Mental Health Legislative Network of Minnesota

2018 Legislative Issues

Mental Health Legislative Network 2018

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

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

Amherst H. Wilder Foundation
AspireMN
Autism Opportunities
Avivo
Barbara Schneider Foundation
Canvas Health
Catholic Charities of St. Paul and Minneapolis
Children's HealthCare Minnesota
Community Involvement Programs
Emily Program Foundation
Fraser
Goodwill Easter Seals
Guild Incorporated
Lutheran Social Service of Minnesota
Mental Health Minnesota
Mental Health Providers Association of Minnesota
Minnesota Disability Law Center
Minnesota Association for Children's Mental Health
Minnesota Association of Community Mental Health Programs
Minnesota Autism Center
Minnesota Behavioral Health Network
Minnesota Coalition of Licensed Social Workers
Minnesota Department of Human Services
Minnesota Organization on Fetal Alcohol Syndrome
Minnesota Psychiatric Society
Minnesota Psychological Association
Minnesota Recovery Connection
Minnesota Society for Clinical Social Work
NAMI Minnesota
National Association of Social Workers, Minnesota Chapter
Ombudsman-MHDD
People Incorporated
Resource, Inc.
Rise
State Advisory Council on Mental Health Subcommittee on Children's Mental Health
Vail Place
Wellness in the Woods
Wilder

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

Table of Contents

Mental Illnesses and the Mental Health System

Mental Illnesses

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Mental illnesses affect about one in five people in a given year. People affected more seriously by mental illness number about 1 in 25. There is a continuum, with good mental health on one end and serious mental illnesses on the other end.

Examples of serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), generalized anxiety disorder, panic disorder, post- traumatic stress disorder (PTSD), eating disorders and borderline personality disorder.

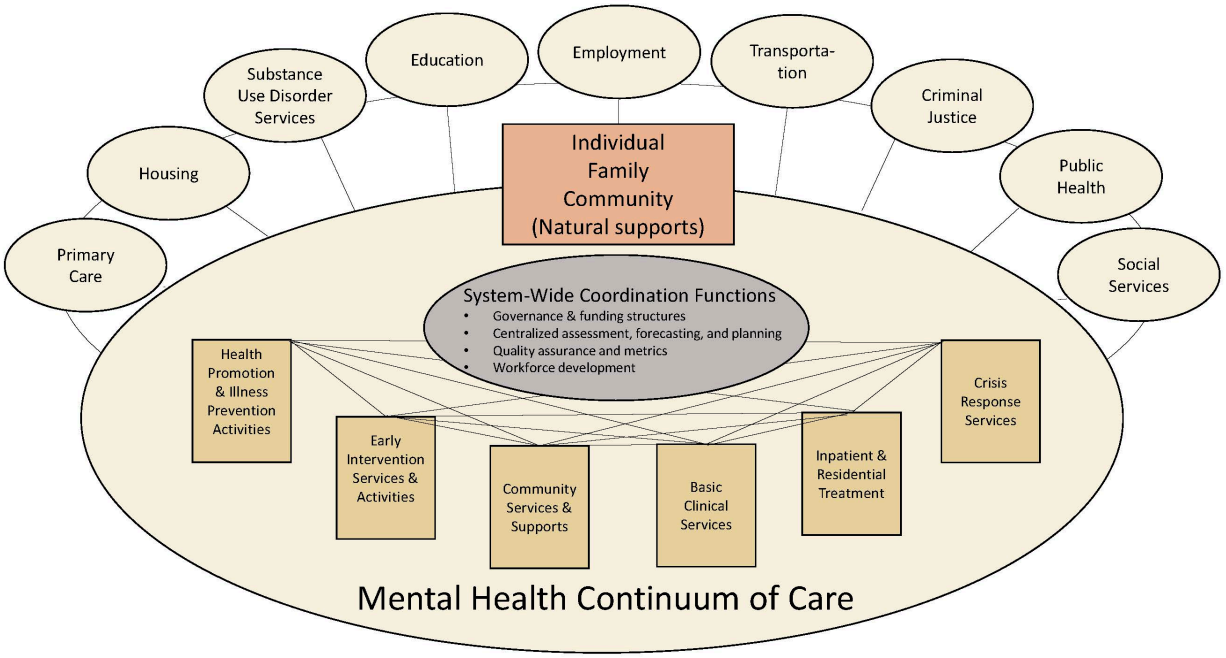
Mental illnesses can affect persons of any age, race, religion, political party or income. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can get better with effective treatment and supports. Medication alone is not enough. Therapy, support, good diet, exercise, stable housing, meaningful activities (school, work, volunteering) all help people recover.

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

Depending on the severity of mental illness and whether timely access to effective treatment and support services are available, mental illness may significantly impact all facets of living including learning, working, housing stability, and living independently. Furthermore, social relationships like family and friends along with social integration into the community may be affected. Some persons with mental illness experience a revolving door relationship with the criminal justice system while others cycle in and out of the shelter system. Poverty is commonplace amongst those living with severe mental illness.

Although we have effective treatments and rehabilitation, the current mental health system fails to respond to the needs of too many children, adults and their families. Timely access to the full panoply of necessary mental health benefits and services, whether treatment or rehabilitation, is often limited due to insurance or public program access issues, unavailability of mental health providers or community based beds, or geographical disparities.

There are long standing structural barriers in the system that impedes the flow of patients from one provider based service to another. Too often a person’s mental health will worsen as they wait for help. Ensuring timelier hand offs in the continuity of care continuum will lead to more effective provision of service resulting in enhanced quality of life for those persons who must navigate the complex mental health care system.



The Federal HHS Administration, SAMHSA, has established a working definition of recovery that 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*. The adoption of the recovery approach by mental health care systems in recent years has signaled a dramatic shift in the expectation for positive outcomes for individuals. Recovery is built on access to evidence-based clinical treatment and recovery support services. 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. The value of recovery-oriented mental health care systems is widely accepted by states, communities, providers, families, researchers, and advocates including the U.S. Surgeon General and the Institute of Medicine.

The range of services required for a person to realize recovery from mental illness in the hopes of achieving greater mental health varies depending on a host of factors. The range of services is as varied as the range of mental health conditions and co-occurring disorders that may be present in any one person. Some people may only need access to standard mental health treatment in a healthcare setting while others may need, in addition, a fuller spectrum of intensive, flexible rehabilitation and recovery services. A broad range of effective and adequate service components across the continuum are required to make recovery possible for persons living with mental illness.

Minnesota's Mental Health System

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. MA is an invaluable program for children and adults with mental illnesses and their families. For many, it is the **only** way to obtain access to treatment and supports.

