MENTAL HEALTH LEGISLATIVE NETWORK OF MINNESOTA

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MENTAL HEALTH LEGISLATIVE NETWORK 2021

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 of St. Paul and Minneapolis
Central Minnesota Mental Health Center
Fraser
Guild
The Heart and Mind Connection
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
Minnesota Association of Resources for Recovery and Chemical Health (MARRCH)
Minnesota Association for Children’s Mental Health
Minnesota Association of Community Mental Health Programs
Minnesota Behavioral Health Network
MN Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Psychiatric Society
Minnesota Psychological Association
Minnesota School Social Workers Association
NAMI Minnesota
National Association of Social Workers, Minnesota Chapter
Northeast Youth & Family Services
NUWAY
People Incorporated
Pregnancy Postpartum Support Minnesota
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.
TABLE OF CONTENTS

About Mental Illnesses ................................................................. Page 4
About the Mental Health System .................................................. Page 5
Key Issues for the Legislative Session .......................................... Page 6
System Issues ........................................................................ Page 7
  • Telehealth
  • Reimbursement Rates
  • Uniform Service Standards
  • Network Adequacy
  • Certified Community Behavioral Health Clinics
  • MA Waivers
  • Direct Care and Treatment
  • Hospital Beds
Adult Mental Health Services and Supports ................................ Page 12
  • Continuum of Care
  • Housing
  • Crisis Response
  • Clubhouses and Community Support Programs
  • First Episode
  • Employment
  • Behavioral Health Homes
  • Sober Homes
Children’s Mental Health ............................................................. Page 17
  • Family First
  • Early Childhood Consultation
  • School-Linked Mental Health Services
  • Children’s Mental Health Supports
  • Education
  • Conversion Therapy
Access to Mental Health Treatment ........................................... Page 21
  • Workforce Concerns
  • Suicide Prevention
  • Community Mental Health Treatment
Criminal Justice ....................................................................... Page 23
  • Competency Restoration
  • Access to Mental Health Treatment
  • Prisons
Other Issues ............................................................................. Page 26
  • Coordinated Care in Integrated and Culturally Diverse Health Settings
  • Cannabis Legalization
  • Establishment of License for Behavior Analysts
  • Paperwork Reduction Process
  • Access to Dental Care

3
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.

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 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.

Access to Treatment and Services: Many people seeking mental health treatment or services struggle to access what they need, especially in rural areas. 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 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.
COVID-19 is a public health crisis that has impacted nearly every aspect of our daily lives...how we live, work and interact with others. It has also resulted in unprecedented stress for people across Minnesota as they face ongoing social isolation, panic and fear as the virus continues to spread in our communities.

Many people who are living with mental illness are particularly vulnerable not just to serious illness if they contract COVID, but also to the negative impact of prolonged social isolation due to the closure/change in delivery methods of many of the services they usually depend on to stay well.

In addition, many others, including our health care workers, farmers, teachers, and other essential workers are facing unprecedented stress. Nationally, mental health screenings have increased significantly, and here in Minnesota, online mental health screenings offered by Mental Health Minnesota increased by 600%+ since COVID-19 began.

The civil unrest that has occurred in recent months has also shone a light on issues related to health equity and the lack of services available to meet the mental health needs of BIPOC communities in our state.

We must acknowledge that another public health crisis is in front of us: mental health. And unless we take action now to continue to build the mental health system and services we need, it will only get worse for people living in Minnesota.

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 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 has created the foundation for a good mental health system in Minnesota. Unfortunately, workforce shortages, poor reimbursement rates, closure of programs and hospitals, 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 2021 Legislative Session**

- Permanently enact changes that allowed for telehealth during the pandemic to ensure and expand access to mental health services
- Stabilize and increase access to effective mental health care throughout the state by increasing rates and funding, eliminating barriers to development and streamlining regulatory systems
- Expand access to intensive treatment and supports
- Provide supports and education that support children to live with their families
- 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 providing adequate mental health care in these systems
- Expand the mental health workforce and improve access to culturally appropriate services
**Issue:** As a consequence of COVID ushering in the widespread use of telehealth, the provision of mental health services has shifted significantly. We need to maintain the changes in telehealth benefits to continue to assure access to care, especially in rural areas and for diverse groups.

