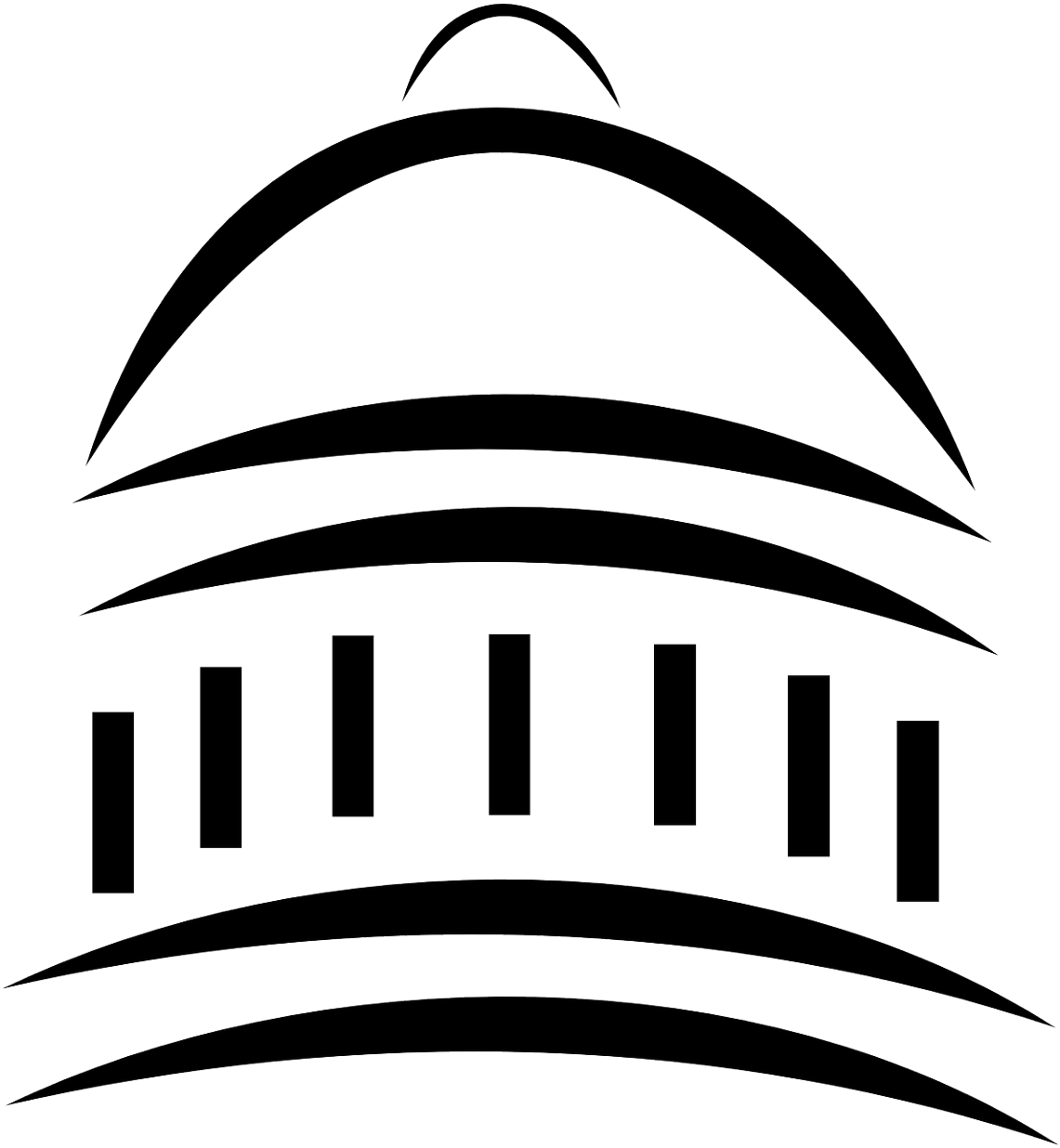
2022 LEGISLATIVE ISSUES



MENTAL HEALTH LEGISLATIVE NETWORK OF MINNESOTA

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MENTAL HEALTH LEGISLATIVE NETWORK 2022

