

NAMI Minnesota 2021 Legislative Goals

NAMI Minnesota champions justice, dignity, and respect for all people affected by mental illnesses. Through education, support, and advocacy we strive to effect positive changes in the mental health system and increase the public and professional understanding of mental illnesses. -- To this end, NAMI advocates for policies that increase access to appropriate treatment and supports that enable children and adults to achieve their hopes and dreams.

Every legislative session elected officials face competing priorities and tough decisions. This year will be no different, except that a significant budget deficit, an economic recession, and ongoing efforts to respond to the worst pandemic in over one hundred years mean legislators will face even tougher decisions.

The impact of COVID-19 on our economy and state budget is clear, but we must also remember the impact on Minnesotan's mental health. In a CDC report from this summer, 40% of adults reported struggling with their mental health or a substance use disorder and just over 10% of respondents reported seriously considering suicide in the previous 30 days. Black and Latinx respondents reported higher rates of substance use and suicidal ideation than white respondents. Essential workers also reported having more acute mental health symptoms. The stress associated with job loss, challenges in the workplace, social isolation, and disrupted childcare or schooling are all leading to this alarming increase in the rates of mental illnesses.

More people than ever need mental health and substance use disorder treatment, so we simply cannot afford to go backwards and cut mental health funding. Our mental health system is still under construction and too many people were falling through the cracks even before the COVID-19 pandemic. Cutting grant programs for school-linked mental health grants or mobile crisis teams will not reduce the need for mental health services. Instead, these cuts will simply push people to other more expensive parts of our system such as hospitalization or incarceration. The top priority of NAMI Minnesota and our grassroots network of advocates is to prevent all cuts to mental health funding.

Even in a challenging budget environment, we still believe is possible to make progress and improve our mental health system. The following legislative goals represent longstanding priorities of the mental health community and reflect input from an annual survey of NAMI members and supporters.

Adult Community Mental Health Treatment

Most adults access their mental health treatment in the community. People should receive help in the community where they live instead of a more restrictive institutional setting. There is a continuum of care for community-based treatment ranging from outpatient treatment from a therapist, to mobile crisis teams, intensive treatment in the person's home, residential treatment, and hospitalization. NAMI Minnesota is committed to driving investments in our community mental health system. NAMI will work on the

following issues:

- **Assertive Community Treatment (ACT) Teams:** ACT teams are a multi-disciplinary team of mental health professionals, practitioners, and peer specialists that provide wrap-around supports for people with a serious mental illness. Services are available 24/7 in the community and the ACT team has a single, fixed point of responsibility for the treatment, rehabilitation, and support needs of clients, including finding housing and obtaining employment. NAMI Minnesota supports increasing start-up funding for both ACT teams and Forensic ACT teams that work with people who have had an encounter with the criminal justice system.
- **Co-occurring Treatment:** With 50% of people living with a mental illness having a co-occurring substance use disorder, and few receiving integrated treatment, NAMI supports increasing funding to incentivize providers to provide evidence-based treatment. It is also very important for substance use disorder providers to offer additional treatment paradigms beyond the twelve-step approach. There is no one-size fits all standard for recovery and many people are not as receptive to faith-based or 12 step approaches to treatment.
- **Cultural Healing:** Address the needs of Black, Indigenous, and other people of color's need to connect with their culture for healing, including allowing elders and healers to be peer specialists.
- **Diagnostic Assessments:** The requirements for a new DA often delay access to care and treatment. This process should be streamlined especially when the DA has not significantly changed over the years, nor have the symptoms of the person involved.
- **Engagement in Services:** In the last session, the legislature passed a comprehensive update of the civil commitment statute. One key change was replacing court-ordered early intervention with new language to promote early intervention by working to engage a person in treatment voluntarily. The goal is to engage someone to accept treatment, services and supports early on, when symptoms are appearing and to prevent someone from being hospitalized, committed, or going to jail. Under current law, counties can opt-in to providing engagement services, but there is no financial support to do so. While we believe many counties have the existing capacity to offer this level of support now such as mobile crisis teams, providing funding to sustain the program is the best route long-term. NAMI Minnesota supports developing a grant program to encourage counties to offer this program, as well as funding for DHS to track the outcomes of people who receive early intervention and support.
- **First Episode Mood Disorder Programs:** The FEP program is a successful and evidence-based intervention that could also be effective for young people with other serious mental illnesses like bipolar disorder or major depression. Like FEP programs, a first episode mood disorder program provides early and intensive treatment as soon as a young person experiences the symptoms of a mood disorder. NAMI Minnesota supports funding for this program to pay for the important services – such as a person to help with employment and education – that are not paid for by insurance.
- **First Episode Psychosis (FEP):** The word psychosis refers to conditions that affect

the mind where the individual has lost some contact with reality, including hallucinations, paranoia, or delusions, as well as disordered thoughts or speech. Psychosis often begins when a person is in their late teens to mid-twenties and can be a symptom of a mental illness. FEP programs provide an early and intensive intervention when someone experiences their first psychotic episode and helps them get back to work or school. Early treatment for psychosis is crucial, but studies show that many will wait over a year after their first psychotic episode before accessing treatment. FEP programs make an immediate intervention before the person's psychosis becomes debilitating. There are currently four FEP programs in Minnesota and we need at least eight.