Coverage for mental health treatment is not currently mandated for self-insured plans or commercial or private insurance. Mental health parity only requires plans to ensure parity IF they cover mental health or substance use disorder treatment. There are exemptions for individual policies and small businesses, although every plan offered through MNSure must cover mental health and substance use disorder treatment and follow mental health parity laws.

Access to Benefits: If mental health treatment is covered under private insurance, what is covered is variable. Few private plans cover the model mental health benefit set which is included under Medical Assistance and MinnesotaCare. The model mental health benefit set is based upon research and evidence of effectiveness and include service such as crisis services, Assertive Community Treatment (ACT), Intensive Residential Treatment Services (IRTS), Children's Therapeutic Services and Supports (CTSS), etc.

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. Grant funding was cut over $52 million between 2009 and 2011 which negatively affected people with mental illnesses and thus greatly reduced people's ability to access needed supports to live well in the community.

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

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 increases consumer purchasing power, attracts qualified professionals to service, improves earlier access to treatment, and supports saving money and time. Increased reimbursement enables agencies to hire and supervise qualified workers, which reduces turnover and saves time and money. Without adequate salaries, qualified mental health professionals leave their careers. Rates paid through managed care Medical Assistance are often lower than fee-for-service rates.

Looking to the Future

More than ever before, we know what works. Early intervention, evidence-based practices and a "model mental health benefit set" have created the foundation for a good mental health system in Minnesota. Unfortunately, workforce shortages, poor reimbursement rates, and lack of coverage by private plans have resulted in a fragile system that is not available statewide and is not therefore able to meet the demand.

People often look for "quick fixes" such as more beds. Children and adults with mental illnesses spend the majority of their lives in the community. Thus, the "fix" is more complex in that we need to work to ensure that the services that support people in the community are readily available to provide early identification and intervention, address a mental health crisis, and provide ongoing supports in the community.

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

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

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

Our juvenile justice and criminal justice system have been used for over 50 years to care for youth and adults with mental illnesses who have committed largely nonviolent crimes. Steps have been taken to address this including training of public safety officers, the development of mental health courts and the creation of mental health crisis teams.

Suicide rates are increasing in Minnesota. The data, which is more than two years old, tell us that 726 people died by suicide in 2015.

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

On the federal level there is discussion about repealing the Affordable Care Act and block-granting Medicaid. Legislators should know that the ACA provided an opportunity for people to have insurance to cover their needed mental health treatment for the first time by not allowing denial of coverage due to a pre-existing condition, by allowing young adults (a key age to develop a mental illness) to stay on their parents' plan until age 26, by expanding Medicaid to low-income childless adults so that they don't have to say to the Social Security Administration that they will never work again and by requiring policies offered through MNSure to cover mental health and substance use disorder treatment and follow mental health parity. The mental health system was not built due to dependence on funding that was turned into a federal block grant that gave funding to states with few strings attached. We began to seriously build our mental health services when treatment and services were billed through Medicaid and MNCare. We are very concerned about how actions on the federal level could destroy what we have built the last decade.

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

Key Issues for the 2018 Legislative Session

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

Adult Mental Health Services and Supports

Housing

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

Background: People with mental illnesses cannot achieve recovery without stable housing. The shortage of affordable housing, including supportive housing, has led to people remaining at the Anoka Metro Regional Treatment Center longer than necessary and resulted in people being discharged from hospitals and Intensive Residential Treatment Services (IRTS) to shelters.

Bridges provides housing subsidies to people living with serious mental illnesses while they are on the waiting list for federal Section 8 housing assistance. As with Section 8, people on Bridges rent an apartment at the regular market-rate and pay 30% of their income for rent. The program provides vouchers to cover the balance. Bridges is administered by local housing authorities or other entities who manage Section 8 programs.

The legislature in 2013 approved an additional $400,000 for the Bridges program. MHFA provided a competitive RFP for the funds and received 12 proposals, requesting a total amount of $1.4 million in order to serve 187 households per month at full utilization. One grantee accepted applications for one day only and received about 100 applications for only 12 vouchers. There are an estimated 1366 households on waiting lists for Bridges as of July 2014. It would take an estimated $17.147 million in biennial budget just to serve all households on the waiting list. This figure does not include serving areas without current access to Bridges funding.

The grant program called Housing with Supports for Adults with Serious Mental Illness provides grants to housing developers, county mental health authorities and tribes to increase the availability of supportive housing options. Supportive housing is an effective and inexpensive way to assist people with serious mental illnesses to live in the community. Supportive housing often provides housing stability, prevents homelessness and even hospitalizations. In the 2017 Legislative Session, supportive housing funding was increased by $2.15 million dollars.

Housing Support (formerly known as Group Residential Housing, or GRH)) pays for room and board costs for adults with low-income who have disabling condition. Recipients of Housing Support live in licensed facilities (e.g. Adult Foster Care, Board and Lodge, Assisted Living) or in their own home with a signed lease. In either case, a provider or "vendor" manages the room and board expenses on behalf of the individual. However, some people prefer not to live in a licensed facility and/or have a vendor managing their room and board needs, and would rather manage their own budget to meet their needs.

Minnesota Supplemental Aid (MSA) Housing Assistance provides a direct benefit to individuals with disabilities to help them afford housing. However, the amount of MSA Housing Assistance is not enough support more people to live in the community and is not available to people on GRH who want to move out of a group setting and/or manage their own room and board needs.

In June 2015, the Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin regarding the coverage of housing-related activities and services for individuals under Medicaid. The bulletin identifies how housing-related activities and services can be incorporated into a Medicaid benefit set for individuals to achieve optimal community integration. The 2016 legislature directed DHS to design a housing support service to help people with disabilities locate and secure stable housing as well as maintain housing through support services.

Recommendations:

- Increase funding for the Bridges Program.

- Increase funding for housing supports for adults with serious mental illnesses.
- Increase the MSA-Housing Assistance benefit and expand eligibility to people leaving Housing Support (formerly known as Group Residential Housing, or GRH).
- Pursue a Housing Support Services Medicaid benefit

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 stigma and discrimination when applying for jobs and may face other obstacles such as losing health insurance coverage for their mental health treatment and medications or lack of transportation. In addition, few receive the supported employment opportunities shown to be effective for people with mental illnesses.

During the 2013 legislative session, Minnesota lawmakers made a number of important changes to the law governing supported employment programs for people with mental illnesses to reflect the evidenced-based model of Individual Placement and Support (IPS). Changes were also made to Minnesota's Adult Mental Health Act to underscore the importance of competitive employment and to encourage counties to fund IPS programs. In the 2015 special session IPS employment received an additional $1 million a year to continue the projects that were converted to IPS last year. The next step is to provide on-going funding and to increase the number of IPS programs to help all Minnesotans with a mental illness who want to work find a meaningful and well-paying job and make sure DEED programs know how to help.