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

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

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

ACCORD
Allina Health System
Amherst H. Wilder Foundation
Avivo
AspireMN
Barbara Schneider Foundation
Catholic Charities of St. Paul and Minneapolis
Central Minnesota Mental Health Center
Fraser
Guild
The Heart and Mind Connection
Hennepin Healthcare
Lutheran Social Service of Minnesota
Mental Health Minnesota
Mental Health Providers Association of Minnesota
Mental Health Resources
Mid-Minnesota Legal Assistance/Minnesota Disability Law Center
MARRCH - Minnesota Association of Resources for Recovery and Chemical Health
Minnesota Association for Children's Mental Health
Minnesota Association for Marriage and Family Therapy
Minnesota Association of Community Mental Health Programs
Minnesota Behavioral Health Network
MN Office of Ombudsman for Mental Health and Developmental Disabilities
Minnesota Prenatal to Three Coalition
Minnesota Psychiatric Society
Minnesota Psychological Association
Minnesota School Social Workers Association
Minnesota Social Service Association
NAMI Minnesota
National Association of Social Workers, Minnesota Chapter
Northeast Youth & Family Services
NUWAY
People Incorporated
Pregnancy Postpartum Support Minnesota
State Advisory Council on Mental Health
Subcommittee on Children's Mental Health
Touchstone Mental Health
Vail Place
Washburn Center for Children
Wellness in the Woods

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

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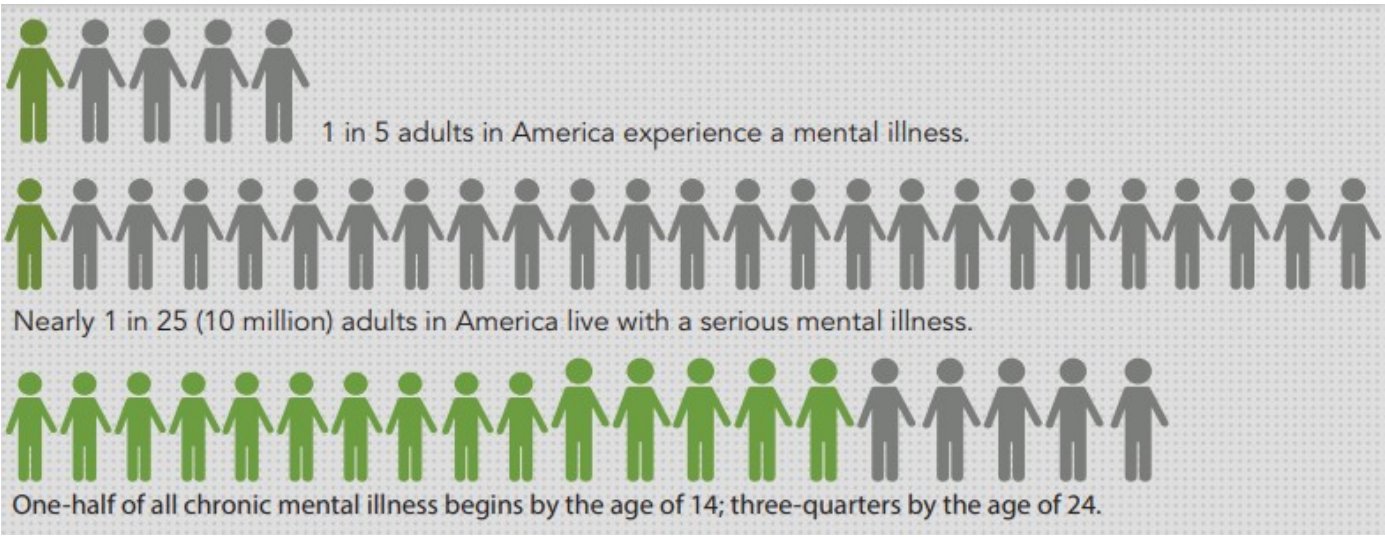
MENTAL ILLNESSES