- **Intensive Residential Treatment Services (IRTS) Facilities:** IRTS facilities provide residential care for up to 90 days, most often when someone is at risk of hospitalization or are stepping down from a higher level of care. IRTS facilities are relatively small with less than sixteen beds and offer around the clock care. NAMI Minnesota supports expanding the number of IRTS facilities and creating a model that could safely support people coming from the jail or a state operated program when the person is deemed incompetent to stand trial.
- **Local Advisory Councils:** Minnesota requires counties to establish Local Mental Health Advisory Councils (LACs) where people with mental illnesses, family members, and local providers can share their experience and offer input to policy makers at the county level. Minnesota counties have an important role in our mental health system and it is important for them to hear from those with lived experience. NAMI Minnesota supports DHS dedicating resources to coordinate, train, and support LACs across the state. It is also crucial for leaders at the county level to ensure that LACs are heard during opportunities for public input on the development of the local mental health system.
- **Mother Baby Programs:** There are excellent programs that treat the mother of a baby or young child together, so that they are not separated. Programs such as these have higher costs and should be reimbursed at a higher level.
- **Sober Homes:** Sober homes provide a chemical free environment for people in recovery from a substance use disorder to live with their peers. Sober homes do not provide medical treatment and are not currently licensed at the state level, although some substance use disorder providers require residents to stay at a sober home as a condition for receiving outpatient treatment. NAMI Minnesota has received numerous complaints about sober homes including poor living conditions, substance use in the residence, and mismanagement. Currently, there is no place for residents to register their complaints about poor service. NAMI Minnesota supports developing a process for sober home residents to lodge complaints and to bring together stakeholders to discuss potential strategies for oversight of sober home operations.

Cannabis

The legalization of recreational cannabis is an unavoidable issue at the legislature. As more states move to legalization, Minnesota must make careful considerations of the risks associated with recreational cannabis use, and take the proper steps to protect people who are at a higher risk for negative impacts such as children and youth, people with

mental illnesses, and people in the criminal justice system. Research has tied cannabis use to negative outcomes for people with mental illnesses including increased risk of experiencing psychosis in some people. NAMI Minnesota will advocate for strong measures to reduce harm and continue to build our mental health system if Minnesota considers legalization:

- **Decriminalize:** While NAMI cautions Minnesotans to move slowly on full legalization of recreational cannabis, decriminalization can be done immediately. Minnesota law charges possession of more than 42.5 grams (about 1.5 ounces) of marijuana as a felony. 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. Furthermore, the racial disparities associated with the criminal justice system are well documented, and criminalizing drug use is a primary source of racial trauma in the BIPOC communities by separating families through incarceration and undermining social supports necessary for recovery. Considering the prevalence of co-occurring substance use disorders with mental illnesses, and the discrimination that people with criminal histories and mental illnesses already experience, decriminalization is the best way forward for promoting recovery in our communities. NAMI will advocate for decriminalization and avenues to expunge past convictions and restore rights to those who have been harmed by these laws.
- **Increase investments:** Because recreational cannabis use is associated with negative outcomes for people with mental illnesses and substance use disorders, legalization should not be considered without adequate funding into prevention and treatment, to meet new and increased needs. This should especially include investments into first episode psychosis programs.
- **Labeling:** It's important that labeling in terms of strength and amount be clear.
- **Research:** Any legalization of recreational cannabis must be rolled out slowly and with extensive research and data collection to monitor the effects of legalization on education, car accidents, homelessness, and other psychosocial factors.
- **Youth:** If legalization is considered, then proper protections must be implemented to educate youth and families on the possible adverse effects of marijuana use, especially for families with histories of serious mental illnesses. NAMI also contends that the legal age for cannabis use should be 25 because this is the age when the adolescent brain stops growing and developing.

Children's Residential Treatment

Children's Residential Programs provide high-intensity services for children and youth with serious mental illnesses. Implementation of the Federal Family First legislation will lead to significant changes in how families will access this level of care. The intent of this legislation is to reduce out-of-home placements and the use of congregate care (residential treatment) centers. While the focus is on child protection, this will also have a significant impact on children with mental illnesses who need residential mental health treatment.

NAMI Minnesota and the mental health community have significant concerns about requirements for children voluntarily seeking mental health treatment at a residential program to undergo an embarrassing and unnecessary relative search and enlarged juvenile screening team. While we were unable to reach an agreement with the Department of Human Services in the 2020 legislative session, we are working over the interim to find a solution that works for everyone.

Minnesota has also recently created a new level of care called a Psychiatric Residential Treatment Facility or PRTF, where children and youth receive more intense care than at a residential facility but less intensive treatment than an inpatient psychiatric unit. Unlike children's residential programs, PRTFs are not considered an Institute of Mental Disease (IMD) and can bill Medical Assistance, but private insurance is still not covering treatment at a PRTF.