**Background:** Mental Health and Substance Use Disorder providers have been able to better and more efficiently serve many clients as a result of changes to the allowable and billable services permitted, given CMS’s allowances and the permissions provided in the Governor’s emergency powers orders. Especially important changes include: 1) allowing patients to receive telehealth services in their homes rather than having to go to a clinic site (originating site) 2) expanding the population of individuals eligible for telehealth by removing geographic restrictions 3) removing limits on the number of telehealth sessions permitted per week 4) providing reimbursement for healthcare services provided through audio only means 5) expanding the provider types able to provide telehealth services. As a result of these changes Minnesotans have been well served while gaining increased access to care. It has been especially helpful for specific underserved diverse populations, including rural Minnesotans. In order to address disparities in healthcare, the reimbursed audio only services allowed individuals with no access to broadband or technology to receive much needed services.

In a survey of 944 mental health professionals in Minnesota, 74% indicated that telehealth services increased care coordination, and 63% noted increases in client attendance indicating more people were being served. Eighty-three percent of providers sometimes used audio only service delivery. Of these providers, 64% believe that if audio only services are no longer available it will significantly impact access to care. In a survey of 900 Minnesota clients, 88% stated that they benefited from telehealth services and 89% reported that they felt engaged in those services. We know that telehealth services are not for everyone, but they well serve many in our community who otherwise would not receive care.

Phones/audio-only should be an eligible telehealth mode if video is not available due to a lack of infrastructure and technology available to support video based platforms. Phone service delivery sustains continuity of care and support from the provider to client in circumstances where web-based platforms are not available.

It is also essential that Minnesota looks toward the future of telehealth by developing public-private statewide telepresence in health care, supporting collaboration, advancing health equity, and improving population health through access to services throughout the state.

**Policy Recommendations:**
- Maintain same coverage for telehealth as in-person services
- Maintain changes to geographic and originating site (so client can be wherever client is, and so the provider can operate from a non-clinic based site)
- Maintain removal of restrictions on the number of telehealth services that can be provided each week
- Reimburse telehealth visit at the same rate as in-person visits, utilizing the same prior-authorization and the coding/modifiers that are currently in place for billing
- Change definition of telehealth to include audio-only services
- Not have separate provider networks for in-person vs. telehealth services
- Extend coverage of telehealth to services provided by mental health practitioners under supervision, as well as substance use disorder service providers
- Cover group mental health visits held via telehealth, including day treatment, ABA and group therapy
- Cover psychological and neuropsychological testing
- Ensure that written consent requirements do not interfere with provision of service
- Do not require an initial in-person visit prior to beginning use of telehealth services
- Ensure that these changes apply to both commercial and Medicaid plans
**Reimbursement Rates**

**Issue:** There is not a sustainable reimbursement rate for mental health and Substance Use Disorder (SUD) 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 proposes reform for mental health and substance use disorder service delivery and payment system to address the immediate need and longer-term solutions to solvency, including:
- An immediate rate increase for key outpatient and community-based services
- An accountability mechanism to ensure payments, including any increases, under managed care are realized by the providers directly serving clients
- Develop and implement a sustainable rate methodology for outpatient and community-based services under medical assistance that reflects the costs, intensity and scope of services provided
- Develop rates that reflect the challenges of providing co-occurring mental health and SUD treatment
- Acknowledgement of cost of care coordination for co-occurring disorders

**Uniform Service Standards**

**Issue:** Complicated and at times contradictory standards make it difficult to administer and regulate community mental health services.

**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.
- Improve 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.

**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, 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.

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, 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:**
- 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.
- Require training for health care and mental health care providers on how to treat people who are suicidal

**Certified Community Behavioral Health Clinics**

**Issue:** Statute changes are needed as Minnesota’s CCBHC model transitions into a Medicaid benefit.

**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 federal CCBHC model from 2017.

CCBHCs are “one stop” shops that provide more seamless care. We have 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.