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

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

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

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

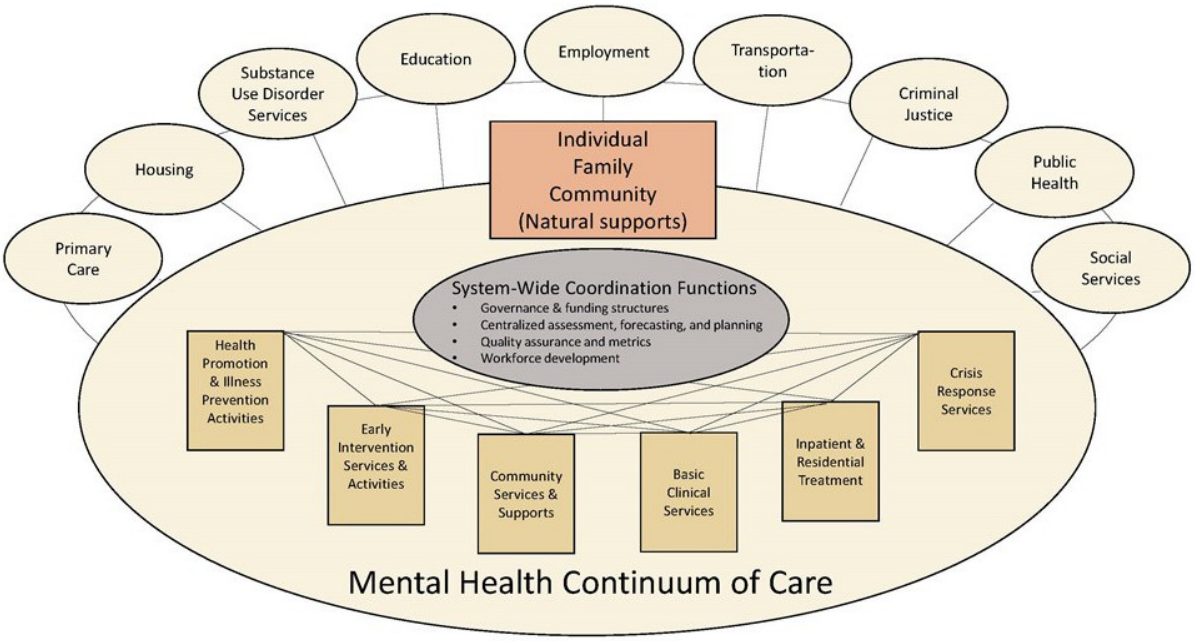
Some people need access to basic mental health treatment. Others need mental health support services such as case management (and/or care coordination) to assist in locating and maintaining mental health treatment and services. Still others need more intensive, flexible services to help them live in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

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

Although there are effective treatments and rehabilitation, the current mental health system fails to respond timely to the needs of too many children, adults and their families. Timely access to the full array of necessary mental health benefits and services, whether treatment or rehabilitation, is often limited due to lack of insurance coverage, low payment rates, workforce shortages or geographical or cultural disparities.

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

THE MENTAL HEALTH SYSTEM



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

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

Insurance Coverage: The main access to the mental health system is through insurance – either private health plans or a state program such as Medical Assistance (MA) or MinnesotaCare. For those who have no insurance or poor coverage, access is then through the county or a community mental health center. Private health plans often do not cover the full array of mental health services. Mental health parity only requires plans to ensure parity IF they cover mental health or substance use disorder treatment. Under the Affordable Care Act (ACA) individual policies and small group plans must cover mental health and substance use disorder treatment and follow mental health parity laws. Enforcement needs to be stronger.

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

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

Reimbursement Rates: Historically, poor reimbursement rates in public mental health programs have contributed to the problems of attracting and retaining mental health professionals. Improved payment to mental health providers allows providers to hire and supervise qualified workers to better meet the needs of people with mental illnesses in a timely way. Rates paid through managed care Medical Assistance are often lower than fee-for-service rates.

KEY ISSUES FOR THE 2022 LEGISLATIVE SESSION

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

More people than ever before are seeking treatment and support for their mental health concerns, but there is not sufficient access in Minnesota to the treatment and services people need. As a result, many people face a mental health crisis before they are able to get help. There is a significant human cost to this, as well as a financial one. It is imperative that we recognize mental health in Minnesota as a public health crisis that requires immediate action.

We know what works. Early intervention, evidence-based practices and a wide array of mental health services has 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 2022 Legislative Session

- Permanently enact changes that allowed for telehealth in an audio-only format
- Stabilize and increase access to effective mental health care throughout the state by increasing rates and funding, eliminating barriers to development, and streamlining regulatory systems
- Expand access to intensive treatment and supports
- Provide support and education that support children
- Help people living with mental illnesses obtain stable housing and employment
- Expand access to home and community supports through waivers and in-home services
- End the inappropriate use of the criminal and juvenile justice systems for children and adults with mental illnesses and providing adequate mental health care in these systems
- Expand the mental health workforce and improve access to culturally appropriate services
- Ensure access to mental health crisis services and support implementation of 988

SYSTEM ISSUES

Telehealth

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

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

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

Policy Recommendations:

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

Reimbursement Rates

Issue: Reimbursement rates for mental health providers are unsustainable in a time when need has grown by 800%. Providers are leaving the field because of unsustainable rates. While a rate development study is underway by DHS, funds are needed now, on an emergency basis, to meet the skyrocketing need.

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

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

Policy Recommendations:

- Create a floor for MA PMAP payments for mental health services that is equal to the fee-for-service Medical Assistance rate.
- Recognize that all providers are critical, and extend the 2007 rate increase of 23.7% to "critical access providers" to all providers.

