a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim. If a duty to warn arises, the duty is discharged by the provider if he or she makes "reasonable efforts" (communicating the serious, specific threat to the potential victim and if unable to make contact with the potential victim, communicating the serious, specific threat to the law enforcement agency closest to the potential victim or the client.) to communicate the threat.
Legislation was changed in 2016 to provide duty to warn protection for trainees in the disciplines of Psychology, Marriage and Family Therapy, and Licensed Alcohol and Drug Counseling. Social Work and Licensed Professional Clinical Counselor trainees were not covered in the legislation.

Policy Recommendation:

- Expand duty to warn to other appropriate mental health trainees

Suicide Prevention

Issue: Suicide is one of the leading causes of death for Minnesotans and has become a public health crisis with close to 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. The federal suicide prevention grant requires states to have accredited lifelines which MN does not have.

Policy Recommendations:

- Increase training and education in suicide prevention and treating people who are suicidal for health and mental health professionals
- Increase funding for suicide prevention training
- Provide targeted support to communities experiencing high rates of violence, trauma, and suicides
- Fund lifelines
- Fund an online suicide prevention training for teachers

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
- Expand ACT teams to people experiencing depression
- Review the role of the county as the mental health authority
- Expand transportation options so that more people can be involved in the community

Racial Disparities and Mental Health Equity

Issue: People of color and new immigrants are much less likely to have access to culturally appropriate care from a mental health provider they trust.

Background: The racial disparities in Minnesota's mental health care system are well documented, but we have yet to take action to begin meeting the needs of indigenous communities and people of color across Minnesota.

In addition to the possibilities in trauma informed care and developing a diverse mental health workforce, the Mental Health Legislative Network is particularly interested in the possibility further investment in traditional healing.

Traditional healing is a multigenerational, multi-disciplinary approach to reduce the chronic mental health and substance use disparities experienced by Native Americans. This work engages all aspects of living: emotional, physical, and spiritual to promote the health and healing of Native Americans.

Policy Recommendations:

- Require continuing education on cultural competency
- Increase the funding for multigenerational treatment methods that include adults and children
- Fund Native American healers

CRIMINAL JUSTICE

Prisons

Issue: More people than ever are entering the prison system with mental illnesses, while other inmates are developing a mental illness during their time in prison.

Background: Whether it's a nuisance crime like spitting or something more serious, people with mental illnesses are much more likely to have an experience with the criminal justice system. This can result in a dangerous encounter with the police, time in jail, or incarceration. For those people with mental illnesses who become incarcerated, it is imperative that they receive the mental health treatment they need to recover while in prison and successfully transition back to the community.

Minnesota has slowly expanded the access to mental health services in the Corrections system. In 2016, the legislature made new money available for treatment beds, with $750,000 in fiscal year 2017 for 70 new chemical or mental health beds and $250,000 for two chemical dependency release planners, one at Stillwater and one at Shakopee.

However, these increases are not keeping pace with larger prison populations and higher needs for mental health and substance use disorder treatment.

The Corrections System has also faced persistent staffing shortages for corrections officers, support personnel, and especially the mental health workforce. Without an adequate workforce investment, staff turnover will continue to be a problem and the prison environment will not be safe for inmates or staff.

Policy Recommendations:

- Increase staffing levels, including mental health and substance use disorder treatment staff
- Increase funding for mental health services
- Place fewer conditions on eligibility for mental health services in prison

Administrative and Disciplinary Segregation

Issue: Segregation and isolation have a negative impact on a person's mental health.

Background: "Disciplinary segregation" is used when an inmate was found in violation of a facility rule or state or federal law or when segregating the inmate is determined to be necessary in order to reasonably ensure the security of the facility or the inmate.

There is research to support the psychological stress and strain that result from the use of disciplinary segregation in prisons, especially for persons with mental illnesses. Individuals who are held in solitary confinement spend nearly every hour of the day in a small windowless cell with no contact with others. The use of segregation and isolation is also extremely expensive and counterproductive if the hope is to support rehabilitation back into the community.

In 2017, the Department of Corrections made a series of policy changes regarding the use of solitary confinement. These policies were developed internally without the consultation of key stakeholders, were never properly explained to the staff tasked with implementing these policy changes, and have only very recently been adequately staffed. Given this lack of transparency, it is not surprising that there has been a great deal of confusion amongst Department of Corrections administrators, prison staff, and inmates.

Other states who have made much stronger solitary confinement reforms – including Maine and Colorado – have seen a significant decrease in violence following the roll-out of their changes.

Policy Recommendations:

- Require graduated sanctions for rule violations, so that segregation becomes the last resort
- Establish appropriate physical conditions of segregated units, including reduced lighting during nighttime hours, rights of communication and visitation, and furnished cells
- Require mandatory review of disciplinary segregation status by the warden of the prison and commissioner or deputy or assistant commissioner
- Prohibit releasing an inmate to the community directly from segregated housing
- Require the Department of Corrections to issue a yearly report to the legislature with data on the use of solitary confinement

CRIMINAL JUSTICE

Jails

Issue: Every jail has a drug formulary and are not required to provide a person who is detained with the exact psychotropic medications they are prescribed. Although jails require mental health screenings during intake, mental health assessments and follow up for ongoing mental health services often do not happen.

