

2024 LEGISLATIVE ISSUES



Mental Health LEGISLATIVE NETWORK

Mental Health Legislative Network 2024

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	Minnesota Behavioral Health Network
Allina Health	Minnesota Disability Law Center
Amherst H. Wilder Foundation	Minnesota Psychiatric Society
AspireMN	Minnesota Psychological Association
Avivo	Minnesota Society for Clinical Social Work
The Barbara Schneider Foundation	Minnesota Social Service Association
Catholic Charities Twin Cities	Minnesota School Social Workers Association
Central Minnesota Mental Health Center	NAMI Minnesota
Children's Minnesota	National Association of Social Workers
Fraser	Northeast Youth and Family Services
Greater Minnesota Family Services	NuWay
Guild	Nystrom & Associates
Hennepin Healthcare	Office of Ombudsman for Mental Health and Developmental Disabilities
Lutheran Social Service of Minnesota	People Incorporated Mental Health Services
MAMFT	Prairie Care
Mental Health Minnesota	RISE, Inc.
Mental Health Providers Association of Minnesota	SAVE - Suicide Awareness Voices of Education
Mental Health Resources	Tasks Unlimited
Minnesota Association for Children's Mental Health	Touchstone Mental Health
Minnesota Association of Black Psychologists	Vail Place
Minnesota Association of Community Mental Health Programs	Washburn Center for Children
Minnesota Association of Resources for Recovery and Chemical Health	

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



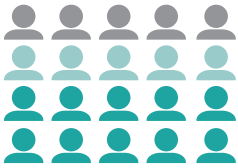
1 in 5

adults in America experience a mental illness



1 in 25

(10 million) adults in America live with a serious mental illness.



Half

of all chronic mental illness begins by age 14; three-quarters by the age of 24

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

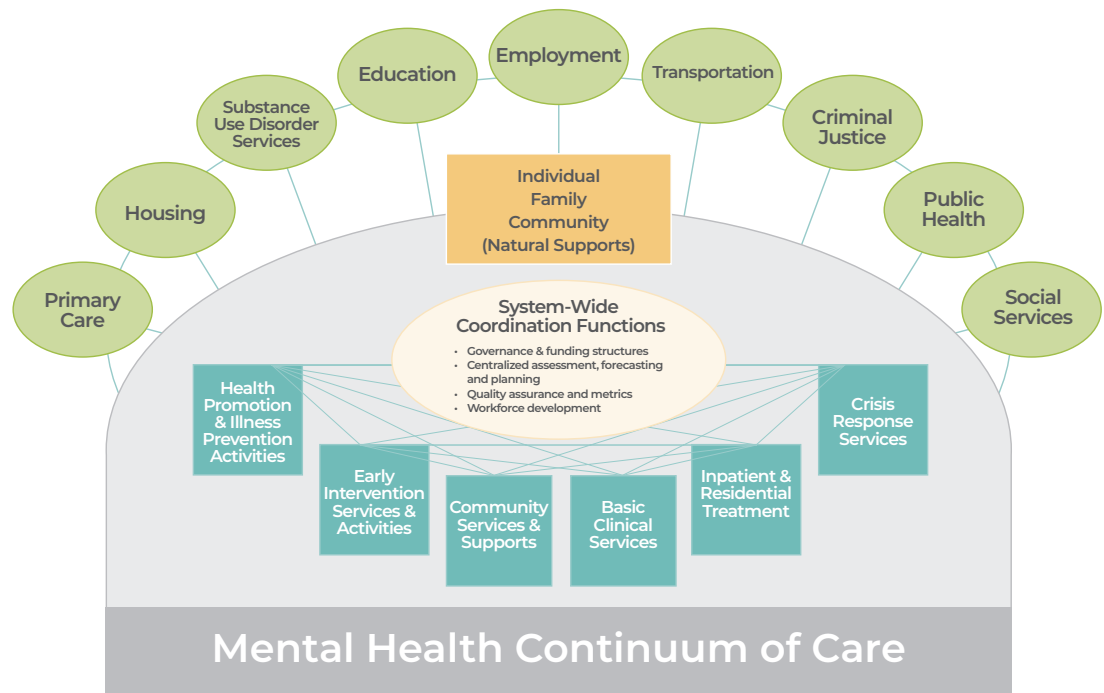
Without access to treatment and support, people with mental illnesses may cycle in and out of the criminal justice system or homelessness, drop out of school, be unemployed and be isolated from family, friends, and the community.