Thanks to the legislature’s passage of 20219 legislation, Minnesota’s CCBHC model is transitioning into a Medicaid benefit. We are advocating for updates to our MN statute, which will codify critical components of the model, update federal citations and provide clarity in guidance to several aspects of the model as Minnesota’s model transitions and continues to refine.

**Policy Recommendation:**
Update statutes as needed to sustain CCBHCs under Medicaid

**MA Waivers**

**Issue:** People with mental illnesses face additional barriers to access the services they need through a MA waiver.

**Background:** A Medical Assistance waiver provides additional support to enable someone to live in the community. In order to be eligible, someone must have a disability and be at serious risk of hospitalization or placement in a nursing home without additional supports beyond what is generally offered through Medical Assistance. People with mental illnesses are eligible for the Community Access for Disability Inclusion (CADI) waiver and do not have an option that is specifically tailored to their unique needs.

CADI waivers are a vital source of support for people with serious mental illnesses. Unfortunately, people with mental illnesses face serious barriers to obtaining a CADI waiver. The MN Choices assessment still struggles to adequately assess the needs of people with mental illnesses, leading to them not being eligible for the services they need to stay in the community and avoid other negative outcomes like an encounter with the criminal justice system. Even if someone with a mental illness successfully obtains a CADI waiver, they lose eligibility after being in a hospital or an IRTS Facility for 30 days or more. It can take 30-60 days to obtain a new assessment for a CADI waiver, significantly disrupting the ability of someone with a mental illness to access the care they need upon discharge.
In an effort to simplify MA Waivers and provide greater flexibility to people with disabilities, DHS is seeking to consolidate the five existing waivers into a waiver for residential services and a waiver for people who choose to live independently or at home with their family. While there is a clear need to simplify the opaque MA Waiver process, the MHLN has concerns that the mental health community has not been adequately engaged during the development process for this major change.

Policy Recommendations:

- Allow for the suspension of an MA Waiver during a hospitalization or residential treatment for 136 days
- Oppose limits on the number of people in a building on a home and community based waiver. This impacts people with mental illnesses accessing supportive housing and other effective housing with services programs.
- Ensure that the Waiver Reimagine project will meet the needs of people with mental illnesses.
- Increase filing times to ensure that people on Medical Assistance don’t lose their health insurance due to missed paperwork.

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 Recommendations:

- 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 and unable to access mental health treatment.

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.

**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.
ADULT MENTAL HEALTH SERVICES AND SUPPORTS

**Continuum of Care**

**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 261 in 2020.

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.

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.

**Policy Recommendations:**
- Provide funding for mental health treatment to inmates in jail
- 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
- Fund small IRTS 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

**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. While eviction moratoriums at the state and federal level have protected many families during the pandemic, there is a significant chance of a surge in the number of people experiencing homelessness once these moratoriums expire.
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.

Policy Recommendations:
• Increase funding for the Bridges Program
• Increase funding for Housing with Supports for Adults with Serious Mental Illnesses
• Provide funding for affordable housing
• Expand the landlord risk mitigation fund and provide the funds to agencies serving people who are homeless

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 are a good alternative to a police response. 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 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
• Require 911 operators to collaborate with mental health crisis teams
**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 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 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

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**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, will 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:** 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. 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 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.

**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 provides a mechanism to address clients’ physical and mental health symptoms. Most importantly, it provides 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
- Streamline the BHH rate structure from two tiers to one aligns payment to policy changes. This is the remaining proposal from the 2019 bill. We hope to bring forward legislation in 2022 or 2023

Sober Homes

Issue: Minnesota should encourage all recovery residences in the state to adhere to quality standards to ensure consistent, high-quality support for people with substance use disorders living in recovery residences.

Background: Recovery housing refers to safe, healthy, and substance-free living environments that support individuals in recovery. The intent of recovery housing is to provide peer support and a connection to services that promote long-term recovery. Individuals with histories of addiction generally lack essential recovery capital such as: low or no income; poor rental history; poor credit; limited education; and limited work history.