Policy Recommendations:
HF1783/SF 1441

- Require the commissioner of DEED to, in consultation with stakeholders, identify barriers that people with mental illnesses face in obtaining employment, identify all current programs that assist people with mental illnesses in obtaining employment and submit a detailed plan to the legislature.
- Require DEED to fund work training programs for people with mental illnesses to assist them in securing employment of their choice that pays at or above the federal minimum wage.
- Fund programs, such as IPS, that provide employment support services to persons with mental illnesses.

Supporting Parents with Mental Illnesses

Issue: Parents with a mental illness face unique challenges as caregivers. This can include developing a healthy attachment with their child, treatment challenges for families where the child and parent both have a mental illness, and additional burdens accessing and coordinating services.

Background: In a DHS report from 2013, there were 13,000 parents with a serious mental illness currently caring for their children, with over 60% of families in the child protection system having issues with mental health and or substance use disorder. These parents require additional supports and services to care for their children.

Families who are on child-only MFIP, where the parent is deemed disabled and is on Supplemental Security Income (SSI) /Social Security Disability Insurance (SSDI), do not have access to child care. It is very difficult for a parent to engage in treatment without dependable and quality child care. A

person may need intensive treatment that could potentially involve attending treatment daily during a week to properly address and fully manage mental health symptoms. Parents should not have to choose between caring for their children and addressing their own mental health needs.

A number of well supported studies, such as the Adverse Childhood Experiences (ACEs) study, identify that having a parent with a mental illness is a risk factor for poor quality of life in the future. Parents who have access to subsidized child care can access mental health treatment and children can have a stable adult in their lives.

Multigenerational treatments are an evidence-based practice designed to increase supportive and responsive caregiving of parents with serious mental illness and to conduct an independent evaluation of the effectiveness of these interventions. Research has shown that many parents who have a serious mental illness also have a child with mental health challenges and this model seeks to address the needs of both the parent and their children in an integrated fashion.

The mental health block grant was used to fund multi-generational grants in Duluth, St. Cloud, and St. Paul with great success. Unfortunately, the block grant cannot be tapped again as a funding source. That means that state funds must now be utilized to begin offering these highly effective services again.

Policy Recommendations:
HF 2101/SF 1978

- Expand child care assistance to families who have a child under the age of six and are on child-only MFIP for up to 20 hours of child care per week as recommended by the treating mental health professional.
- Appropriate $575,000 to fund multigenerational mental health programs for three years.
- Increase the rate for Mother Baby program. The reimbursement rate for intensive outpatient services does not reflect the level of care provided as well as the fact that treatment is provided to both the mother and the child.

Fund early childhood mental health consultation.

Clubhouse Services

Issue: Increase access to Clubhouse services across the state

Background: Clubhouse programs help people with mental illnesses stay out of hospitals while achieving social, financial, educational, and vocational goals. People are members, not clients. Studies show that Clubhouse members are more likely to report that they have close friendships and someone they could rely on when they needed help, meaning that Clubhouse programs reduce disconnectedness. "C*lubhouse members (versus clients) appeared to experience the WOD (Word Ordered Day) as meaningful because it helps them, at its best, reconstruct a life, develop their occupational self and skill sets and experientially learn and live what parallels a good life in the general community. It appears that these experiences, interconnecting with the fundamental human needs for autonomy and relationship, point to wellbeing and recovery as part of personal growth" (Tanaka, K. & Davidson, L. (2014) Psychiatric Quarterly.)* There are over 12 clubhouses in Minnesota, although only one is currently accredited. This is one model, but it is not designed to replace community support centers.

Community Support Programs, including those run by Clubhouse programs, rely on a limited funding stream: Community Support Grants (part of the State Adult Mental Health grants) and local county dollars. Reliance on this often at-risk funding restricts the further dispersion of 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 – reviewed and accepted by SAMHSA for inclusion on the USA National Registry of Evidence Based Programs and Practices (NREPP). This is one model and is not designed to replace drop-in centers.

Recommendation: Ensure that state funding to counties is used to support clubhouses

Personal Care Assistance Services

Issue: For a personal to be eligible for personal care assistance services they must require cuing and constant supervision to complete daily task. Persons living with mental illnesses can benefit from this service, but do not necessarily require constant supervision and thus, may have very limited eligibility for PCA services.

Background: Personal care assistance (PCA) is a home care service. Personal care assistants provide services and support to help people who need assistance in activities of daily living, health-related tasks, observation and redirection.

In 2009, Minnesota passed PCA reform legislation which included changes to the assessment and authorization process required to access PCA services. As a result, individuals who were not constantly dependent on a PCA worker to complete at least on daily task lost this service. In a 2010, a report from the Department of Human Services outlined a requirement that "DHS must implement an alternative service for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community."

During the 2011 special session, legislation was passed to restore limited eligibility of a half hour per day to some children and adults who would have been terminated from PCA services under the cuts adopted in 2009. However, there are still individuals who either lost or cannot access services because of current statute language.

The legislature directed DHS in 2015 to look at who lost services. Their report estimated that 1,877 people could use CFSS if the word "constant" was removed.

Policy Recommendation: Remove the word "constant" from the PCA statute so that individuals who would benefit, but who do not need constant supervision can still access these services. HF 1132/SF 1102

Access to Mental Health Treatment

Crisis Response Services

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: Existing services are spotty across the state with mental health crisis response services available mostly in the metro area. Counties all have a crisis number but not all have a mobile crisis response. An appropriate continuum of crisis response care should include at a minimum:

- 24/7 crisis phone
- Mobile crisis response
- Residential and foster care crisis beds
- Urgent care or walk in clinics
- 911 and emergency department collaboration with crisis teams
- Crisis homes

Crisis services prevent more costly hospitalizations. Over the past several years data show that for both children and adults over 80% of those served by crisis teams were able to avoid hospitalizations. Providing a mental health response also limits interactions with police.

Policy Recommendations: Continue to build Mobile Crisis Response to achieve 24/7 coverage across the state by 2018. To stabilize and expand mobile crisis services, two key issues need to be addressed – workforce shortages and funding.

Many rural and even metro teams struggle with hiring appropriate level of staff for their teams. The nature of crisis services makes it an unattractive opportunity and many crisis teams are staffed with new and inexperienced staff. Increasing pay to employees providing this service would assist in keeping and hiring staff. Building teams around mental health practitioners and certified peer specialists will also create a larger pool of resources.

State grants were developed to cover the uninsured population and Medicaid rates are insufficient to cover the costs of mobile crisis teams. Some counties subsidize the teams, but not all. Private insurance in Minnesota is required to cover crisis teams as they do for ambulance services but it has not been implemented, leaving a large part of the population not covered or depending on the public system to cover their share. Most if not all mobile crisis teams are struggling to cover their bottom lines. This also makes it difficult for providers to pay higher rates to attract more experienced staff.