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 most of them were closed largely, by 1980. Since then, we have identified what works and advocated for funding to build a more effective mental health system.

Yet, barriers to fully building our mental health system exist, and we hope to address them this session.



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

INSURANCE COVERAGE: The main access to the mental health system is through insurance – either private health plans or state programs such as Medical Assistance (MA) or MinnesotaCare. For those who have no insurance or limited coverage, access is 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. Yet, parity is not effectively enforced, resulting in people not being able to access care under private insurance or paying more out-of-pocket for mental health treatment.

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, waived services, and in-home supports. These services are often funded by state grants, Medical Assistance, and county funds.

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

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

Key Issues for the 2024 Legislative Session

Many of the policy issues the Mental Health Legislative Network advocated for in the 2023 legislative session passed, but total funding was less than what was requested. Some key policies were not adopted and thus many of the same barriers to mental healthcare and wellness Minnesotans have long struggled with persist.



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

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

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

Key Issues for the 2024 Legislative Session

- Stabilize and increase access to effective mental health care throughout the state by increasing rates and funding, using cost-based rates, eliminating barriers to development, and streamlining regulatory systems.
- Fund and expand services in the children’s mental health system
- Implement key programs that address equity and disparities
- Help people living with mental illnesses obtain and maintain stable housing and employment
- Expand access to home and community supports through waivers and in-home services
- End the inappropriate use of the criminal and juvenile justice systems for children and adults with mental illnesses and provide adequate mental health care in these systems
- Expand and diversify the mental health workforce
- Ensure access to the range of mental health crisis services by increasing funding and setting expectations
- End discriminatory policies related to disability and life insurance
- Expand the types of services covered under Medical Assistance
- Screen students to identify those at risk of mental illnesses
- Increase access to Assertive Community Treatment (ACT) Teams
- Increase funding for early intervention programs and services
- Fund pilots for engagement in services and treatment
- Fund and expand the Substance Use Disorder system



System Issues

Reimbursement Rates

ISSUE: Reimbursement rates for mental health providers are unsustainable at a time when the need has grown so greatly, and wages have been low. Providers are leaving the field, and programs are closing because of unsustainable rates. DHS recently released the rates report, which confirms that rates must be consistently and transparently raised. Funds are also needed now, on an emergency basis, to meet the skyrocketing need and maintain critical services in place today. We need to ensure our foundation of the mental health system is solid.

BACKGROUND: Reimbursement rates for mental health services under Medical Assistance have been problematic for many years. DHS' initial rates report revealed what providers already knew to be true: Medicaid rates setting is convoluted, confusing and hard to administer for providers and/or the people who use them. Rates for mental health services are not set with parity to physical health services; mental health and substance use treatment rate setting methods are in high need of reform. We need a consistent, simple, and transparent framework for setting rates and paying for services under Medicaid. There should be options for enhanced rates based on a client's context. Mental health and substance use disorder treatment rates need to be substantially raised.

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

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POLICY RECOMMENDATIONS:

- Establish a single statewide reimbursement rate for behavioral health home services that meets the costs of the services
- Allow MNCare coverage of room and board for adults accessing Intensive Residential Treatment Services (IRTS) and Residential Crisis Services
- Allow reporting and reimbursement of estimated direct staffing costs in cost based mental health services
- Allow reporting and reimbursement of estimated facility improvement costs in cost based mental health services
- Require DHS and MMB to develop recommendations to move specific recurring grants into a reimbursable service or formula based funding
- Authorize reforms and increases recommended in DHS' medical assistance rates study, including up to double digit increases to Fee for Service codes
- Align Medicaid rates for services also paid by Medicare equal to at least 100% of Medicare rates
- Continue annual inflation adjustor equal to the Medicare Economic Index
- Eliminate the 20 percent decrease in Medicaid payments to Masters' level licensed providers
- Increase rates paid for HCPCS H, S & T codes (non-Medicare services)
- Ensure rates for in-home and family services are equal to other outpatient and community-based services' rates