Unfortunately, it has been very challenging for new PRTFs up and running due to licensing challenges with DHS and MDH. There are two operating PRTFs in the state and two more that are soon to be operational. NAMI will work on the following issues:

- **Family First:** One of the funding streams for children's residential programs are Federal Title IV-E dollars. In the past, DHS and the mental health community reached a compromise that would allow for children and youth who are voluntarily seeking residential mental health treatment to avoid extensive interactions with child protection services, such as a relative search. Unfortunately, complications with the Family First Legislation has disrupted this compromise. The long-term solution to this problem is to replace Title IV-E dollars with an appropriation from the state. In the meantime, NAMI Minnesota and our partners are working with DHS to reach a compromise around children and youth who are voluntarily seeking residential treatment, which may include state dollars being used to pay for room and board so that IV-E dollars are not used.
- **PRTFs:** This is a relatively new level of care in Minnesota and there are still unnecessary hurdles to developing PRTFs. It is crucial that the Departments of Health and Human Services collaborate and eliminate overlapping and conflicting rules. Differing reporting requirements and other inconsistent regulatory standards create unnecessary confusion and make it harder to license new PRTFs and operate existing programs.
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Community Children's Mental Health Services

Half of all mental illnesses emerge by the age of fourteen. If these children wait until they are adults to begin receiving treatment, they will have waited too long. Untreated or undertreated mental illnesses have numerous negative impacts and increase the likelihood that the child or youth will be suspended, drop out of school, or end up in the juvenile justice system. One of the most important community-based programs for children is school-linked mental health. Under this model, community-based mental health providers co-locate in the school building in order to provide on-site mental health treatment. These

providers can bill Medical Assistance and private insurance, while also having the expertise to abide with HIPAA and maintain a firewall between a student's private health information and their educational records. Half of all students who receive school-linked mental health treatment received care for the first time, with half of these students having a serious mental illness.

Early intervention and access to comprehensive mental health treatment at school and in the community is hugely important, but some children and youth are going to require more intensive support than they can get through visits with a therapist. Unfortunately, there are very few options for children to receive intensive mental health supports in the community.

Minnesota has multiple community-based programs with very successful outcomes for children with complex mental health needs like Youth Assertive Community Treatment (ACT) Teams or Intensive Treatment in Foster Care (ITFC).

Youth ACT provides 24/7 support from a multi-disciplinary team of mental health providers for youth with serious mental health needs. NAMI introduced legislation in the 2020 session to allow older and younger children to be eligible for Youth ACT services. Currently the services are restricted to youth between the age of 16 and 20. While some policy changes were passed into law, we were unable to expand age eligibility criteria.

To make matters worse, Youth ACT and ITFC are chronically underfunded and do not reach enough children. In the past year, two of the four Youth ACT providers dropped out of the program due to low reimbursement rates. These programs work and it is unacceptable that they are inadequately funded.

NAMI Minnesota is committed to building our community-based mental health system for children and youth. NAMI will work on the following issues:

- **Children's Crisis Teams:** Children and youth can also access mobile crisis services. However, mobile crisis teams still need more training in order to effectively engage young people experiencing a mental health crisis.
- **CTSS:** Children's Therapeutic Services and Supports or CTSS is a flexible package of mental health services for children and youth under the age of 21. Counties, community mental health programs, hospitals, tribal entities, and special education programs can all offer CTSS services. Core CTSS services include therapy, skills training for the child and family, crisis assistance, treatment plan development, and other supports that meet the need of the child or youth. NAMI Minnesota supports efforts to improve the quality of care and funding for CTSS to better serve children with mental illnesses.
- **Conversion Therapy:** Conversion therapy is the fraudulent practice where someone claims to "cure" someone of being LGBTQ. Children and youth subjected to conversion therapy experience significant trauma and are at much greater risk of dying by suicide. NAMI Minnesota supports a ban on the use of conversion therapy for LBGTQ youth and vulnerable adults. This would not have any effect

on consulting a trusted advisor or faith leader with questions about sexual identify.

- **Crisis Homes:** Unlike the adult system, there are currently no crisis homes that can serve children who need to stabilize in a more structured environment with ongoing mental health supports. Crisis homes for children could help children avoid a hospitalization or step down from more intensive treatment at a residential program. NAMI supports developing and funding crisis homes for children and youth.
- **Early Childhood Mental Health Consultation:** The suspension rates for very young children in early learning programs or pre-kindergarten are unacceptably high, particularly for young students of color. Early childhood mental health consultation provides support for school staff to recognize the impact of trauma and emotional dysregulation in young children in order to avoid suspension. NAMI Minnesota supports increasing funding for this vital program.
- **Emergency Rooms:** There is a serious lack of inpatient hospital beds for children with a mental illness and there are no psychiatric emergency rooms for them. NAMI will support the development of psych ERs and encourage more beds.
- **Emotional Disturbance:** Currently, Minnesota law classifies young children as having an “emotional disturbance” rather than a mental illness. This language is needlessly abrasive and creates confusion with the eligibility standards for special education and the category of a child with an emotional or behavioral disorder. While there will have to be nuance around the use of this term for very young children, NAMI Minnesota supports replacing references to an emotional disorder with a mental illness.
- **MFIP Child-Only:** Families who receive support through the MFIP child-only program do not receive any assistance obtaining child-care. This makes sense because the parent is not required to work and thus can care for their child. Unfortunately, this arrangement does not work for parents with a serious mental illness, many of whom face the impossible choice of leaving their young child alone in order to access medically necessary treatment for their mental illness. NAMI Minnesota supports allowing Minnesota Family Investment Program (MFIP) child-only parents to receive childcare upon the recommendation of a mental health professional.
- **Respite Care:** It can be exhausting to be the primary caregiver for a child or youth with a serious mental illness. Respite care is an important service that allows for parents and caregivers to recharge, while someone provides appropriate care and supervision of the child. Respite care reduces out-of-home placements and hospitalizations and is an important part of the continuum of care for children with mental illnesses. Funding for respite care, including crisis respite care, needs to be increased.
- **School-Linked Mental Health:** The legislature made significant progress in funding school-linked mental health programs in the previous biennium. In addition to new funding, policy changes were made that clarified the eligible uses for grant dollars. Although school-linked programs can bill public and private insurance, grant dollars can cover burdensome co-payments, build the capacity of schools, purchase telemedicine equipment, and other important roles. Despite new

funding, school-linked mental health services are still not available in every school building in the state nor are they able to meet the needs within current schools.