Uniform Service Standards

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

Policy Recommendations:

- Advance legislative changes that increase access to and quality of mental health services by clarifying and streamlining standards across mental health services where appropriate.
- Improve ability of community mental health service providers to meet the immense need for quality mental health services in a time of a severe workforce shortage and inadequate reimbursement rates.

Network Adequacy

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

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

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

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

The pandemic has had a negative impact on Minnesotans' mental health – of all ages. Over 700 Minnesotans died by suicide last year. To respond to this crisis and ensure that Minnesotan's have access to mental health services, the MHLN believes it is necessary to allow any willing mental health provider to offer in-network services if they are willing to abide by the same requirements and rate structure as other in-network providers.

Policy Recommendations:

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

Certified Community Behavioral Health Clinics

Issue: Statute updates are needed to unify all state requirements for CCBHC services under uniform certified entities.

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

Thanks to the legislature's passage of 2019 through 2021 legislation, Minnesota's CCBHC model is a permanent Medicaid benefit.

As Minnesota continues to progress in our CCBHC model, the next critical step is to consolidate the numerous current licenses CCBHCs must maintain and align conflicting state requirements of the underlying services.

We are advocating for policy updates to our MN CCBHC statute, which will further align the state regulations and requirements with the founding purposes of CCBHC –

- increase access and ease for clients to receive community behavioral health care
- increase providers' ability to deliver high quality and coordinated care to children, adults and families in Minnesota
- lessen the time and capacity providers must take to complete paperwork and reporting to state regulatory agencies

Policy Recommendation:

- Update statutes as needed to unify all CCBHC services requirements under a single uniform certification

Direct Care and Treatment

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

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

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

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

Policy Recommendations:

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

Hospital Beds

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

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

When someone is finally able to access an inpatient mental health bed, they are often forced to travel hundreds of miles or even out of state. This is an unacceptable situation that would never be tolerated for someone experiencing a heart attack or another acute health need.

As the needs for mental health care are expected to increase, not decrease, it is essential that patients do not lose access to current inpatient beds, or we risk the unstable situation becoming a full-blown crisis.

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

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

Policy Recommendations:

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

ADULT MENTAL HEALTH SERVICES AND SUPPORTS

Continuum of Care

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

Background: Many people across Minnesota, including children, wait in emergency rooms for a hospital bed. Still others wait in hospital psychiatric beds for an opening at AMRTC to continue their care. To make the situation worse, many people at AMRTC do not need that level of care and are waiting to transition into the community and the state is not using all of the beds that are licensed or funded.

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

Policy Recommendations:

- Provide funding for mental health treatment to inmates in jail
- Expand the Transition to Community Initiative to serve people over age 65, people in Community Behavioral Health Hospitals (CBHHs), and people in community hospitals seeking admission to AMRTC
- Fund small IRTS projects that offer high intensity, secure facilities for people with complex mental health needs who are deemed incompetent to stand trial
- Increase the number of Forensic Assertive Community Treatment Teams
- Expand the Elderly Waiver to meet the mental health needs of older adults at AMRTC or MSH

Housing

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

Background: People with mental illnesses are much more likely to face housing instability or even homelessness. Unmanaged mental health symptoms, job loss, inpatient mental health treatment, or an experience with the criminal justice system all increase the challenges that people with mental illnesses face when trying to find and maintain a stable housing situation. People with mental illnesses cannot achieve recovery without stable housing.

Homelessness has been getting worse in Minnesota. Before the start of the COVID-19 pandemic, the most recent Wilder Homeless Count found a 10% increase in the number of people experiencing homelessness between 2015-2018 with a higher rate of growth in Greater Minnesota. Just as concerning, there was a 62% increase in the number of people that are not staying in a formal shelter setting. Most homeless adults also have a chronic health condition, with 64% of respondents having a serious mental illness and 24% living with a substance use disorder. While eviction moratoriums at the state and federal level protected many families during the pandemic, there is a significant chance of a surge in the number of people experiencing homelessness once these moratoriums expire.

Many studies show that supportive housing successfully interrupts this cycle. For those with a history of incarceration or treatment in a state-operated facility, access to permanent supportive housing significantly reduces their time in these systems. In one study, 95% of the costs of supportive housing were offset by lower treatment costs.

The grant program called Housing with Supports for Adults with Serious Mental Illness provides grants to housing developers, counties and tribes to increase the availability of supportive housing options. In the 2017 Legislative Session, supportive

housing funding was increased by $2.15 million dollars in one-time funding. The 2018 bonding bill also included $30 million dollars to develop or renovate supportive housing for people with mental illnesses.

As of October 2018, over 5,280 Minnesotans with mental illnesses were on a waiting list to receive supportive housing, including 2,390 outside of Ramsey and Hennepin Counties. Bridges provides housing subsidies to people living with serious mental illnesses while they are on the waiting list for federal Section 8 housing assistance. There are long waiting lists for this program.