Regulatory Standards

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

POLICY RECOMMENDATIONS:

- Address challenge created with new Uniform Services Standards medication dispensing requirement
- Eliminate old level of care mandates to align with recent statute changes in 245I and 256B.
- Simplify documentation requirements
- Streamline access to care for children by relying on clinical experts to identify the best assessments for each child, and eliminate requirements to use specific assessments
- Provide for flexibility for the LADC requirement in Intensive Rehabilitative Mental Health Services
- Address challenges with IRTS weekly team meeting requirement

Certified Community Behavioral Health Clinics

BACKGROUND: The Certified Community Behavioral Health Clinics (CCBHCs) are “one stop” shops that provide seamless behavioral health care to clients under a sustainable MN Medicaid model. The CCBHC model is an opportunity for redefining how Minnesota can holistically integrate our community mental health and substance use disorder care and wrap it around a client, based on what each client needs.

Thanks to the legislature’s passage of 2019 through 2021 legislation, Minnesota’s CCBHC model is a permanent Medicaid benefit. Additionally, Congress and the Federal Government continue to support CCBHC nationally with ongoing investments, model updates and extending and expansion of the National CCBHC Demonstration. Crucially, last year, the legislature placed CCBHCs back in the Federal Demonstration project and aligned our state CCBHC model with the federal model, following federal standards and criteria.

We continue to evolve Minnesota’s CCBHC model as our experience grows and we learn more. Next steps in our evolution include:

POLICY RECOMMENDATIONS:

- Build the framework for transitioning the CCBHC model into a unified (single) licensed entity, on January 1, 2026, under consistent oversight by the state
- Align state mandates and processes to federal SAMHSA criteria for CCBHC - streamlining regulations, documentation standards and care delivery

Hospital Beds

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

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

Hospital Beds

continued

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.

Any new beds should be within a regular hospital to ensure that Medicaid funds can be used and should have an emergency room. Note that there is a long-standing federal law that does not allow Medicaid to pay for mental health or substance use disorder treatment in any facility with more than 16 beds where more than half of the patients are being treated for mental health or substance use disorders. The way that people are admitted to a hospital is through an emergency room. Without one, people are unnecessarily being transported from another hospital and such a hospital could refuse to treat people with the most serious mental illnesses. Finally, our head is connected to the rest of our body and people can come into an inpatient psychiatric unit with other health conditions. Hospitals need to be able to treat the whole person.

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.

POLICY RECOMMENDATIONS:

- Increase reimbursement rates for inpatient psychiatric care to make it more sustainable for hospitals to offer this level of care.
- The state must use bonding dollars to increase the mental health beds in other hospitals, including adding beds to Direct Care and Treatment and to Critical Access Hospitals

Commerce Issues

ISSUE: Survivors of people who die by suicide are unable to receive their loved one's life insurance benefits if the policy was started within one year of dying. Disability insurance treats mental illnesses differently.

BACKGROUND: Last year, the legislature modified Minnesota life insurance companies' antiquated language to say that survivors are unable to get life insurance benefits of a person who dies by suicide started a policy within one year of dying, rather than two years. We know that suicide is largely impulsive and that people who complete suicide don't do so for an insurance payout, and their families deserve the financial support that other beneficiaries receive. Disability insurance often limits benefits for mental illnesses regardless of how disabling it is.

POLICY RECOMMENDATIONS:

- Amend life insurance policies' suicide exemption clauses to delete discriminatory language and allow payment of benefits if the person dies by suicide after three months of taking out the policy rather than one year.
- End discriminatory policies for mental illnesses under short and long term disability policies.
- Further define network adequacy for health plans.



Adult Mental Health Services and Supports

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.