As a result, many of these individuals have difficulty accessing private or public housing. Some federal policies do not classify addiction as a disability; therefore, individuals with histories of addiction cannot access the same income, employment, and housing benefits available to people with mental illnesses or other disabilities. For example, people in addiction recovery cannot access Medicaid coverage through the Aged, Blind, and Disabled category, nor can they access disability income, vocational rehabilitation services, and Section 8 rental assistance.

Because sober home residents are not tenants, they also have very few protections under the law. Rule violations or a relapse can lead to immediate discharge—often in the middle of the night—placing them in a very vulnerable situation where continued relapse is likely.

In October 2019 the Substance Abuse and Mental Health Services Administration announced their recovery housing best practices suggestions. These recommendations mirror the National Alliance of Recovery Residences. Minnesota’s affiliate to the national alliance is the Minnesota Association of Sober Homes. Minnesota does not know how many recovery residences are operating in the state. This problem is exacerbated by confusion with other programs like halfway houses.

Other than passing the city requirements for operating there is no mandate for recovery residences to participate in other quality standards.

It should be noted however, that the Minnesota Association of Sober Homes (MASH) has fully adopted the SAMHSA/NARR best practices standards and is currently implementing these comprehensive standards for all of its 186 member recovery homes in the State of Minnesota. There are policy considerations the legislature can consider to encourage recovery residences to adopt the SAMHSA recommended standards.

Policy Recommendations:
- Fund a study to establish a baseline of standards and consistent quality in the operation of recovery residences
**Issue:** Federal Family First Legislation will require families to seeking voluntarily residential mental health treatment for their child to go through the “child protection door”.

**Background:** Minnesota’s children’s residential mental health programs have experienced numerous changes in the past few years. With the designation of Children’s Residential Programs as Institutes of Mental Disease or IMDs, these programs could no longer bill Medical Assistance and this gap had to be filled with state dollars. 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. The only solution to avoid putting families through the child protection door would be to replace Title IV-E dollars with a state appropriation, just as it does for treatment costs.

**Policy Recommendation:**
- Pay for room and board with state dollars

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**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:
- On-site mental health consultation and support for child care agency staff. Mental health agencies will also work directly with families as appropriate
- Referral for children and their families who need mental health services
- 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:**
- 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 School-linked Mental Health program and rebuild/reform underlying (funding) model.

**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.

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 2020 COVID-19 pandemic has negatively impacted the mental health of our children. Distance learning has been difficult and the isolation even more so. Children will be returning to in-person having experienced the trauma of COVID-19, food insecurity, and more. The need for mental health services will be 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 by 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

**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. 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
- Increase funding for respite care
- 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
- Fund child care for mothers with mental illnesses who have MFIP child only grants when it is recommended by a mental health professional
• Expand eligibility for Youth ACT services to children as young as 8 and as old as 25
• Replace the term “emotional disturbance” with “mental illness” in state statute
• Fund multi-generational treatment teams
• Fund transition age programs
• Allow young adults transitioning to the adult mental health system to keep their current case manager, even if they choose to drop out of the program

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 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 number of student support personnel
• 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 the Kognito suicide prevention training for teachers
• Place the suicide prevention lifeline on student IDs
• Increase funding for substance use disorder services in the schools
• Restore funding for mental health professionals to provide services in the classroom at intermediate school districts, special education cooperatives, and level IV settings
• Create a designated office of mental health within the Department of Education.
• 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

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 Concerns**

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

**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. This challenge is heightened with the recently documented rise in mental illness, with the Center for Disease Control estimating that fully 40% of the population meet the diagnostic criteria for anxiety, depression, or substance use disorder. 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. Many of these recommendations have yet to be implemented. We need to carry through these recommendations as we face a skyrocketing need. We also need to invest in traditional healing models that incorporate multigenerational and multidisciplinary approaches.

There is also a significant shortage of BIPOC mental health professionals and mental health professionals that are culturally informed. People of color and new immigrants face additional hurdles when trying to become licensed as a mental health professional. Finding a supervisor can be expensive and there are very few BIPOC supervisors, board exams are not culturally informed, and many cannot afford to work without pay during a practicum or internship.