Policy Recommendations:

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

Crisis Response

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

Background: Mobile crisis teams are a good alternative to a police response. Research has shown that mobile crisis services are:

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

Mobile crisis interventions are face- to-face, short-term, intensive mental health services provided during a mental health crisis or emergency. These services help the recipient to:

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

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

Policy Recommendations:

- Increase state funding for crisis teams and homes
- Allow flexibility with funding in order to meet demands at key times
- Require training on children's mental health

Clubhouses and Community Support Programs

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

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

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

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

Policy Recommendations:

- Ensure that state funding to counties is used to support Community Support Programs and Clubhouse Model Programs
- Fund Community Support Programs and Clubhouses to carry out employment programming

First Episode

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

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

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

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

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

Policy Recommendations:

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

Employment

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

Background: People living with mental illnesses face a number of barriers to finding and keeping a job. They often face

discrimination when applying for jobs and may face other obstacles such as losing health insurance coverage for their mental health treatment and medications or have a lack of transportation.

In addition, few receive the supported employment opportunities shown to be effective for people with mental illnesses and few employers know about accommodations for a mental illness.

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

Statewide expansion would require new funding for direct service (grants to providers) and infrastructure to support training, technical assistance, data collection, program monitoring, and evaluation. Not all counties follow the requirement to use some of their state mental health funds for IPS.

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

Policy Recommendations:

- Require the commissioner of DEED, in consultation with stakeholders, to identify barriers that people with mental illnesses face in obtaining employment, identify all current programs that could assist people with mental illnesses in obtaining employment and submit a detailed plan to the legislature how to expand the numbers of people with mental illnesses working
- Increase funding for the IPS program for both expansion and infrastructure, explore the use of Medicaid for IPS, require a memorandum of understanding between DEED and DHS
- Require workforce centers to have training on accommodations for a mental illness
- Fund community support programs to assist people with mental illnesses to find and keep employment
- Require DHS and DEED to consider racial and geographic disparities in their efforts to help people with disabilities obtain competitive, integrated employment.

Behavioral Health Homes

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

Background: BHH is a newer Medicaid service, beginning in 2016. As we move the whole mental health system forward, we believe our system is enriched by the broad spectrum of services, including BHH, that are available to our community of individuals who have a wide variety of needs.

BHHs are serving individuals in over 60 counties across the state, including community mental health providers and primary care providers. Since beginning in July 2016, over 2,700 individuals received BHH services. We thank the Legislature for updating and strengthening the framework of Behavioral Health Home services in 2019. The BHH is a program that can dramatically improve people's lives by treating the whole person in the community. BHH provides a mechanism to address clients' physical and mental health symptoms. Most importantly, it provides a mechanism to coordinate care and address clients' social determinants of health risk factors in conjunction with their mental and physical health symptoms.

Policy Recommendations:

- Update reimbursement rates for BHH services to ensure the rates are more reflective of the actual cost of providing this critical service, to increase access. This is the remaining proposal from the 2019 BHH reform bill.

CHILDREN'S MENTAL HEALTH

Early Childhood Consultation

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

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

Early childhood mental health consultation grants support having a mental health professional, with knowledge and experience in early childhood, provide training and regular onsite consultation to staff serving high risk and low-income families, as well as referrals to clinical services for parents and children struggling with mental health conditions. Early childhood mental health consultation has three main components:

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

Policy Recommendation:

- Increase funds to expand early childhood mental health consultation grants

School-Linked Mental Health Services

Issue: There is a need to increase funding investments in School-linked Mental Health program and rebuild/reform underlying (funding) model.

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

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

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

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

Policy Recommendations:

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

Children's Mental Health Supports

Issue: When a child is facing significant mental health challenges, there are not enough options for the child and their family to obtain the level of support they need. Without adequate support in the community, children and youth will develop more serious mental illnesses and require more intensive treatment.

Background: While some progress has been made there are still significant gaps in our children's mental health continuum of care. Respite care is a very successful program where the parents of children with a mental illness are given a break to recharge. There are currently no crisis homes for youth or crisis respite care. We also need to support parents who are living with a mental illness so that they can raise healthy children.

Building on these efforts and providing more community-based supports will allow children with mental illnesses to get the level of care they need in the community where they live.