The legislature allocated a lot of funding to critical programs such as Bridges Rental Assistance, which provides direct rental assistance for families and individuals with mental illnesses waiting on a permanent housing voucher. There was also funding allocated to incentivize property owners to rent to people with challenging rental histories.

We still urgently need to sustain permanent supportive housing. Supportive housing is currently mostly used as temporary transitional housing, but many people with mental illnesses thrive with ongoing housing-linked support that provides a range of services to help them stay in their homes, care for their homes, and develop positive relationships with their property management and neighbors.

POLICY RECOMMENDATIONS:

- Increase funding for Housing with Supports for Adults with Serious Mental Illnesses

Clubhouses

ISSUE: Increase access to Clubhouse Model programs across the state.

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

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

Community Support Programs/Clubhouse Programs rely on a limited funding stream: Community Support Grants (part of the State Adult Mental Health grants) and local county dollars. Cuts in this funding last year caused clubhouses to reduce their services, despite the fact that they are among the most cost-efficient community support services available and have been proven effective.

POLICY RECOMMENDATIONS:

- Clarify that clubhouses can be funded under Community Support Programs
- Seek coverage of Clubhouses services under Medical Assistance.
- Fund the continuation and expansion of Clubhouses

First Episode

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

BACKGROUND: Individuals experiencing their first psychotic or mood disorder episode are not receiving the intensive treatment they need to foster recovery. On average, a person waits 74 weeks to receive treatment. Our mental health system has relied on a “fail-first” model of care that essentially requires people experiencing psychosis or serious mood disorder to be hospitalized or committed multiple times before they can access intensive treatment and supports. With schizophrenia being one of the most disabling conditions in the world, it is crucial that we intervene early with intensive services. Waiting costs our system a great deal in terms of hospitalizations, homelessness, and involvement with the criminal justice system. It costs the individual even more.

First Episode Projects, focusing on psychosis and mood disorders, offer coordinated specialty care including case management, 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.

Last year, the legislature approved an additional \$2.7 million per year for First Episode Psychosis programs, which is a great first step. We need more funding for First Episode Psychosis programs and to begin funding Emerging Bipolar Disorder programs.

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74

weeks to receive treatment.

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
- Require a report from DHS on how the federal and state dollars are being used
- Create a clearer connection between first episode programs and access to ACT services
- Require Medical Assistance to cover coordinated specialty care.

Employment

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

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

Individual Placement and Support (IPS) is an evidence-based employment program for people with serious mental illnesses. There are only eight in the state. In 2023, the Legislature appropriated a \$2.5 million increase in funding for IPS in fiscal years 2024 and 2025. IPS is a critical program that requires a sustainable and robust funding source.

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

Employment *continued*

POLICY RECOMMENDATIONS:

- Require the commissioner of DEED create a taskforce to identify all current programs that could assist people with mental illnesses in obtaining employment, research racial and geographic disparities in people with disabilities obtaining competitive, integrative 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, identify a sustainable funding source for IPS.

Voluntary Engagement

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

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

Under current law, counties can opt-in to providing engagement services but there is no financial support to do so.

POLICY RECOMMENDATIONS:

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

Protected Transport

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

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

Providers who supply protected transport services get people to the appropriate care in a dignified manner...

POLICY RECOMMENDATIONS:

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

Substance Use Disorder Treatment

ISSUE: Substance use disorder (SUD) is a chronic disease. Minnesotans deserve quick access, and ample support throughout their recovery journey. Programs need adequate funding to maintain appropriate staffing levels to deliver life-saving care.

BACKGROUND: The Substance Use Disorder (SUD) field has undergone substantial changes in a relatively short amount of time. Since 2017, SUD program standards were moved under a new statute called 245G; the 1115 Waiver was introduced as a demonstration and subsequently became a mandate, and the state has been moving towards meeting a national standard referred to as ASAM (American Society of Addiction Medicine). Additional pressures that have overlaid this timeframe have been the COVID pandemic, social justice efforts, and an unparalleled workforce crisis.