The Legislature increased state funding by $800,000 in one time funding for the biennium to expand crisis services, including co-locating crisis services in urgent care clinics and to develop psychiatric emergency rooms.

State funding should make this increase permanent and continue to grow in the future.

Patient Flow

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. The '48 hour rule" gives jail inmates who are committed priority to access state

facilities, in particular AMRTC. 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, a large percentage of people – ranging from 20% to 50% - of people at AMRTC do not need that level of care and are waiting to transition into the community. The Minnesota Hospital Association reports that roughly 20% of the people in an inpatient unit are waiting for another level of service.

Background: In Minnesota, there are 1,124 inpatient community mental health beds statewide: 960 for adults, 164 for children/adolescents in community hospitals. There are also 646 available beds at Intensive Residential Treatment (IRTS) and crisis facilities and seven 16-bed Community Behavioral Health Hospitals.

Inpatient community mental health beds are not the only way to treat people with a serious mental illness, but they are an important part of the service continuum. Currently, the lack of inpatient psychiatric beds has become so extreme that patients are essentially being boarded in emergency room for weeks or even months while they wait for an opening. This need has become so dire that it is necessary to provide more options and new incentives to encourage the development of inpatient mental health beds.

Minnesota also needs to add mental health care to current urgent care centers to provide rapid access to treatment when it is needed in a very cost-effective way. We also need to increase support for psychiatric ED services, which can offer a faster hand-off when police bring someone into the ED; crisis teams; crisis homes; and more supportive housing for people to transition out of AMRTC. The 2013 Legislature created the *Transition to Community Initiative* to help people being served at Anoka Metro Regional Treatment Center (AMRTC) and the Minnesota Security Hospital (MSH) who no longer require the level of care provided at these facilities, to transition to the community. The initiative provides access to a range of services, including home and community based services waivers, to help people leave these facilities and live successfully in the community.

Several additional groups of people would benefit greatly from the initiative. They include people over age 65, individuals at a state-operated Community Behavioral Health Hospital (CBHH), and adults who are waiting in our community hospitals and/or on the AMRTC wait list. As with people currently served at AMRTC and MSH, many of these individuals face serious barriers that prevent them from transitioning back to the community when they no longer need the level of care provided in those facilities.

People over age 65 face an additional set of unique challenges. For many individuals age 65 and older who are transitioning back into the community, the individual budgets available through the Elderly Waiver (EW) are not sufficient to meet their complex needs. Individuals age 65 and over who were being served on Brain Injury (BI) waiver or Community Alternatives for Disabled Individuals (CADI) prior to turning 65 can continue to be served under these waivers, but they cannot enter these programs after turning 65. The lack of sufficient resources for home and community-based services creates a barrier to an appropriate and timely discharge for this population.

Policy Recommendation: Address the "flow issues" that are backing up our emergency rooms, hospitals and Anoka Metro Regional Treatment Center (AMRTC) by:

- Repeal the 48 hour rule and provide funding for mental health treatment to inmates in jail.
- Expanding the Transition to Community Initiative to serve people over age 65, people in Community Behavioral Health Hospitals (CBHHs), and people in community hospitals seeking admission to AMRTC.
- Rework hospital construction moratorium to eliminate barriers to the development of additional in-patient psychiatric beds.

- Create a pilot project for specialized IRTS facilities to serve people from the criminal justice system to prevent people entering and to assist them in leaving AMRTC.
- Remove requirements placed upon new and existing providers to execute host county contracts in order to enroll as a MHCP provider for various behavioral health services—specifically ACT services, IRTS, and Residential Crisis Stabilization Services.
- Remove requirements placed upon new or expanding substance use disorder treatment provider to prove that need for such services exist within a specific geographic area, and instead allow new or expanding providers to proceed with the licensure process and be licensed absent a specific finding by DHS that current services are sufficient and additional services would be detrimental to individuals seeking such services.
- Allow, under limited circumstances, for a transfer of a license or certification of certain behavioral health providers so that continuity of care and continued access to services can be maintained in circumstances where existing providers are unable to continue existing operations short of utilizing the voluntary receivership processes currently available in statute.

Mental Health Parity

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

Background: The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law aimed at preventing group health plans and health insurance agencies that provide mental health or substance use disorder services from imposing less favorable limitations on mental health and substance use disorder services than on other medical services.

The three pillars of mental health parity are:

- Out of Pocket Costs: mental health parity requires, with few exceptions, that copayments cannot be higher for mental health care than other medical surgical benefits, nor can there be a different deductible or higher out-of-pocket maximums for mental health care.
- Treatment Limits: Health plans cannot establish different quantitative limits for mental health care than other medical benefits. For example, it is a parity violation to offer unlimited primary care appointments but only three mental health therapy appointments.
- NQTL: A Non-Quantitative Treatment Limitation (NQTL) makes non-numerical limitations to the scope or duration of benefits for treatment. An NQTL can take the form of step-therapy for a medication, different standards for a provider to enter a network including reimbursement rates, or other limits based on facility type or provider specialty that limit the scope or duration of health plan benefits. Mental health parity stipulates that the standards that a health plan uses when making an NQTL cannot be any more stringent or restrictive for mental health and substance use disorder treatment than it is for other categories of health care.

While all three of these parity violations still occur, the most common form of discrimination that mental health and substance use disorder patients experience is through NQTLs from their health plan.

For example, many plans pay for rehab in a nursing home after a hip replacement but won't pay for rehab in an Intensive Residential Treatment Program for someone with a serious mental illness leaving the hospital.

.

Policy Recommendations:

HF 1974/ SF 2028

- **Annual reporting**: Require health plans that offer mental health and or substance use disorder services to submit an annual report to the commissioner that documents every NQTL applied to mental health or substance use disorder benefits and medical and surgical benefits, as well as an analysis that confirms that the standards for determining an NQTL for mental health and substance use disorder treatment are not more stringent or restrictive than for other medical or surgical benefits.
- **Enforcement**: Department of Commerce and the Department of Health should monitor the implementation of mental health parity and ensure that health care plans are following mental health parity requirements.
- **Regular market analysis:** Because there often substantial differences in access to in-network mental health care and out-of-pocket costs when compared with coverage for other medical conditions, it is very important for the Department of Commerce to conduct regular audits of the health insurance market to ensure compliance with federal parity regulations.

Access to Medication

Issue: Individuals experience barriers to obtaining prescribed best-choice medication due to frustrating and problematic regulations.