- **Youth ACT Teams:** Youth ACT teams are one of the few intensive, community-based treatment options for children and youth. Unlike Adult ACT teams, youth can be eligible for Youth ACT teams without having a diagnosis of psychosis. NAMI Minnesota supports efforts to expand Youth ACT eligibility to younger children and youth over the age of 18 who are transitioning to the adult mental health system and to adequately fund them. NAMI also supports making the transition from Youth ACT to Adult ACT more seamless.
- **Transition Age Mental Health Services:** Far too often, teens fall through the cracks when they transition from the children to the adult mental health system. Additional support and attention from the mental health system is necessary to maintain the continuity of care for youth during this stressful period in their life. NAMI will work to improve transition services for youth with mental illnesses between school and college or employment (TIP model).

Criminal Justice

Whether it's a nuisance crime like spitting or something more serious, people with a mental illness are much more likely to have encounters with the criminal justice system that can result in a dangerous encounter with the police, time in jail, or incarceration. We need to prevent these encounters but also ensure that everyone receives the mental health treatment they need in jail, prison, and as they transition back to the community. NAMI will work on the following issues:

- **Competency Restoration:** If a defendant in criminal court has a mental illness or cognitive impairment and cannot understand the court process or contribute to their own defense and work with their attorney, they are deemed incompetent to stand trial (IST). The process in Minnesota to determine if a person is IST and to restore them to competency is complex and wrought with gaps and delays, which are costly and often fail to meet people's needs.

One of the largest issues is a lack of coordination between the court system and the mental health system. Several states have created positions called "forensic navigators" to help people with mental illnesses in the court system, especially those who are found IST. Forensic navigators can help people connect to treatment and social supports and lower the risk that a person will miss a court date or an evaluation and be returned to jail.

They also help expedite the process by ensuring that records are shared quickly between providers and court officials and they could provide competency restoration education in the community or in jail. Following the recommendations of the Community Competency Restoration Task Force, NAMI will be working to increase diversion and prevention, increase mental health education for court officials and the quality competency examinations to reduce the time that people found IST spend in the justice system.

We will also work to address racial disparities across the system and increase access for BIPOC people to enter the workforce, as well as to create and fund community competency restoration programs and forensic navigator programs.

- **Crisis Response:** While Minnesota's mental health system remains under construction, law enforcement is left as the primary responders to mental health crises. Some of the largest barriers to accessing a mental health response during a crisis are lack of funding for crisis teams, collaboration with 911 dispatch, and inadequate partnerships with law enforcement. NAMI will be working to avoid cuts and increase resources to mobile crisis teams. We will be working to require 911 dispatch to be trained in de-escalation and recognizing mental health crises and to send out crisis teams when it is safe and appropriate. We will also work to increase co-responder teams of community providers and law enforcement and create pilot programs for police to connect quickly with crisis teams through tablets and telehealth services. We will also work to encourage counties and crisis teams to use protected transport more frequently.
- **Families and Incarceration:** Research from the University of Minnesota has shown that the children of incarcerated parents have increased adverse childhood experiences (ACEs) and poor health and social outcomes throughout their development, including increased mental illnesses and substance use disorders. Children of incarcerated parents are also more likely to encounter the juvenile justice system themselves. The same research reported 56% of incarcerated men and 66% of incarcerated women in Minnesota had minor children living with them at the time of their arrest, higher than the national average. Additionally, the 2018 Children of Incarcerated Parents Work Group reported racial disparities and several systemic gaps in addressing the needs of children, including "confusing and stressful" visiting processes at jails and prisons. This is significant as families with lived experience have expressed the benefit of visitation and a 2020 U.S. Department of Justice study of Minnesota prisons reported that visitation reduced recidivism rates for prisoners. NAMI will be working to simplify and increase access to visitation and supports for children and families of prisoners.
- **First Responder Wellness:** First responders of every kind routinely experience more traumatic events and higher rates of suicide than the general public. However, systems of support and access to trauma-informed and professionally specific care are not broadly available to most. Failing to properly support our first responders impacts their lives and families, and ultimately the entire community's safety. NAMI's national office worked with the U.S. Department of Justice's Office of Community Oriented Policing Services (COPS) in 2018 to release a report addressing police officer wellness with recommendations for maintaining officer mental health. The report detailed elements of a continuum of mental health and wellness programs for officers. First responders should receive preservice education and training about mental health and trauma. Many supports can be embedded into departments for all first responders to promote wellness such as EAP programs, peer-to-peer support programs, dedicated staff for resources and referrals, and off-site mental health professionals hired by the department to provide privacy and safety for responders who seek help. Leadership within

departments is crucial in modeling a healthy work/home balance, exercising, taking vacation, and changing culture that equates seeking help to being weak. Implementing trauma-informed practices for debriefings of critical incidents are important so that required administrative reporting does not re-traumatize first responders. NAMI Minnesota will advocate to protect necessary funding to maintain current wellness programs in Minnesota emergency response departments, and for new innovations and programs to support first responder wellness.