The movement towards meeting ASAM standards through delivering evidence-based practices is seen as good thing, however, the timing and cost of implementation must be taken into account. The rate methodology recommendations developed by Burnes & Associates have diligently taken into consideration the costs of delivering comprehensive care at various ASAM levels. Any further delays in addressing SUD rates will result in more burnout and program closures. With overdose deaths at an all-time high, we are at a critical breaking point and need immediate and long-term relief.

With overdose deaths at an all-time high, we are at a critical breaking point and need immediate and long-term relief.

POLICY RECOMMENDATIONS:

- Substance Use Disorder (SUD) rates
- “Unstrike” SUD and be included in 3% increase effective 1/1/2024 and auto-inflation adjustment
- Implement Burnes & Associates rate methodology recommendations
- Extend the rate study to include adolescent SUD (residential/non-residential, Withdrawal Management) and Room and Board payments
- Develop group peer rate
- Apply for 1115 Waiver for people incarcerated
- Waiving fees for IDs
- SUD treatment effectiveness
- Transition Support workgroup
- Align ratios with American Society of Addiction Medicine (ASAM)
- Certification/Alternative Licensing Inspections
- Hard deadline for paperwork reduction of December 2024
- County Affidavit for Behavioral Health Fund eligibility
- Deduct student loan payments from MN taxes
- Expand alternative paths to licensure



Children's Mental Health

Children's Mental Health Building Blocks

ISSUE: Children's mental health needs are going unmet, due to a lack of mental health services. Children are waiting for months to access needed treatment and families are too often forced to rely on hospital emergency departments as their front door to care. This crisis is not new and it's getting worse. It is harming children and families, debilitating our emergency systems and needs immediate attention. Children's Therapeutic Services and Supports funding had not been increased since 2007. In 2024, they received a meager 3% increase. Right now, children's mental health organizations are not able to recruit and retain staff because of these very poor reimbursement rates. Children at-risk and their families are not getting services.

The solution is to build the mental health system children and families need to live their best lives. The following Building Blocks outline the investments and infrastructure required to solve the current crisis and provide treatment to our children.

By investing in the building blocks of children's mental health, we can build the continuum that children and families need to access treatment and live their best lives.

POLICY RECOMMENDATIONS:

- Increase access to quality, timely mental health care by increasing reimbursement rates
- Expand family-centered in-home services by investing in:
 - Children's Intensive Behavioral Health Services (CIBHS)
 - Youth Assertive Community Treatment (Youth ACT)
 - In-Home Children's Therapeutic Services and Supports (CTSS)
 - Bridging Services (CIBS)
 - High Fidelity (HiFi) Wraparound
- Fund respite care, Children's Residential Crisis Stabilization, and Community-Based Group Home Care
- Sustain access to Children's Residential Mental Health Treatment and Psychiatric Residential Treatment Facilities by establishing the Youth Care Professional Training Institute to support adding new staff teams and building capacity to care for children
- Apply for federal flexibilities (eg: 1115 waiver authority) to support children's residential treatment.
- Ensure aftercare services are available after discharge from residential care settings
- Improve MnCHOICES assessment processes to ensure timely access to individualized care
- Create a child-mode under Nonemergency Medical Transportation (NEMT)

School-Linked Mental Health Services

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

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

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

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

Last year, the Legislature appointed \$14 million for school-linked services in fiscal year 2024 but only \$9 million for fiscal year 2025.

Of the children served in [the School-linked Mental Health program]...

50% *had never been served before.*

50% *had a serious mental illness.*

POLICY RECOMMENDATIONS:

- Continue increased school-linked funding at the FY 2024 level to the next biennium (\$5 million).

Education K-12 and College

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

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

School support personnel have incredibly high caseloads, making it difficult to meet the needs of students.

Minnesota students are often unable to access even basic information about what mental illnesses are, what the symptoms are of mental illnesses, and what they need to do if they are worried about themselves, a friend, or someone in their family.

POLICY RECOMMENDATIONS:

- Fund college-linked mental health services at community and technical colleges
- Require and fund mental health screenings for children in K-12.
- Allow high school students to access available rooms to conduct telehealth with a private therapist.