Policy Recommendations:

- Fund training for crisis teams to understand the unique needs of children and their families experiencing a mental health crisis
- Increase funding for respite care
- Develop and fund crisis homes for children and youth
- Move funding for Evidence Based Practices out of school- linked grants and other grants and concentrate all in one grant to an agency to increase training and their use of Evidence Based Practices
- Explore developing intensive in- home services for children with a mental illness
- Fund child care for mothers with mental illnesses who have MFIP child only grants when it is recommended by a mental health professional
- Replace the term "emotional disturbance" with "mental illness" in state statute
- Fund multi-generational treatment teams
- Fund transition age programs
- Allow young adults transitioning to the adult mental health system to keep their current case manager, even if they choose to drop out of the program
- Increase funding for shelter-linked mental health grants
- Expand eligibility for intensive mental health treatment in foster care

Education

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

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

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

Policy Recommendations:

- Increase number of student support personnel
- Expand and continue Positive Behavioral Interventions and Supports (PBIS)
- Fund social emotional learning programs to reduce or eliminate use of suspensions in grades K-3
- Provide year-round education to students who miss out on school due to being in the juvenile justice system or residential mental health treatment or day treatment
- Increase funding for substance use disorder services in the schools
- Restore funding for mental health professionals to provide services in the classroom at intermediate school districts, special education cooperatives, and level IV settings
- Create a designated office of mental health within the Department of Education.
- Fund trauma informed schools
- Fund training for paraprofessionals to ensure they can work effectively with students
- Fund programs to reduce the use of seclusion and restraints

Conversion Therapy

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

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

Conversion therapy practitioners base their treatments on unscientific and inaccurate understandings of sexual orientation, gender identity, and gender expression. Being LGBTQ is not a mental illness and therefore therapy is not needed.

There is no scientifically rigorous evidence demonstrating the effectiveness of conversion therapy. Scientific studies have found negative effects associated with conversion therapy, however, including increased levels of depression, suicidal thoughts, suicide attempts, and substance abuse in adults.

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

Policy Recommendation:

- Ban conversion therapy as a harmful and ineffective practice

ACCESS TO MENTAL HEALTH TREATMENT

Workforce Concerns

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

Background: For many years Minnesota has experienced a shortage of providers for mental health services. This shortage is felt most acutely in rural areas and for culturally specific providers. Nine of eleven geographic regions in Minnesota are designated as mental health shortage areas by the Health Resources and Services Administration. This challenge is heightened with the recently documented rise in mental illness, with the Center for Disease Control estimating that fully 40% of the population meet the diagnostic criteria for anxiety, depression, or substance use disorder. As more people will need to seek mental health treatment, there is an urgency to the need to increase the supply of community mental health professionals, especially those able to meet the needs of our diverse community. In the wake of the recent unrest, it is anticipated that there will be a greater need for diverse providers.

The 2015 Mental Health Workforce Task Force made a number of recommendations to address shortages by increasing the number of qualified people working at all levels of our mental health system. 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. But more must be done due to the critical workforce shortage. We also need to invest in traditional healing models that incorporate multigenerational and multidisciplinary approaches. People of color and new immigrants face additional hurdles when trying to become licensed as a mental health professional.

Policy Recommendations:

- Fund providers largely serving Medicaid clients or diverse populations to provide supervisory hours for free for mental health certification and licensure
- Create a program to support people working in the mental health field for more than two years to obtain their master's degree to become a mental health professional
- Increase funding to train more peer and family peer specialists
- Alter the number of direct clinical hours required for the loan forgiveness program so that more supervisory hours can be provided without losing eligibility for the program
- Allow mental health professionals to be case managers
- Add state funds to the cultural and ethnic minority infrastructure grant program
- Create a website to serve as a clearing house for mental health professionals
- Increase funding for rural health professional education loan forgiveness program
- Require private health insurance to cover treatment provided by a clinical trainee
- Add LMFTs and LPCCs to the MERC program
- Provide grant funding to every Tribal Nation and Indian Community in Minnesota as well as the five urban Indian communities to support a full-time traditional healer
- Charge DHS to work with mental health licensing boards to create alternative pathways to licensure for mental health professionals from diverse backgrounds.
- Require DHS and MDH to convene licensing boards to develop recommendations for cross-licensure supervision, counting internship hours towards licensure, and practicum hours towards supervisory experience.
- Expand licensing supervision requirements to increase the virtual supervision options, including interactive audio and visual communication, up to 100%

Suicide Prevention

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

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

Policy Recommendations:

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

988 Implementation

Issue: With the implementation of 988 as the new three-digit number for the National Suicide Prevention Lifeline, Minnesota must build the capacity needed to respond to incoming calls, texts and chats 24/7 beginning July 2022.