- **Increase investment in diversion programs:** Many people with mental illnesses can be diverted away from punishment and into treatment. Diversion can happen at every point in the process: before an arrest, after booking, during court appearances, and even after conviction by sentencing to treatment or by using a mental health court. Successful diversion programs require partnerships between the mental health system, social supports, and justice professionals like law enforcement, prosecutors, public defenders, and judges. By embedding community providers at every point in the process they can coordinate with law enforcement pre-arrest so that no charges are filed or coordinate treatment and social supports with agreements to resolve charges with lawyers and judges. NAMI will work to avoid any cuts to diversion programs and increase incentives and resources to expand programs and mental health courts in Minnesota.
- **Mental health care in jails:** While every jail in Minnesota screens for symptoms of mental illnesses at booking, conducting an assessment when a person will be in the jail for two weeks or more rarely happens. Follow up care varies greatly with few jails providing adequate mental health care while a person is awaiting trial. Because most people only stay in jail for a few days, NAMI is working to ensure that people who stay longer than 14 days are connected to an assessment and treatment. This should include access to effective medications in jail and at release, Medication Assisted Treatment (MAT) for people with substance use disorders, therapy, ITV care, and health care workers who will administer medications under JARVIS orders (court ordered involuntary medication). Several innovative programs in Minnesota have embedded community social workers in jails to provide better screening, create a continuum of care through discharge planning, and coordinate diversion when possible. Some jails contract with community providers as the mental health care provider which NAMI supports as a best practice. In 2020, the Department of Corrections (DOC) also came under scrutiny for a history of violating suicide prevention policies and failing to adequately investigate jail deaths. NAMI will work to expand diversion programs and community partnerships, and to ensure the best practices for suicide prevention are in policy and being followed with appropriate oversight and accountability.
- **Prison and probation issues:** Minnesota prisons do not have enough resources to meet the mental health treatment needs of prisoners. The DOC reported in 2018 that 66% of prisoners used mental health services and in 2019 that 90% of prisoners are diagnosed with a substance use disorder (SUD). However, the department is only funded to serve less than 25% of those prisoners with a SUD and has faced numerous issues providing adequate treatment staff, which means

less prisoners receive services and overall conditions become less safe for staff and prisoners.

Another issue is that many prisoners in Minnesota are sentenced to less than 90 days for technical probation violations, but due to the lack of resources people with such short sentences are not engaged in ongoing treatment or programming. 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. Moreover, the Minnesota Sentencing Guidelines has reported significant racial and geographic disparities in probation revocations.

NAMI will be working to increase community alternatives to returning people to prison for violations and increase resources for probation officers and the DOC to provide treatment and transitional support to prisoners.

Education

Schools are often the place where the signs of a mental illness are first recognized. Whether it's support from a school counselor or treatment from a school-linked mental health provider, many students rely on schools to access mental health services. Children with mental illnesses have high suspension and dropout rates, poor transition planning, and are more likely to experience the use of seclusion and restraints. Unfortunately, poor student mental health is a growing problem. In the 2019 Department of Education student survey, 13% of students reported seriously considering suicide in the past year, which is up from 9.7% in 2013. With COVID-19 we know the need is increasing and it is crucial for the legislature to support the full continuum of mental health supports in schools.

NAMI will work on the following issues:

- **Exclusionary Discipline:** Too many students are unnecessarily suspended and expelled, with children of color much more likely to experience exclusionary discipline. All disciplinary interventions must be trauma-informed, culturally appropriate, and prevent students from entering the school-to-prison pipeline. We must build on work in the last session and prevent the suspension and expulsion of students up to grade three.
- **Intermediate Districts and Special Ed Coops:** Intermediate school districts and Special Ed cooperatives work with students who have the highest needs, including many students with mental illnesses. In 2017 the legislature provided \$4.9 million for a more intensive program in the Intermediate Districts and Special Education Coops so that they could develop more therapeutic teaching models to support children who have intense and high complex needs. NAMI supports continuing and increasing this funding.
- **Lead:** There needs to be a designated lead in MDE on mental health to provide guidance and support to districts.
- **Mental Health Education:** Districts are encouraged to provide mental health education to students. NAMI supports requiring education of middle and high school students with the Department of Education certifying or recommending programs for schools to use.

- **Multi-Tiered Systems of Support:** Multi-tiered systems of supports are evidence-based programs that develop disciplinary frameworks to ensure that students get the right level of support and to reduce exclusionary discipline like suspensions. Expand and continue Positive Behavioral Interventions and Supports (PBIS). More schools need to have access to the funding necessary to offer multi-tiered systems of supports.
- **Restorative Practices:** Restorative practices help students learn to resolve disagreements, take ownership of their behavior, and engage in acts of empathy and forgiveness. Districts should be encouraged to engage in these practices and the Department of Education should provide guidance and funding.
- **Seclusion and Restraint:** NAMI supports providing additional funding and support to districts to reduce the use of seclusion and restraints. Efforts to reduce the use of seclusion and restraints should also include data tracking on the number of calls to the police and the number of students who are homebound, as these are often the only alternatives to the use of emergency procedures.
- **School Support Personnel:** School support personnel such as school social workers, academic counselors, nurses, and school psychologists all have an important role to play in meeting the needs of Minnesota students. While not all school support personnel are mental health professionals, many have the skills and training to help students with mental illnesses manage their emotions and successfully engage in their education. The ratio of students to school support personnel is too high and more funding should be made available to increase these resources.
- **Social Emotional Learning:** Social and emotional learning (SEL) helps children understand and manage emotions, set, and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions. More districts should be providing evidence-based SEL.
- **Trauma Informed Schools:** In trauma informed schools, teachers and school staff are prepared to recognize and respond to students who have been impacted by traumatic stress. Decades of research has demonstrated that children who experience adverse child experiences or ACES are more likely to exhibit negative behaviors at school, with children of color much likely to have at least one adverse childhood experience. Trauma-informed schools allows for teachers and school staff to collaborate in a way that supports a student's mental and physical health so that learning can occur. NAMI Minnesota supports funding to increase the number of trauma-informed schools in Minnesota.