Access to Mental Health Treatment

Workforce Shortages

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

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

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

In 2023, the Legislature increased funds for loan forgiveness for mental health professionals, established a program to train pediatricians and primary care providers with psychiatrists, funded an additional psychiatry residency slot, funded BIPOC mental health professionals to become supervisors, and provided funding for students at community mental health agencies to receive free supervision.

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

9 out of **11**
*geographic regions
 in Minnesota are
 designated as
 mental health
 shortage areas.*

POLICY RECOMMENDATIONS:

- Create alternative pathways to licensure for mental health professionals from diverse backgrounds and work with the licensing boards to encourage people to provide demographic/ethnic information in order to measure progress.
- Establish a mental health and substance use disorder education center at the Minnesota Department of Health to increase the workforce and diversity, and target training to have a culturally informed and responsive workforce
- Create an interstate compact to allow LPCCs in other states to practice in Minnesota
- Update children's licensing category for the Youth Care Professional Institute and fund the institute
- Change the definition of clinical trainee to mirror practitioner to allow post-intern and pre-program completion employment as a clinical trainee.
- Align the state's peer specialist standards with SAMHSA's
- Add "rural" to supervision funding as a priority

Crisis Response

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

BACKGROUND: Research has shown that mobile crisis services are:

- Effective at diverting people in crisis from psychiatric hospitalization
- Effective at linking suicidal individuals discharged from the emergency department to services
- Better than hospitalization at linking people in crisis to outpatient services and
- Effective in finding hard-to-reach individuals.
- Providing a mental health response also limits interactions with police.

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

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

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

\$102

cost-savings per person avoiding hospitalization.

\$1,080

cost-savings per person avoiding the criminal justice system.

POLICY RECOMMENDATIONS:

- Keep strengthening collaboration between crisis teams, 988 and 911.
- Better align expectations and requirements for mobile crisis and define crisis response
- Increase crisis funding for the next biennium so that it stays at the same level as this biennium
- Provide sustainable funding for Minnesota warmlines

Behavioral Health Homes

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

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

POLICY RECOMMENDATIONS:

- Update reimbursement rates for BHH services to ensure the rates are more reflective of the actual cost of providing this critical service, to increase access.
- The Commissioner for the Department of Human Services should implement a single statewide reimbursement rate for behavioral health homes that shall be adjusted annually by CPI for medical care services.

Community Mental Health Treatment

ISSUE: Minnesotans continue to lack access to adequate mental health treatment in the community where they live. Many people across Minnesota, including children, wait in emergency rooms for a hospital bed. Still others wait in hospital psychiatric beds, an Intensive Residential Treatment Services (IRTS) facility, and in jail for an opening at Anoka Metro Regional Treatment Center (AMRTC). People who are at AMRTC are waiting for community services.

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
- Add occupational therapists as a billable services under ARMHS.
- Expand the Transition to Community Initiative to serve people over age 65, people in Community Behavioral Health Hospitals (CBHHs), and people in community hospitals seeking admission to AMRTC
- Pay for IRTS and Residential Crisis Stabilization room and board costs under MinnesotaCare.
- Ensure IRTS and Residential Crisis Stabilization (RCS) service facilities are equipped to meet standards like accessibility by funding facility upgrades.
- Increase the number of Forensic Assertive Community Treatment Teams
- Expand the Elderly Waiver to meet the mental health needs of older adults
- Increase funds to add staff to the State Medical Review Team (SMRT)
- Allow texting under case management

Collaborative Care Management

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

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

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

Collaborative Care Management

POLICY RECOMMENDATION:

- Mandate that Minnesota Medical Assistance and MN Care pay for all necessary collaborative care services in all settings with a sustainable rate.

Assertive Community Treatment

ISSUE: Assertive Community Treatment services are a critical part of our state's mental health services continuum. In their efforts to continue to sustain and grow access to Assertive Community Treatment services, stakeholders have identified areas of statute where we can modernize ACT regulation to increase access to this services and allow mental health service staff to focus on quality service delivery.