Background: A federal law in 2020 designated 988 as the new nationwide three-digit number for the National Suicide Prevention Lifeline. This new 3-digit number will replace the current 10-digit number (800-273-8255). Beginning July 16, 2022, anyone can dial or text 988 to reach the Lifeline. All states, including Minnesota, are expected to handle 988 calls, chats, and texts within their states 24 hours a day, seven days a week.

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

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

Policy Recommendations:

- Increase network and capacity of Minnesota Lifeline response centers to meet the goal of answering 95%+ calls, texts and chats in-state
- Create a back-up call center within the state to minimize use of regional call centers in other states
- Ensure that all Lifeline centers in Minnesota meet minimum standards set by 988, including the ability to provide a warm hand-off to crisis services or emergency services as needed
- Establish a statewide 988 special revenue fund
- Implement a 988-telecom surcharge on all wired lines, wireless, prepaid and VOIP lines to support 988 work

Community Mental Health Treatment

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

Background: While we have come a long way in Minnesota in the development of our community based mental health services system, we must continue to grow our community based mental health service system in order to meet the critical

mental health needs present in our communities. We know what works in the area of community based mental health services: earlier intervention services provided where Minnesotans with need for services are located and a continuum of care with transitions allowing individuals to move to levels of care that meet their changing levels and kinds of need.

Policy Recommendations:

- Increase funding for the community mental health system, including grant programs that support Assertive Community Treatment (ACT) teams, First Episode Psychosis programs, mental health crisis teams, and more
- Review the role of the county as the mental health authority
- Expand transportation options so that more people can be involved in the community

MA Reimbursement for Collaborative Care Management (CoCM) Codes

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 (both primary care and specialist) and improved patient satisfaction, thus *achieving the quadruple aim*.

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 pay 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 was convened by ICSI in 2021. The group resoundingly expressed that integrated behavioral health care in primary care, specifically CoCM, is a solution that must be expanded.

Because payer alignment is necessary to ensure economic viability for providers and patient access to care, one of the key findings of the multi-stakeholder group was: *"CoCM codes need to be covered by Medicaid in Minnesota."*

Policy Recommendation:

- Mandate that Minnesota Medical Assistance and MN Care pay for all necessary collaborative care services in all settings (CPT Codes 99492, 99493, 99494, and 99484, and corresponding G-Codes G0502, G0503, G0504, and G0507). The rates for all CoCM codes need to be set at a sustainable rate AND broadly publicize this fact and the details of the sustainable rate.

CRIMINAL JUSTICE

Competency Restoration

Issue: Everyone charged with a crime in the United States has the right to a fair trial. If a person can't understand what's happening in court or work with their defense lawyer, they are legally incompetent - they cannot plead, be tried, or be sentenced. Right now, there is no law in Minnesota holding any agency responsible for restoring people to competency. The only directive is that people ruled incompetent will be referred for civil commitment (court ordered involuntary treatment). Civil commitment is a high legal standard – a person must be dangerous to themselves or others. Only about half of the people ruled incompetent will meet the commitment standard. The rest fall into a gap with no engagement or supervision except examinations every six months.

The number of cases where a defendant was examined for competency increased 73% from 2014 to 2018. Judicial branch spending rose 40% in that same period, topping off at over $6 million spent in 2018 on forensic exams alone. Additionally, navigating the legal and mental health systems is difficult for anyone. Many people ruled incompetent have complex social needs and may be facing serious charges without any formal support system. The lack of clear directives, support for defendants, and community competency restoration programs is costing Minnesotans safety, money, and justice. Right now, we are all paying for a dysfunctional system - millions in inefficient court exams, civil commitments, and a revolving door of incarceration and re-arrest. The impact is missed opportunities to engage treatment, reduce crime, and experience recovery for thousands of Minnesotans.

Background: In 2013 the Legislature passed the "48 hour" law. The law requires DHS to admit people from jail who have been civilly committed to Anoka Metro Regional Treatment Center (AMRTC) within 48 hours of the order. As the number of people found incompetent to stand trial increased year over year, it caused an incredible strain on DHS's ability to serve people in the community. DHS took on the responsibility to not only treat people at AMRTC but work to restore their competency before provisionally discharging them. To serve more people in the community, DHS decided in 2018 that they would treat patients to stability but would no longer wait for people found incompetent to be legally restored before provisionally discharging them. With no directives in the law and no community programs, the issue persisted but now includes people who did not meet the commitment standard *and* people discharged from AMRTC.