Background: A Legislative Auditor's report (March, 2016) showed vastly different practices in assessment and treatment around the state.

Although jails are required to administer simple mental health screenings during the booking process, there is no requirement to follow up for those who screen "positive," with either a diagnostic assessment or the implementation of a care plan.

Maintaining healthcare costs in jails claims a large portion of the correctional budget. In order to cut costs, many facilities contract with an external health care company to control costs. These companies often have extremely limited formularies, or approved drug lists. For those inmates who are able to access their mental health medication while in jail, it can be a challenge to continue receiving their medications following discharge.

The report also found : (1) a need to develop a broader continuum of options to support individuals who have been found "not competent to stand trial" and need "competency restoration" services in order to participate in their defense and (2) a need to expand the availability of community mental health services that support people involved in the criminal justice system, including Forensic Assertive Community Treatment (FACT) teams.

Policy Recommendations:

- Require a county or regional jail to provide a prisoner who has a valid prescription for a psychotropic medication the same psychotropic medication while incarcerated
- Connect every jail inmate with a mental illness with a prescriber upon discharge if they are currently using or could benefit from mental health medication
- Create incentives to contract with local community mental health provider to offer mental health services and prescribe medications in jail in order to facilitate better discharge into the community
- Provide grants to counties, regional county partnerships, and/or community-based mental health providers to develop local, community-based, competency restoration services
- Provide start-up grant funding to establish new FACT teams as well as funding to increase the capacity of Minnesota's existing traditional ACT teams to serve individuals with extensive legal/criminal justice histories

Ombudsman

Issue: There is no central office or easily accessible grievance procedure for individuals with a mental illness who have been incarcerated. In the county jails, oversight is provided only by a small staff of state jail inspectors, who inspect a jail every two years.

Background: A 2016 OLA report found there is direct and indirect support for the creation of an ombudsman office to focus on issues related to mental health services in correctional facilities. The indirect support consists of themes that run through the whole report: lack of consistent practices around the state, and absence of oversight as to how jails actually apply the rules that do exist. Besides helping individuals with specific issues, an Ombudsman for Mental Health Services would be a force for greater adherence to statutes and rules.

Policy Recommendation:

- Establish a separate state ombudsman specifically focused on investigating issues related to mental health services in correctional or detention facilities
- Authorize the Ombudsman to report systemic problems to the Governor and Legislature

OTHER ISSUES

Civil Commitment

Issue: The civil commitment statute is outdated.

Background: Civil commitment is the legal process court orders mental health treatment with the goal of providing necessary care. Patient rights are mandated under Minnesota law under the Commitment and Treatment Act, Minnesota Statute 253B.

A formal review of the entire civil commitment statute has not been completed in over 20 years.

The civil commitment statute is outdated and does not reflect the way Minnesota currently treats people with a serious mental illness in the commitment process. Stakeholders came together to address the civil commitment statute in a more comprehensive way, including sheriffs, hospitals, community providers, mental health professionals, counties, defense attorneys, DHS, advocacy organizations, as well as people with lived experience with civil commitment.

After over a year of hard work, the task force is ready to introduce a comprehensive revision of the civil commitment chapter.

Policy Recommendation:

- Changes outdated language
- Clarifies use of Jarvis order to include other medications
- States that commitment does not automatically end if 30/60/90 paperwork is lost or not properly filed
- Clarifies transport and emergency holds
- Replaces early intervention section with a new engagement service that:
  - ⇒ Targets people with mental illnesses who are developing the symptoms of a serious mental illness or those who are likely to decompensate and require commitment unless they are engaged in treatment.
  - ⇒ Requires 90 days of assertive outreach to encourage the individual to voluntarily engage in treatment and connect the person with resources

Provision of 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 from a variety of diverse settings. Electronic mechanisms now available can improve care integration.

Background: Hospitals and physician practices have widespread adoption of Electronic Health Records, but much of the care received by individuals with mental illness occurs in community settings. Many of these settings also have electronic records, but there is a failure to connect the dots and link all information. Behavioral health settings have struggled because they have been ineligible for resources. Stigma and other misinformation have worked against the integration of mental health information that is vital to care. Individuals must always give consent for information to be shared.

Imagine a world where a case manager gets an alert when an individual is being discharged from the hospital so that immediate follow up can provide the needed resources to maintain them in the community and avoid readmission. Or where an individual's advance psychiatric directive is available when they check into the Emergency Department, so caregivers know their history and preferences with regard to different treatments. EMTs can know the individual's diagnosis and medication list, to intervene swiftly and effectively. Sixty percent of routine outpatient mental health services are not captured in the Primary Care Provider's Electronic Health Record because services are provided offsite. Records of acute psychiatric services are missing from the Primary Care Provider's record 89% of the time. All providers must have access to key mental health information.

Policy recommendations:

- Make small strategic investments in electronic health records and data exchange to support communication between community mental health and acute care settings.
- Encourage big health systems to exchange information with the community through alerts (admission, discharge, or transition in care), care summaries, and direct messaging to care team members.

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