Employment

People with a mental illness are far more likely to be unemployed, and often face additional hurdles to successfully holding a job. However, there are very few programs specifically designed to help people with mental illnesses find and maintain employment. We need to ensure that every person with a mental illness who is ready to work can obtain the support they need. NAMI will work on the following issues:

- **Individual Placements and Supports:** Individual Placements and Supports (IPS) is an evidence-based program that supports people with serious mental illnesses find and keep a job. Unlike other job programs, IPS provides ongoing support to the

person with a mental illness to ensure that they can succeed in their employment goals. NAMI Minnesota supports increasing grant funding for this program so that more people with mental illnesses can accomplish their employment goals.

- **Workforce Centers:** DEED operates workforce centers through the state to help unemployed people find a good job. People with mental illnesses walk often turn to workforce centers for help, but these programs do not have any training or support to effectively meet the needs of people with mental illnesses. NAMI is working to make sure DEED equips Workforce centers do better and support employers and job seekers with a mental illness.

Health Care

Too many children and adults living with a mental illness do not receive adequate coverage for their health and mental health care needs. We need to ensure that Minnesotans on both public and private insurance plans have more options, lower premiums and deductibles, adequate coverage, and access to basic mental health treatment - especially community supports. NAMI will work on the following issues:

- **CADI Waiver:** The Community Access for Disability Inclusion or CADI Waiver provides additional support for people beyond what someone would normally access through Medical Assistance. In order to be eligible for a Medical Assistance Waiver, you must have a disability and be at risk of institutionalization. There are currently many different Waivers, but people with mental illnesses are eligible for the CADI Waiver and the life-changing benefits it can provide. Because the CADI-Waiver is designed to help people with disabilities avoid treatment in an institutional setting like a hospital, people lose their CADI Waiver after they receive treatment for 30 or more days at a hospital or residential program like an IRTS facility. It is very disruptive for people with mental illnesses to lose their CADI Waiver because they need extended treatment at a hospital or IRTS facility. Once they lose their waiver, it can take 60 or more days to re-qualify. NAMI Minnesota supports freezing a CADI waiver when someone is hospitalized for 30 or more days. When they are discharged, the Waiver could be restarted at the level it was at prior to the hospitalization. In addition, protections need to be added to protect people from being evicted from a CADI home without some sort of due process.
- **Family Involvement Act:** The MN Family Involvement Act allows an “oral” approach to the sharing of basic information regarding someone with a mental illness to their caregivers. Unfortunately, few hospitals are using this as an option leading to too many people being discharged from hospitals without anyone else in the room – leading to readmissions. NAMI Minnesota supports creating incentives for hospitals to use this avenue to improve discharge planning and connection to community supports.
- **Jarvis Orders:** In the previous session, the legislature passed a comprehensive update of the civil commitment law. However, stakeholders were unable to reach consensus on language surrounding Jarvis orders (involuntary administration of medication) and ensuring that the rights of patients are protected while ensuring they are prescribed the most appropriate medications. NAMI Minnesota has been

working with stakeholders during the interim and will have a compromise bill for the upcoming legislative session.

- **Network Adequacy:** Private health plans develop networks of providers in order to guarantee quality and manage costs. However, mental health parity regulations prohibit health plans from creating narrower networks for mental health or substance use disorder treatment. Despite progress in the enforcement of mental health parity, people with mental illnesses still face narrower networks and fewer provider choices. The current definition for network adequacy is based on travel times or mileage to an available provider. However, health plan provider lists are often incomplete and do not indicate if the in-network provider is accepting new patients. NAMI Minnesota supports developing a more accurate test of network adequacy like appointment wait times or requiring plans to accept any provider who meets their quality requirements.

Housing

Access to stable and affordable housing is consistently a number one issue for NAMI members. Unfortunately, lack of affordable housing is getting worse in Minnesota. According to the most recent homelessness count from the Wilder Foundation, there was a 10% increase in the number of people experiencing homelessness. The number of people who are unsheltered and experiencing homelessness saw an alarming 62% increase between 2015 and 2018. This is not just a metro issue either, with the non-metro communities seeing an even higher increase of 13%.

Alongside regional challenges, there are also significant racial disparities in housing instability. People of color are much more likely to experience homelessness, particularly for indigenous people who make up 12% of the homeless population while only constituting one percent of Minnesota's population. There are roughly 10,000 people (including families) who are homeless in our state.

People with mental illnesses are also much more likely to experience housing instability or homelessness. Without access to safe and affordable housing, people with mental illnesses are unable to focus on their recovery. For those with serious mental illnesses, stable housing prevents repeated hospitalizations, homelessness, and even entering the criminal justice system. Section 8 Housing Vouchers and other programs like Bridges provide a lifeline for many people with a serious mental illness, but in some cases even access to subsidized or even free housing is not enough and they require additional support, skills training, and connections to mental health resources. Permanent supportive housing meets this need on an ongoing basis and allows for people with a serious mental illness to take steps towards recovery.