**Policy Recommendations:**

- Create access to affordable supervisory hours for mental health certification and licensure
- Increase funding for rural health professional education loan forgiveness program to expand access to the program for BIPOC mental health professionals
- Require private health insurance to cover treatment provided by a clinical trainee
- Add LMFTs and LPCCs to the MERC program
- 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
- Charge DHS to work with mental health licensing boards to create alternative pathways to licensure for mental health professionals from diverse backgrounds.
- Require mental health professionals to have at least 6 of their 40 hours of continuing education on cultural awareness, racism, and cultural humility
- Allow Licensed Alcohol and Drug Counselors to access the health professional education loan forgiveness program.
- Create a grant program to pay for supervision of clinical trainees in clinics that serve Medicaid recipients and are supervising BIPOC clinical trainees.
- Require DHS and MDH to convene licensing boards to develop recommendations for cross-licensure supervision, counting internship hours towards licensure, and practicum hours towards supervisory experience.
- Create a grant program to pay for BIPOC mental health professionals to become supervisors for people working towards licensure.
- Allow people completing internship and graduate level training programs in social work, psychology, and counseling to be mental health practitioners.
- Require all licensing boards to reflect diversity in terms of geography, race, and ethnicity.
- Establish a statewide task force on mental health services being culturally responsive and informed.
## 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.

**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

## 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
**CRIMINAL JUSTICE**

**Competency Restoration**

**Issue:** Competency restoration refers to the legal process when a person cannot stand trial because of a mental illness or cognitive impairment. Unlike many U.S. states, Minnesota’s statutes do not require any agency to restore people if they are found incompetent. Rule 20 of the Minnesota Rules of Criminal Procedure is the sole source for this process.

Competency restoration has two elements: psychiatric stability and court education. Currently, the only treatment option in the Rule 20 process is civil commitment. While a person may be treated in the community, there are no formal competency restoration programs in Minnesota outside of Anoka Metro Regional Treatment Center (AMRTC). If a defendant does not meet the standard for civil commitment they fall into a gap – they must seek treatment voluntarily, and even then, there are no programs offering court education. Without adequate processes and services, people with mental illnesses move through a revolving door, returning to the justice system and missing opportunities to connect to treatment.

**Background:** The Rule 20 process today is unable to meet the highly variable needs of people with mental illnesses in the court system, needs that have increased significantly in recent years. The number of cases where a defendant was examined for competency increased 73% from 2014 to 2018. Judicial branch spending rose 40% in that same period, topping off at over $6 million spent in 2018 on forensic exams alone. The strain on the system has made it so that Minnesotans cannot practically access our only state-operated psychiatric hospital without going through the criminal court system – and our counties, jails, and community mental health providers have all felt the impact.

In 2019, the legislature created the Community Competency Restoration Task Force with 25 members representing the criminal legal system, the mental health system, Minnesota counties, and people with lived experience. After a year and a half of research and diligent problem solving, the task force’s final report makes recommendations to build a full continuum of competency services, update the competency procedures, and continue to build the mental health system to increase prevention and diversion.

**Policy Recommendations:**

- Create a process in statute directing defendants found incompetent to a continuum of competency restoration services in inpatient, community, and jail settings.
- Update timelines from the current Rule 20 process to reduce the time defendants remain in the system and use court resources more efficiently.
- Update the process to be more person-centered including more opportunities for diversion, mental health courts, and engagement in voluntary treatment.
- Create Forensic Navigator positions as liaisons between the court and mental health systems to coordinate treatment and assistance, promote education and collaboration, and even provide competency restoration education directly.
- Build the mental health system to prevent criminal involvement and provide adequate access to care throughout the legal system, especially mental health care in jails.