Background: Finding the right medication and treatment for a mental illness can be difficult. Adherence to a treatment plan can be even more difficult. Research has shown that when an individual with a mental illness is engaged in developing the treatment plan and when there is shared decision making, the outcomes are better. The individual and their physician should work together to determine a best-choice medication based upon treatment goals and risk of side-effects.

Step therapy, where you must start with typically the cheapest and oldest medication and must "fail" before trying another medication, does not allow for best practices in terms of treatment engagement nor does it allow the physician to recommend which medication may work best based on a number of items including research and family history. Some side effects are more tolerable than others, which means it is critical that the individual be involved in the decision making. Mental illnesses have a genetic component. If a family member has, for example, depression and has found a medication that works well, it may be appropriate for another family member to try that medication first.

Controlling costs through fail-first approaches conflicts with most clinical treatment guidelines for mental illnesses. By limiting the array of medication options to people with mental illnesses, both physicians and individuals are forced to compromise their treatment decisions. While studies may show that there is relatively little difference in the effectiveness of a class of medication, these studies provide no information on discontinuation of medications or intolerable side effects or failure to adequately control symptoms. These "cost saving measures" often place people with mental illnesses at risk of poor outcomes such as psychiatric decompensation and re-hospitalization, with little evidence that they save money or improve quality of care over the long-term.

An individual may also have to change a medication that has been working for them should they decide to switch to an insurance plan that better meets their needs. People should not be limited to certain health care insurance plans for fear they might lose access to their prescribed medication.

Often, a person with a mental illness will have to fail on one or more medications before they are allowed access to the medication they would have tried as an initial treatment. It is poor clinical care to delay the start of effective treatment and expose a person with mental illness to increased risks.

Policy Recommendation: Advocate that state laws do not interfere with people obtaining the most effective medication.

HF 747 / SF 593

- Any prior authorization for a prescription drug must remain valid for the duration of the contract year unless the drug has been deemed unsafe by the FDA, there is evidence of enrollees abuse or mistreatment of the drug,
- A health plan that provides prescription drug coverage and uses a formulary must disclose its formulary and related benefit information at least 30 days prior to annual renewal dates.
- Once a formulary is established, a health plan can only remove a brand name drug or place it in a higher cost benefit category if this drug is replaced with a generic drug deemed therapeutically equivalent or a biologic drug rated as interchangeable according to the FDA.

Step Therapy Legislation

- The legislation allows step therapy only if certain requirements are followed in developing the step therapy tool.
- The legislation also allows a prescriber or patient to request an override of the protocol in specific circumstances when non-prescribed drug is likely not medically appropriate for the patient.

Early Intervention and First Episode Psychosis Programs

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

Background: Individuals experiencing their first psychotic or manic episode are not receiving the intensive treatment they need to foster recovery. On average a person waits 74 weeks to receive treatment. Our mental health system has relied on a "fail-first" model of care that essentially requires people experiencing psychosis to be hospitalized or be committed multiple times before they can access intensive treatment and supports. This costs our system a great deal and costs the individual even more. There is compelling evidence that intensive early intervention can foster recovery and prevent adverse outcomes frequently associated with untreated psychosis.

To address the need in Minnesota we estimate that eight teams would be needed and each would serve 30 young people at one time. People stay with the team an average of two to three years. Each team, based on calculations used in New York, would cost roughly $250,000, in addition to reimbursement by insurance.

During the 2015 legislative session funding of $260,000, in addition to the ten percent from the federal mental health block grant, was made available to create evidence-based interventions for youth at risk of developing and experiencing a first episode of psychosis. Projects will offer coordinated specialty care including case management, psychotherapy, psychoeducation, support for families, cognitive remediation, and supported employment and/or education. These programs provide intensive treatment right away for someone experiencing symptoms of psychosis. In greater Minnesota the geographic catchment area to reach the needed population will be great

meaning that housing must be made available for the young person and their family to access this outpatient treatment program. Currently there are only three programs in Minnesota.

In 2017, the legislature appropriated an additional $1 illion dollars in one time dollars for the biennium to fund first episode programs, including the use of funds to ensure that individuals who live in rural areas can access the program by paying for travel, housing, and additional barriers to access.

Policy Recommendations:

- Increase the number of first episode psychosis (FEP) programs so that young people experiencing their first psychotic or first manic episode receive intensive treatment. We will require 8 FEP programs to adequately meet statewide demand for this evidence-based practice.

Mental Health Services

Reimbursement Rates for Mental Health Services

Issue: Existing public program (Medical Assistance and MinnesotaCare) rates paid to mental health providers are insufficient. As a result, community mental health providers are hemorrhaging financially. The existing rates, and inadequate rate setting process, threatens the on-going operation of mental health services, particularly safety net services.

Background: Existing mental health reimbursement rates are too low and not sufficient to sustain Minnesota's mental health safety net network. Planning related to building a more sustainable, integrated behavioral health care system promises to enhance the funding, accessibility, and quality of mental health services statewide. These reforms, however, take time to shape and implement.

To sustain core services for the low-income individuals and the uninsured in the short term, there is an urgent need to increase reimbursement rates for mental health providers. The negative impact of historically low rates is compounded by increases in the minimum wage, new federal overtime mandates, increased demand for services, and much higher wages offered by certain for-profit private providers and government agencies. With some current rates to providers between 0.37 to 0.50 cents on the dollar, this is not sustainable.

Policy Recommendation: Review federal regulations for managed care to ensure that these plans offer adequate rates and access for mental health treatment.

Medical Assistance Payments Under Managed Care

Issue: The financial distress being experienced by community mental health providers is fueled in part by PMAPs not paying the full, approved MA fee-for-service rates for some or all services.

Background: In the words of one provider, "nothing is consistent with any of the payments from any of the PMAPs." In 2016, the plans paid below MA rates to the majority of the providers who responded anonymously to a survey conducted by MACMHP. The same inconsistent payments are similar for the new codes and recent legislation mandating a five percent (5%) increase for MA services.

Minnesota Association of Community Mental Health Programs (MACMHP) members surveyed expect to lose revenue as a result of the new managed care contracts in 2016. Providers are investing a significant amount of time in reprocessing claims and in appealing rejected claims. In addition, there are inconsistent decisions around staff credentials. Overall, the inconsistency, lack of clear information, long delay in reimbursement and high level of administrative effort is making the business relationship with a Managed Care Organization an unsustainable proposition.

Policy Recommendation: Ensure accurate reimbursements are paid to providers for services contracted under managed care - payment rates equal to or above MA fee-for-service rates.

Mental Health Workforce Shortages

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

Background: Psychiatry, psychology, clinical social work, psychiatric nursing, marriage and family therapy and professional clinical counseling are considered the "core" mental health professions. For many years, Minnesota has experienced a shortage of providers of mental health services. This shortage has been felt most profoundly in the rural areas of the state. There is also an ongoing-shortage of culturally competent and culturally specific providers.