While the eviction moratorium has prevented people from losing their housing under most circumstances during the pandemic, there is a risk of a wave of evictions once the public health emergency concludes. The legislature must be prepared to tackle this ongoing problem and be ready for a surge in the need for emergency housing supports. NAMI will work on the following issues:

- **Assisted Living:** Allowing smaller apartment building to house people with serious mental illnesses who use a CADI or Elderly Waiver could support people to live well in the community and avoid hospitalizations or jail. When there are enough apartments in a building enough funding is available to have 24/7 available.
- **Bridges:** The Bridges grant program provides a housing voucher for anyone on a Section 8 wait list where the individual or adult family member has a serious mental illness. People with very low incomes can be on a section 8 wait list for years before getting this support, making the Bridges program a crucial lifeline.
- **Landlord Risk Mitigation Fund:** Unfortunately, many landlords believe that some people are higher risk tenants. This includes people with housing vouchers, a mental illness, or experience with the criminal justice system. Landlord risk mitigation funds decrease the perception of risk about renting to these tenants. Should a tenant damage property in excess of the security deposit or have some unpaid rent, the landlord would be able to tap into the risk mitigation fund to cover these expenses.
- **Permanent Supportive Housing:** Permanent supportive housing provides ongoing support at someone's apartment or residence to help them succeed in their housing situation. NAMI supports increasing funding for the Housing with Supports for Adults with Serious Mental Illness (HSASMI) grant, as well as other important funding streams that sustains these programs like the Housing Supports funding formerly known as GRH.

Juvenile Justice

The Bureau of Justice Statistics reports that over 70% of children in the U.S. juvenile justice system have a mental illness. NAMI Minnesota is committed to closing the school-to-prison pipeline and diverting youth before they are trapped in the juvenile justice system and face long-term hardships throughout their development. NAMI will advocate and support the following issues:

- **Data Collection:** Without proper data collection and analysis across jurisdictions we cannot understand the scope of disparities in the juvenile justice system or find adequate solutions. NAMI supports the creation of a statewide data hub that requires stakeholders to report regularly and for accurate real time tracking of the number and demographics of kids in the system, so that meaningful changes and improvements can be made.
- **Keep MN Youth in MN:** In 2019 American Public Media reported on a practice of sending Minnesota children who are most at-risk with complex needs out of state for placement. NAMI will work with partners to develop and provide resources for interagency solutions for children with the most complex needs to stay as close to home as possible.
- **Alternatives to Detention:** Minnesota's juvenile justice system needs increased collaboration and use of best practices throughout the state, particularly for children under 13 who get caught in the system. We will support legislation that offers clear diversion and appropriate response to young children and ban detention for children under 13, except in the most extreme of circumstances. Along with these initiatives we will promote better education for

judges, lawyers, and law enforcement, early record expungement for youth with mental illnesses, and use of mental health court principles and trauma-informed practices in juvenile courts. We will also work to increase alternatives to detention for all youth and use of best practices like the crossover youth model for youth moving between the juvenile justice system child welfare systems.

- **Resources and Reform:** While the number of youth who are detained in Minnesota has gone down in recent years, the juvenile justice system still needs many resources and reforms to improve outcomes and provide the best and most restorative options for kids in need. A uniform Risk or Needs Assessment Instrument for all facilities across Minnesota would provide consistency and better standards to ensure kids are getting what they need to succeed immediately and in the future. We will also work to reform any policies that do not promote dignity and recovery for all youth such as indiscriminate shackling of youth, mandatory juvenile life without parole sentences, strict criteria for youth to qualify for services, and sentencing and record keeping practices that create harsh collateral consequences long after adolescence.

Mental Health System

You cannot build the mental health system without paying for it. Low reimbursement rates from both private and public payers are a well-known problem, with Medical Assistance often failing to even cover the cost of providing care.

Our mental health system has also changed due to the COVID-19 Pandemic. While there have been numerous challenges, there have also been some positive developments that we should continue once the public health emergency is over. Expanding access and limiting the requirements around the use of telemedicine has been very successful.

Telemedicine does not work for everyone – particularly children – but additional flexibility around using a telephone and being able to have more than three visits a week have been very helpful. These are NAMI Minnesota's priorities to improve our mental health system:

- **Case Management:** Targeted case Management coordinates the care for adults and children with serious mental illnesses and helps them obtain necessary medical, educational, and vocational supports they need. Case managers have a vital role to play in our mental health system, but unfortunately there are numerous challenges with this program. Low reimbursement rates lead to high turnover among providers. This disrupts the care for people with serious mental illnesses and increases overall costs as counties or providers must routinely train new case managers.
- **Mobile Crisis Teams:** When someone in the community is experiencing a mental health crisis, the mobile crisis team can engage that individual in person or over the phone, assess their mental state, react to the immediate stressors that led to the crisis, refer the person in crisis to the appropriate level of care if necessary, and help the person in crisis and their family make a plan to better respond to challenges in the future.

Some counties operate their own crisis teams, while others contract with a local mental health provider. NAMI Minnesota supports increasing funding to sustain and expand crisis teams, as well as efforts to improve the quality and effectiveness of this important program. Should there be a funding shortfall, we encourage DHS to engage the providers to determine the most efficient way to use limited resources like prioritizing services during times of the day with peak demand.