**Access to Mental Health Treatment**

**Issue:** Recent data from the Department of Justice shows that over half of the adults incarcerated in prisons and jails experience mental illnesses, and around 70% of juveniles have a diagnosable mental health condition. While we work to build our mental health system, people with mental illnesses remain disproportionately vulnerable to harmful law enforcement encounters and involvement in the criminal legal system. Minnesotans need more access to adequate mental health treatment at every point in the justice system, and trauma-informed professionals from law enforcement and jails, to courts, prisons, and reentry. Decriminalizing mental illnesses not only saves resources in the long term, but it saves lives and promotes safety and justice for all Minnesotans.
Background: Everyone knows to call 911 in an emergency, but for people experiencing a mental health crisis, especially those in the BIPOC community, 911 is not always a guarantee of help or safety. While Minnesota already has a statewide infrastructure for mental health crisis response, our mobile crisis teams are underfunded and not integrated into 911 dispatch. There are 40 different numbers to reach crisis teams depending on where you live, even the recently dedicated **CRISIS line only works for cell phones and on certain networks. 911 dispatch should collaborate with crisis teams and develop training and procedures for appropriately dispatching crisis teams, co-responders, and law enforcement. The legislature must also ensure that the mental health of law enforcement officers is a priority through wellness programs and annual counseling sessions.

If a person with a mental illness is taken to jail, the care they receive can vary greatly from facility to facility. While every jail in Minnesota screens for symptoms of mental illnesses at booking, few jails can provide adequate assessment or mental health care for people who stay longer than 14 days. Some jails contract to external health care providers with very limited formularies and provider hours. A person may be released having their insurance suspended or terminated and with only a few days’ supply of medication. Jails should contract with community providers so there is a continuum of care at discharge, and more resources are needed for jail social workers and training for staff.

Specialty courts like mental health, veterans, competency, and restorative courts can also be used to divert people away from incarceration and into treatment. Specialty courts can handle a broad range of charges from first time misdemeanors to felonies, and defendants must choose to participate through an agreement with the court to avoid a harsher sentence. By taking the time to address the broader underlying issues, people in specialty courts are less likely to return to the justice system. There are currently only four mental health courts in Minnesota in Hennepin, Ramsey, and St. Louis County.

The juvenile justice system also needs significant reforms, and the legislature must address the impacts of incarceration on children and families. Minnesota still has a mandatory life without parole sentence for juveniles and outdated laws treat young children the same as teenagers and create barriers to recovery long after a juvenile charge is resolved. The juvenile system also needs a centralized data collection system to better address racial disparities. Recent research from the University of Minnesota showed that over half of all adults incarcerated in Minnesota jails and prisons are caretakers of minor children. Further research has shown that children with incarcerated parents are more likely to be involved in the juvenile system and face negative outcomes in health, education, and social life down the road. Children and families need resources to connect with their loved ones and prevent generational cycles of incarceration.

Policy Recommendations:
- Require 911 dispatch to collaborate with mobile crisis teams
- Require minimum standards for mental health training for 911 dispatchers
- Create incentives to contract with local community mental health providers to offer mental health services in jail and continuum of care upon release
- Ensure and expand mental health care in jails including: access to ITV, broad lists of prescription medications, mental health treatment, and appropriate health staff to involuntarily administer medications
- Require updated policies and procedures on suicide prevention and mental health care in jails
- Expand and invest in diversion programs and collaborations by embedding mental health professionals in law enforcement, jails, and courts
- Provide resources for officer wellness programs following best practice for first responders to get help
- Review critical incident debriefing practices to follow trauma-informed best practices
- Create a centralized database for the juvenile justice system
- Ban indiscriminate shackling of youth in the juvenile system
- 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
**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. 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.

Additionally, incarceration of Minnesotans with mental health and substance use disorders, who are technical-violators, lower risk level, nonviolent or short-term, is ineffective. Incarceration of this target population does not protect the safety of the public in the long term or lower crime rates. However, it is more costly in the long term for state and local budgets and results in significant societal costs, including worse life outcomes for criminal justice involved persons e.g. mental health, recovery, social support, employment, and housing.