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

Adding to this, reimbursement rates for mental health services that have not kept pace with other health care services or health care inflation. Over the past ten years there have been inconsistent increases amounting to minor increases for mental health service when averaged over time.

The 2013 legislature passed a bill requiring Minnesota State Colleges and Universities (MnSCU) to hold a mental health summit and develop a comprehensive plan to increase the number of qualified people working at all levels of our mental health system, ensure appropriate coursework and training and create a more culturally diverse mental health workforce.

In 2015 the Mental Health Workforce released the report with recommendations to address workforce shortages by increasing the number of qualified people working at all levels of our mental health system, ensure appropriate coursework and training for mental health professionals and create a more culturally diverse mental health workforce. In 2016 a workforce summit was held to further address workforce shortages, especially in the direct support and care fields.

Policy Recommendations:

- Ensure access to affordable supervisory hours for mental health certification and licensure.
- Reduce barriers to mental health workers obtaining supervision hours required to be a mental health practitioner.
- Increase funding for the rural health professional education loan forgiveness program and set aside funds for people working in metro area programs where more than 50% of the patients are on Medicaid or uninsured. SF 1452
- Require insurance to cover treatment and services provided by a clinical trainee. HF 871/SF 1577
- Revise experience and credentialing requirements for three entry-level worker mental health positions. This reform of credentialing requirements for entry-level workers must be coupled with an increase in wages for these workers.
- Add LMFTs and LPCCs to the MERC program. HF 1749/SF1626
- Provide grant funding for culturally competent mental health provider consultation. HF 1700

Expand Use of Telemedicine

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

Background: Telemedicine has emerged as a viable, cost effective, and appropriate vehicle for delivering a range of mental health services in the community. State policy and statutes need to be updated to support the expansion and accessibility of this care delivery model. More people will have access to quality care consistently when the range of providers and hours of care provided via telemedicine are expanded.

Policy Recommendation: Increase the cap on the number of encounters permitted in a week from three to ten.

Licensure and Supervisory Requirements

Issue: Psychologists and applicants for licensure are experiencing challenges related to the changing implementation of the Psychology Practice Act

Background: Recently there have been concerns raised about the Psychology Practice Act or licensure statute for psychologists. Concerns have been raised about the clarity of stated requirements for supervision which are being further specified. This revision streamlines mobility of licensure for individuals licensed at the doctoral level in other jurisdictions, which helps to address workforce issues..

Policy Recommendations: Support the bill to update and clarify the Psychology Practice Act to improve access to care.

Duty to Warn

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

Background: Minnesota statute defines duty to warn as the duty to predict, warn of, or take reasonable precautions to provide protection from violent behavior when a client or other person has communicated to the licensee a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim. If a duty to warn arises, the duty is discharged by the licensee if he or she makes "reasonable efforts" (communicating the serious, specific threat to the potential victim and if unable to make contact with the potential victim, communicating the serious, specific threat to the law enforcement agency closest to the potential victim or the client.) to communicate the threat.

Legislation was changed in 2016 to provide duty to warn protection for trainees in the disciplines of Psychology, Marriage and Family Therapy, and Licensed Alcohol and Drug Counseling. Social Work and Licensed Professional Clinical Counselor trainees were not covered in the legislation. These groups may wish to consider inclusion of their trainees in the duty to warn protections.

Policy Recommendation: Expand duty to warn to other appropriate mental health trainees.

Children's Mental Health

Early Childhood Consultation

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

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

Some children, particularly when exposed to trauma, would greatly benefit from obtaining immediate treatment. Children from culturally specific communities often do not become involved in treatment due to the need for the families to develop trust and a relationship with the mental health professional. The requirement that a diagnostic assessment be completed before treatment begins hampers our ability to immediately assist a child who has experienced trauma and to develop a relationship with families. Allowing an exception could provide early treatment and prevent disability.

Policy Recommendations:

- Appropriate funds to expand early childhood mental health consultation grants HF 2101/SF 1978

School-Linked Mental Health Grants

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

Background: Since 2008, grants have been made to community mental health providers to collaborate with schools to provide mental health treatment to children. This program has produced wonderful outcomes and has reduced barriers to access such as transportation, insurance coverage, and finding providers. It was so successful that the legislature increased funding in 2013 and 2016.

Following the increased funding in 2013 SLMH was expanded to all but eight counties in Minnesota. On average 15,000 students are served during the school year. There are 36 SLMH grantees, serving 872 schools within more than 230 school districts. This means services in 85% of the school districts in the state and 45% of total school building.

This program works hand-in-hand with school support personnel such as school nurses, school psychologists, school social workers and school counselors. Efforts must be made to ensure that there are sufficient school support personnel to help those children who do not have a mental health diagnosis.

Policy Recommendations:

- Increase funding for school-linked mental health grants HF 960/SF 1369
- Streamline grant applications to allow previous grantees that have good outcomes and demonstrate support from their current school partners
- Create grants for "community-college" linked mental health services.

Children's Residential Treatment Funding

Issue: Since 2001, with approval from CMS, Minnesota has used Medical Assistance to pay for the treatment portion of the per diem for residential treatment services. Recently, CMS has directed DHS to review each of these facilities to determine whether they meet the definition of Institutions of Mental Disease (IMDs) which would make them ineligible for federal Medicaid funding.

Background: Programs that are larger than 16 beds that provide mental health treatment are considered IMDs under the CMS definition and most of the services in Minnesota are provided in larger programs. Children residing in IMDs would also lose their Medical Assistance eligibility. This loss of federal funding would affect state and local budgets and would impact access to these programs for children and adolescents. Minnesota has over 800 beds in the continuum of care that would be affected by this loss of funding.

Policy Recommendation: The Legislature did provide funding to replace the loss of federal financial participation through Medicaid. However, the state funding must be extended in order to be available through June 20, 2021.

Psychiatric Residential Treatment Facilities

Issue: A Psychiatric Residential Treatment Facility (PRTF) broadens the continuum of care by offering services that are less intensive than inpatient hospital care but more intensive than our current residential programs.

Background: Psychiatric Residential Treatment Facilities (PRTFs) were established under MA for the first time in 2015 with the intention of enrolling up to 150 PRTF beds at a maximum of 6 sites. A PRTF serves youths up to the age of 22 (so long as they entered the program while they were 21). This program provides active treatment rather than rehabilitation must have a psychiatrist or physician as a medical director, and require 24 hour nursing. The rates include room and board under MA and thus parents don't need to go to counties and through county child protection / voluntary placement process. Additionally, PRTFs are exempted from the Institute for Mental Disease (IMD) exclusion, which prohibits Medicaid funding for mental health treatment in any facility greater than 16 beds. This funded up to 150 new beds in up to six sites to be opened in 2017, with additional beds in subsequent years.