BACKGROUND: Assertive Community Treatment services are intensive nonresidential mental health services provided according to a national evidenced based practice certification. Assertive Community Treatment provides a single, fixed point of responsibility for treatment, rehabilitation and support needs for clients. Services are offered 24 hours per day, seven days per week, in a community-based setting. Assertive Community Treatment services are an extremely effective model of care, and are a valuable component of our state's mental health services continuum. In this moment when increasing access to mental health care is critical for our state, we must take steps to streamline regulations, adapt to meet the current workforce environment, address service access barriers, and support mental health staff to focus their efforts as much as possible on quality treatment.

Assertive Community Treatment services are an extremely effective model of care, and are a valuable component of our state's mental health services continuum.

POLICY RECOMMENDATION:

- Allow flexibility in qualifications for the Team lead
- Align diagnostic assessment renewal schedule with the changes passed in the 2023 legislative session for other mental health services.
- Separate the ACT statute from the IRTS and RCS statutes
- Replace current statutory requirements for staffing compliments for various ACT team sizes with requirement to meet a passing score from the most recently available TMACT
- Require DHS to share with providers certification standards and rubric
- Remove requirement that provider organizations have a contract with the local county in order to provide services
- Allow first episode of psychosis programs to determine someone is need of ACT services



Criminal Justice

Juvenile Justice

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

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

Yet, we also need many interventions for youth who have already entered the system. Minnesota has specifically seen a growing crisis with children with very complex needs who cannot find placements around the state. Some board in emergency rooms, some are taken out of state. Many of these children are not involved with the justice system, but for those who are, finding placements can be even harder and the children can be placed in juvenile detention facilities.

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

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

POLICY RECOMMENDATIONS:

- Raise the age of delinquency and detention from 10 to 14
- Increase mental health care in detention facilities
- Create a new juvenile competency restoration system
- Provide funding to expand high fidelity wraparound services
- Require minimum standards for juvenile court examiners
- Create stronger protections and oversight for interrogation of juveniles

Public Safety

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

BACKGROUND: Mental health impacts everyone – victims of crimes, first responders, lawyers, judges, the accused, corrections officers, incarcerated people, and the families and loved ones of every one of these people. While the issues

Public Safety *continued*

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

Many times, symptoms and untreated mental illnesses can result in criminalization, whether it is called trespassing or disorderly conduct, the underlying issue is not criminal behavior, but unmet needs. We know that when we respond to the underlying issues, the criminal concerns often resolve themselves, and in many cases, responding to root social issues costs less to taxpayers and human beings than a criminal legal response. In cases where a person has committed a serious crime, it is also important that adequate mental health supports are in place throughout the legal system so that a person can be held accountable for their harm and that everyone in the community can be safe.

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

POLICY RECOMMENDATIONS:

- Fund reentry coordination programs, or jail social workers
- Eliminate co-pays for mental health medications in jails
- Create a special fund to pay for injectable medications and mental health medications in jail
- Require peace officers to be 21 years of age or older

Prison and Probation

ISSUE: People with mental illnesses need support and treatment while in prison and serving sentences under community supervision. 95% of incarcerated people in Minnesota will reenter the community. Prisons need more mental health professionals and trauma informed practices to ensure that people can live safely while incarcerated and reenter the community with stability and safety.

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

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

POLICY RECOMMENDATIONS:

- Increase staffing levels for mental health and substance use disorder treatment staff
- 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
- Expand release options like work release and compassionate medical release
- Reduce the use of solitary confinement and promote rehabilitative safety measures in prisons



Other Issues

Coordinated Care in Integrated and Culturally Diverse Health

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

Establishment of License for Behavior Analysts

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

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

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

POLICY RECOMMENDATION:

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

Voter Registration

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

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

POLICY RECOMMENDATIONS:

- Clarify that the definition of residential program includes residential mental health treatment programs.

*We need to put a
spotlight on our
mental health system
– focusing on what
works and the work
that is left to do.*



Mental Health
LEGISLATIVE NETWORK