**Policy Recommendations:**
- Increase staffing levels for 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
- 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; these programs are associated with much better life outcomes, and greater reductions in recidivism and relapse rates compared to correctional programming in institutions
- Increase the use of evidence-based practices for criminal justice involved persons in community programs and services, that increase social capital, resiliency factors, and life skills and decrease recidivism and relapse rates of offenders diverted to or released to the community
- Reserve the limited capacity of the prison and jail system for high risk level offenders who are a threat to public safety; and decarcerate through available release options
- 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
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:** Legalization of recreational cannabis is being discussed in the Minnesota Legislature with increasing frequency and many enticing fiscal and ideological incentives are pushing a national trend toward 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 mother 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:**
If recreational cannabis is to be legalized, the MHLN recommends that these considerations be prioritized:
- 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.

Paperwork Reduction Process

Issue: Complicated and at times contradictory standards, as referred to under Uniform Service Standards (USS), make it difficult to administer and regulate community Substance Use Disorder (SUD) and mental health services.

Background: These difficulties have also resulted in excessive paperwork, diverting service provider time from client interactions. The paperwork reduction issues cannot be separated from the systems issues. The Behavioral Health Division of the Department of Human Services has repeatedly been unable to engage other relevant and necessary Divisions or Departments of Minnesota’s administration in resolving these. There is also further need to respect the professional autonomy and parity in treatment of SUD, Mental Health, and Physical Health staff.

Policy Recommendations:
• Legislatively mandate the participation of relevant divisions and departments in a systems review, with special focus on paperwork reduction. The work should be done with an eye to streamlining requirements, making sure data is obtainable, has reasonable chance of being accurate, and provides timely feedback to providers to help them voluntarily improve their process and treatment outcomes.
• Legislatively mandate the integration of representatives of providers, funders and funding authorities throughout the process.
• Preferably provide an experienced, external consultant to guide the process, translate between parties, and assure that views of all relevant parties are considered in the final result.
**Issue:** There is a severe lack of access to dental care for people on Minnesota’s public healthcare programs with serious and persistent mental illness.

**Background:** The number of dentists who accept patients on Medicaid in Minnesota is very limited due to nationally low reimbursement rates and a complex administrative system. For example, according to a recent national study released by the Health Policy Institute of the American Dental Association, Minnesota currently ranks 49th out of the 50 states in the nation for reimbursement rates of children needing dental care. When you add adults to the mix, the state’s standing isn’t much better, ranking fourth from the bottom.

This issue plays out in a severe lack of access to oral health care to Minnesotans on public programs. For example, in St. Louis County and the Duluth area, most dental clinics are not taking new Medicaid patients. One clinic in Duluth has a waiting list of three years for adults who use Medicaid. In October of 2020, 30 dental clinics in a 50-mile radius of Duluth were contacted to try to get an appointment for routine and preventive care. Only one dental provider had an appointment availability within a three-month time frame. Every other provider was not taking new Medicaid patients because of low reimbursement rates. While 55.2% of Minnesota counties are Dental Health Professional Shortage Areas, St. Louis county has a lot of dentists. In fact, they have the 5th best number of dentists per population in the state, yet almost none of them accept Medicaid. This creates a disparity felt by people most in need of dental care.

Available data about dental access bears this out. In 2018, less than 30% of adults on Medicaid in Minnesota had a dental visit and over 70% of the general population has had at least one dental visit in the same time frame. While health plans have set up transportation services to transport people down to the twin cities to access dental care, this is not an option for many people with serious and persistent mental illness due to their symptoms and inability to travel for several hours for multiple dental appointments. In addition, many of the psychotropic medications prescribed create dry mouth which can cause significant dental issues. The lack of routine dental care available complicates this issue for people with serious mental illness. We have heard many accounts of people pulling their own teeth, super gluing their teeth and even one woman who is wearing her deceased mother’s dentures due to inadequate access to dental care.

**Policy Recommendation:**
- Support current Critical Access Dental (CAD) providers on developing a dental home program that would incentivize oral health providers to increase access to public program enrollees while paying for the complexity of the patient and incorporating social determinants of health. Also, rebase dental Medicaid rates to 2020 dental charges. Currently reimbursements are based on an adjustment to 1989 dentist charges and not the costs of current dental services. Lastly, support adding back periodontal (gum disease) coverage to the adult benefit set.