Policy Recommendation:

- Increase number of PRTF beds from 150 to 200 beds. Ensure that this increase is not made by removing beds from another service.

Transportation to Children's Mental Health Services

Issue: Children are being transported in a system that is designed and regulated to respond to the needs of adults.

Background: Non-emergency medical transportation is an essential service to ensure access to mental health services. Children represent a unique population and are often being transported to early childhood mental services that should require the transportation provider to have the right equipment, like car seats, and training so that drivers have the information and skills needed to safely deal with children with special needs.

Policy Recommendation: The commissioner should be directed to consult stakeholders and advocates to develop recommendations for standards and funding for transportation providers who transport children.

Alternatives to Suspension in K-3

Background: During the 2014 school year children in grades K-3 were out of school 8,102 days due to suspensions. Around 3,000 children in these grades are suspended every year. Suspending children in this age group is counter-productive. They do not learn anything when out of the classroom and any underlying issues – such as exposure to trauma, early onset mental illness, lagging in social emotional skills – are not addressed. Some research demonstrates that the more days a child misses up through third grade the greater likelihood that he or she will drop-out of school.

Policy Recommendations:

- Schools should not be allowed to suspend students in grades K-3 and funding should be made available to address the social emotional needs of these children.
- Require a report on a child injuring a teacher to only be forwarded to the next teacher for one year.

Education in Care and Treatment Mental Health Programs

Issue: Children and adolescents who need more intensive mental health services in day treatment and residential treatment programs are often behind in their education due to their mental illnesses and current law limits who can provide education services in these settings.

Background: Current law only allows the local district to provide education services in these programs according to the district's schedule. For some districts that means that the education hours are limited, no education is provided during the summer, and education staff are not able to be integrated into the therapeutic milieu on a consistent basis. More options need to be available to meet the needs of these children when the local district is unable to provide the needed services.

Policy Recommendation: Change the statute to allow MDE to approve other models of education services in these settings including charter schools, contracts for services or program operation of the education services.

Kognito Suicide Prevention Training

Issue: Suicide is the third leading cause of death for youth between the ages of 18 and 24, with an underlying mental illness being present in 90% of the youth who have completed suicide. According to the 2016 Minnesota Department of Education Survey, 9,352 11th graders, 9,678 9th graders, and 8,670 8th grade public school students seriously considered suicide. In Minnesota, 48 youth aged 10-19 completed suicide in 2016. Properly trained teachers can play an invaluable role in engaging youth with mental illnesses and reducing the risk of suicide.

Background: The Minnesota Legislature passed a law in 2016 requiring all teachers to take one-hour of nationally recognized suicide prevention training as part of renewing their teacher's license. Changes in teacher licensure in 2017 kept this requirement for all Tier IV and V licenses. The Minnesota Department of Health has supplemented this effort through a grant that allows schools to apply to have access to the online Kognito Suicide Prevention Training. Through this grant, administered by NAMI Minnesota, 30 school districts and over 1,000 teachers received suicide prevention training.

Kognito's online training is a SAMHSA recognized evidence-based practice that contains role-playing simulations where teachers interact with animated students exhibiting symptoms of mental distress. Teachers learn to use evidence-based techniques to engage in a conversation with a student experiencing a mental health crisis and to encourage that student to seek additional help when necessary. This training can be completed in an hour and is available 24/7 to anyone with internet access. In addition to providing the teacher with evidence-based techniques to interact with their students, the Kognito platform also provides a link to information about local mental health resources.

Policy Recommendation: Make Kognito training available in every school district in Minnesota.

- A 2-year contract with Kognito for the State of Minnesota would be $273,000, or about $44 per school.
- A 1-year contract with Kognito costs $183,000, or about $56 per school.

Criminal Justice

Administrative and Disciplinary Segregation

Issue: Segregation and isolation have negative impact on a person's mental health. Given the high rate of people with mental illnesses in prison, the use of segregation and isolation prevents people from receiving adequate treatment when there is limited treatment in the first place.

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

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

In Minnesota, limited information is available about the use of segregation; but what we do know is that this practice is often used on young adults, involves unduly harsh physical conditions, and can be extended over long periods of time. Disciplinary segregation may be imposed for relatively minor violations of prison rules. There are also discharges directly from solitary confinement back to the community, a situation which imposes enormous adaptive strains on the individuals involved.

Policy Recommendations:

HF 742/ SF 608

- Require the Department of Corrections to develop graduated sanctions for rule violations, so that segregation becomes the last resort.
- Establish appropriate physical conditions of segregated units, including reduced lighting during nighttime hours, rights of communication and visitation, and furnished cells.
- Require mandatory review of disciplinary segregation status every 15 days by the warden of institution and every 15 days thereafter. Once an inmate serves 60 days in disciplinary segregation, the inmate's segregation status must be reviewed by the commissioner or deputy or assistant commissioner and then every 30 days.
- Not allow releasing an inmate to the community directly from segregated housing. Require inmates to serve at least 30 days in the general population before their release.
- If an inmate has been placed in segregated housing for 30 or more days, their transfer to the general population must be reviewed by a mental health professional before this transfer is made.
- Require the Department of Corrections to issue a yearly report to the legislature that documents the use of solitary confinement including the number of inmates in solitary, their ages, the number of inmates transferred from segregation to the mental health unit, the nature of infractions leading to segregation.

Involuntary Administration of Medication in Jails

Issue: A person who has a mental illness and is detained in a jail may not be willing to take their prescribed antipsychotic medication. There are few places worse than jail to suddenly stop an

antipsychotic medication and because there is a lack of mental health services within the jails the outcome can be devastating.

Background: There are not enough community-based mental health services to meet the need. Unfortunately, this means that people with serious mental illness often encounter the criminal justice system before getting appropriate mental health treatment. The criminal justice system is not currently equipped to provide adequate mental health services, support or resources for inmates with mental illnesses.

According to statistic from the Stepping Up Initiative there are nearly 2 million people with serious mental illnesses admitted to jails across the nation each year. Once incarcerated, individuals with mental illnesses have longer stays in jail and are at a higher risk of returning to jail compared to individuals without mental illnesses. In addition, the costs acquired by jails are two to three times higher for adults with mental illnesses.

The jails are not set up to treat mental illnesses. They should, however, be required to follow sensible procedures so that the mental health conditions of people in jail do not go downhill while they are in the custody of the county. In some cases, through evaluation, stabilization, and discharge planning, the individual may be better off at discharge than they were at booking.

In other cases, a person in jail who is not taking medications may decompensate and become a danger to him or herself. In these situations, a sheriff may contact prepetition screening and seek a court order for commitment to administer necessary medication involuntarily.