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

Policy Recommendations:

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

Criminal Justice

Issue: Recent data from the Department of Justice shows that over half of the adults incarcerated in prisons and jails experience mental illnesses, and around 70% of juveniles have a diagnosable mental health condition. While we work to build our mental health system, people with mental illnesses remain disproportionately vulnerable to harmful law enforcement encounters and involvement in the criminal legal system. Minnesotans need more access to adequate mental health treatment at every point in the justice system, and trauma-informed professionals from law enforcement and jails, to courts, prisons, and reentry. Decriminalizing mental illnesses not only saves resources in the long term, but it saves lives and promotes safety and justice for all Minnesotans.

Background: Last year, Travis' Law passed requiring 911 to work with mobile mental health crisis teams across the state. As the work to implement Travis' Law is ongoing, there are many other ways to improve responses to people in crisis. The community needs clarity and coordination from the various responses being offered right now by clearly distinguishing mobile crisis teams, co-responders, mental health units, and embedded mental health professionals in law enforcement agencies. The legislature must also ensure that the mental health of law enforcement officers is a priority through wellness programs and annual counseling sessions.

If a person with a mental illness is taken to jail, the care they receive can vary greatly from facility to facility during an incredibly vulnerable time. Being arrested and booked into jail is a frightening and isolating experience. On top of the emotional impact, people in jail can lose access to important medications, assistance programs, employment, and supportive connections. Promoting recovery over punishment means reducing barriers to people getting the help they need, even in correctional settings. One simple way to increase access to help is making phone calls to case managers and mental health professionals from jail be free. Jails should also be incentivized to contract with community providers so there is a continuum of care at booking and discharge. Additionally, more resources are needed for jail social workers and training for staff.

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

Policy Recommendations:

- Create incentives to contract with local community mental health providers to offer mental health services in jail and continuum of care upon release
- Ensure and expand mental health care in jails including: access to ITV, broad lists of prescription medications, mental health treatment, and appropriate health staff to involuntarily administer medications
- Provide resources for officer wellness programs following best practice for first responders to get help
- Review critical incident debriefing practices to follow trauma-informed best practices
- Create a centralized database for the juvenile justice system
- Reform sentencing and record keeping laws to reduce harmful collateral consequences
- Provide resources for families with incarcerated loved ones including increased quality visitation for children
- Make calls from jail to mental health providers and case managers free for prisoners
- Make calls and video communication from prisons to family members free
- Create and fund effective alternatives to incarceration for juveniles
- Fund more family support staff in the Department of Corrections

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 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 people are successful as they serve their sentences. Startling data from the Department of Corrections last year showed thousands of people are being released from prison into unsheltered homelessness each year.

Background: Minnesota prisons do not have enough resources to meet the mental health treatment needs of prisoners. On top of this shortage of resources, many people are returned to prison for less than 90 days for technical probation violations, where they will not be engaged in programming for such a short sentence. Thus, many people are removed from their community where they may be working, engaging treatment, and supporting families and are returned to prison on small violations with no support, risking loss of treatment, employment, and housing. Minnesota must prioritize resources to people who are on community supervision to ensure that they are successful in the community and to 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 funding for mental health services
- Place fewer conditions on eligibility for mental health services in prison
- Increase diversion of technical-violators, lower-risk-level, non-violent offenders out of the prison and jail systems and into community based alternatives to incarceration; these programs are associated with much better life outcomes, and greater reductions in recidivism and relapse rates compared to correctional programming in institutions
- Increase the use of evidence-based practices for criminal justice involved persons in community programs and services, that increase social capital, resiliency factors, and life skills and decrease recidivism and relapse rates of offenders diverted to or released to the community
- Reserve the limited capacity of the prison and jail system for high risk level offenders who are a threat to public safety; and de-carcerate through available release options
- Provide transitional services to these target populations so that they are eligible for benefits, are assessed for treatment needs, and connected with community providers and supports before and upon release
- Create personalized incentive plans for prisoners to earn early release and reinvest the money saved into community services

OTHER ISSUES

Coordinated Care in Integrated and Culturally Diverse Health Settings

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

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

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

Policy recommendations:

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

Cannabis Legalization

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

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

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

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

Policy Recommendations:

If recreational cannabis is to be legalized, the MHLN recommends that these considerations be prioritized:

- Increase investments in our mental health and substance abuse treatment system
- Increase investments in first episode psychosis programs.
- Invest in research and data collection on the effects of cannabis use prior to legalization

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

Establishment of License for Behavior Analysts

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

Background: While Board Certified Behavior Analysts are mentioned in Minnesota Statute in eight places, they are currently practicing without a licensing board to oversee them. Behavior Analysts serve individuals in their homes, clinical settings, adult residential settings, and schools. Proposed legislation establishes a license for professionals in Applied Behavior Analysis (ABA) under the Board of Psychology. This will ensures 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.

Access to Tobacco Dependence Treatment

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

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

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

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

Policy Recommendations:

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