Policy Recommendation:

- Authorize the sheriff to seek commitment and involuntary administration of antipsychotic medication to a person who is in custody and was admitted with a valid prescription for an antipsychotic medication, but refuses medication.
- Authorize the jail health care staff to implement a current Jarvis order.

Medications and Assessments in Jails

Issue: Jails follow a formulary and are not required to provide a person who is detained with the exact psychotropic medications they are prescribed. Although jails require mental health screenings during intake, mental health assessments and follow up for ongoing mental health services often do not happen. A Legislative Auditor's report (March, 2016) showed vastly different practices in these two areas, around the state.

Background: Although jails are required to administer simple mental health screenings during the booking process, there is no requirement to follow up for those who screen "positive," with either a diagnostic assessment or the implementation of a care plan. As a result, jails across the state have very different practices in responding to new inmates with mental health issues.

Maintaining healthcare costs in jails claims a large portion of the correctional budget. In order to cut costs, many facilities contract with an external health care company to control costs. These companies often have extremely limited formularies, or approved drug lists. A formulary typically contains only the most cost-effective version of a medication. Jail physicians may only prescribe medications from this list, regardless of medications the inmate is currently taking or may have utilized in the past and changing a person's psychotropic medication while they are in jail is simply not a good idea.

In the state of Minnesota, individuals coming into the jails have their current medications switched to formulary-approved medications by jail physicians. If a person gets approval for a non-formulary medication while in jail, Minnesota has no supplemental protocols in place while waiting

for the medication to be approved. If a non-formulary medication were to be approved, the inmate would still be temporarily switched to a different medication. Even a short-term change in medication can cause significant setbacks to a person's mental health.

For those inmates who are able to access their mental health medication while in jail, it can be a challenge to continue receiving their medications following discharge. One potential solution is to have the jails contract with a local community mental health provider. Not only will this allow experts to manage mental health medications for inmates while they are in prison, a community mental health provider can also continue to serve the individual following their release.

In addition, the provision of medication to people to people being discharged from jails is extremely inconsistent from county to county.

Policy Recommendations:

HF 982/SF 1323

- Require a county of regional jail to provide a prisoner who has a valid prescription for a psychotropic medication the same psychotropic medication while incarcerated.
- Require that an adequate supply of the medication be given to the inmate at discharge.
- Require that prisoners who have screened positive for mental illness, who will be in custody for 14 days or more, have a assessment by a mental health professional (unless this has been done recently), and that a treatment plan is developed and implemented.
- Contract with local community mental health provider to offer mental health services and prescribe medications in jail.

Ombudsman for Mental Health Services in Corrections

Issue: There is no central office or easily accessible grievance procedure for individuals with a mental illness who have been incarcerated. In the county jails, oversight is provided only by a small staff of state jail inspectors, who inspect a jail every two years. Recently (March, 2016), the Legislative Auditor found that many jails are understaffed, and unable to provide staff training, and needed programs for inmates.

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

Policy Recommendation:

HF 982/SF 1323

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

Community Mental Health Services to Support People in the Criminal Justice System

Issue: A number of individuals who are civilly committed for competency restoration receive treatment at the Anoka Metro Regional Treatment Center (AMRTC), which is a state-operated

hospital. Often times these individuals reach a point in their treatment where they no longer need the level of care provided at AMRTC but still need on-going competency restoration services. In addition, some individuals who are found to be not competent to stand trial are not eligible for civil commitment. As a result, there are individuals who either have no means of receiving competency restoration services or receive these services in a higher level of care than they need, preventing people who do need that level of care from accessing it.

Background: The Office of the Legislative Auditor (OLA) issued a report in February 2016 on mental health services in county jails. Two findings from the report include: (1) a need to develop a broader continuum of options to support individuals who have been found "not competent to stand trial" and need "competency restoration" services in order to participate in their defense and (2) a need to expand the availability of community mental health services that are support people involved in the criminal justice system, including Forensic Assertive Community Treatment (FACT) teams.

Policy Recommendations:

- Provide grants to counties, regional county partnerships, and/or community-based mental health providers to develop local, community-based, competency restoration services.
- Provide start-up grant funding to establish new FACT teams as well as funding to increase the capacity of Minnesota's existing traditional ACT teams to serve individuals with extensive legal/criminal justice histories

Other Issues

Improving Care Coordination Through Health IT

Issue: Better information at the point of care leads to better healthcare outcomes. Individuals with mental illness often receive poorly integrated care because they receive services from a variety of diverse settings. Electronic mechanisms now available can improve care integration.

Background: Hospitals and physician practices have widespread adoption of Electronic Health Records, but much of the care received by individuals with mental illness occurs in community settings. Many of these settings also have electronic records, but there is a failure to connect the dots and link all information. Behavioral health settings have struggled because they have been ineligible for resources. Stigma and other misinformation have worked against the integration of mental health information that is vital to care. Individuals must always give consent for information to be shared. Imagine a world where a case manager gets an alert when an individual is being discharged from the hospital so that immediate follow up can provide the needed resources to maintain them in the community and avoid readmission. Or where an individual's advance psychiatric directive is available when they check into the Emergency Department, so caregivers know their history and preferences with regard to different treatments. EMTs can know the individual's diagnosis and medication list, to intervene swiftly and effectively. A national study estimates unnecessary of costs of $65 billion annually due to a failure to coordinate care. Sixty percent of routine outpatient mental health services are not captured in the Primary Care Provider's Electronic Health Record because services are provided offsite. Records of acute psychiatric services are missing from the Primary Care Provider's record 89% of the time. All providers must have access to key mental health information.

Policy recommendations:

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

Civil Commitment

Issue: The civil commitment statute needs to be reviewed and recommendations on possible changes reported to the legislature.

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

In 2001, the Minnesota Legislature changed the commitment law by removing the words "imminent" or "immediate" from the statute in order to allow courts or families to intervene earlier when a person does not recognize his mental illness and needs treatment to prevent further deterioration or crisis. As soon as a danger is posed to the person with mental illness or others around her, the Civil Commitment process can be started. However, a formal review of the entire civil commitment statute has not been completed in over 20 years.

Policy Recommendation: The civil commitment statute is outdated and does not reflect the way Minnesota currently treats people with a serious mental illness in the commitment process. Stakeholders came together to address the civil commitment statute in a more comprehensive way.

The updated commitment task force bill will:

- Remove outdated language.
- Provide additional clarity for emergency holds, transportation holds, and who has responsibility throughout the commitment process.
- Create a grace period so that a civil commitment does not end due to a paper-work error or missed deadline.

For additional copies or if you have questions, please contact NAMI Minnesota at 651-645-2948, 1-888-NAMI HELPS or Mental Health Minnesota at 651-493-6634, 1-800-862-1799.