- **Hospitals:** Right now, people are boarding in emergency rooms waiting for an inpatient bed. NAMI wants to see more hospitals create psychiatric emergency rooms and to add more inpatient beds, especially to address when the 118 beds in the M Health Fairview system close.
- **Reimbursement Rates:** Medical Assistance rates under Managed Care are unacceptably low and typically does not cover the actual costs of providing care. This places significant financial strain on community-based mental health providers and impacts their ability to adequately pay (and thus recruit and retain) their staff. The floor for mental health rates under Medical Assistance managed care must not be lower than fee for service Medical Assistance.
- **Telemedicine:** The use of telemedicine during the pandemic has increased access for many people. Once this public health emergency ends, the changes made to the telemedicine program, including the use of phones and weekly limits, should be retained.

Mental Health Workforce

We cannot build our mental health system without also building our mental health workforce. Of Minnesota's 11 geographic regions, 9 have been designated by the Health Resources and Services Administration (HRSA) as mental health shortage areas. While the workforce shortage is felt across Minnesota, the scarcity of mental health professionals is most acute in rural communities and in communities of color.

In order to meet this need, Minnesota will have to address low reimbursement rates, challenges meeting licensure requirements, and the unique challenges developing a diverse workforce in rural and urban areas. NAMI will work on the following issues:

- **Exposure, early recruitment:** Increase awareness of the mental health profession by using school-linked mental health grant dollars to sponsor a career day. Investigate the feasibility of two-week enrichment program for Native American junior and senior high school students to develop foundation for college behavioral science and psychology courses. Create a clearing house of culturally specific mental health professionals willing to speak about mental health careers. Increase exposure to psychiatric/mental health experiences for nursing and medical school students and through increased continuing education offerings for licensed nurses and physicians. Examine the undergraduate requirements with the graduate school requirements to better steer people into these fields
- **Improve collection and dissemination of mental health workforce data at all levels.** If licensees of mental health boards do not reflect the population of

Minnesota, require all mental health licensing boards to address alternative licensure procedures for individuals of diverse groups who are having trouble passing licensure. Work with the licensing boards to encourage people to provide demographic/ethnic information in order to measure progress.

- **Ensure access to and affordability of supervisory hours to become licensed.** It is difficult for providers to provide supervision for free, especially since insurance does not always reimburse for clinical trainees, yet people needing supervision to be licensed cannot afford to pay for it. Funding organizations to provide supervision could help. Require all third party payers/commercial insurers to reimburse in the same way that Medical Assistance does for supervision/internships so that services provided by mental health trainees, under the supervision of a mental health professional, are reimbursable by third-party payers/commercial insurance plans. Provide funding for people to be supervisors, including paying for BIPOC professionals to obtain the CEUs necessary to be able to supervise. Create a BIPOC consultation group to provide support to each other and provide funding to pay for exam and licensure fees for BIPOC individuals to become supervisors.
- **Increase number of MH professionals.** Convene a discussion with representatives from Minnesota's higher education institutions to assess the availability of higher-level mental health degree programs in rural areas of the state. Specific areas to be addressed include: Expansion of psychiatric nurse practitioner programs, expansion of social work and mental health programs to tribal colleges, expansion and/or better promotion of existing weekend cohort or online master's programs. Increase the loan forgiveness program and dedicate a percentage not just to geographic area but to those professionals serving BIPOC and other underserved communities. Examine the undergraduate requirements with the graduate school requirements to better steer people into these fields.
- **Increase number of licensed MH professionals from diverse communities.** Replicate and expand the Diversity Social Work Advancement Program to include additional mental health disciplines (e.g. marriage and family therapists, psychologists, etc.) and practice locations. Create training programs with stipends/scholarships and pathways to licensure targeted at students from diverse communities. Create alternative pathways for licensure for MH professionals – including not requiring the national exam or creating a state exam.
- **Improve and expand cultural competency (awareness) training.** Establish cultural competence (awareness) as a core behavioral health education and training requirement for all licensure/certification disciplines. All RFPs, accreditation requirements, supervision, education, and training must have evidence of components of cultural competence components. Review nationally developed standards and best practices and use them to develop a training package for provider organizations to analyze their cultural competency and to develop a work plan to increase their cultural competence. Require all mental health professionals to have at least three hours of CE in cultural competency in each licensing period.
- **Create career ladders:** Identify gaps in the educational, certification, or licensing systems that impede career movement from entry-level, paraprofessional positions to terminal degrees and licensure as an independent professional.

- **Medical Licensure Questions:** Most of the health care licensing boards include a question regarding the applicant's mental health or previous treatment for a mental illness. While it is important to ensure quality care, these questions discriminate against people with mental illnesses and create the perception that you cannot have a mental illness and be a physician, nurse, etc. NAMI Minnesota supports reviewing these standards in order to foster an environment where doctors feel comfortable accessing treatment their mental illness without threatening their careers.
- **Other:** Create separate programs for the culturally specific grants – one for supporting small BIPOC providers to be solvent, the other focused on providing training and supervision for BIPOC professionals/students. Encourage graduate schools to do better at recruitment from BIPOC communities. Require the licensing boards to reflect the cultural diversity of the state.
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State-Operated Services

State-Operated Services play an important, but limited role, in Minnesota's mental health system. With the closure of most mental health institutions, Direct Care and Treatment (DCT) at DHS is no longer the largest provider in Minnesota's mental health system. In fact, most people who receive court-ordered mental health treatment are now served in the community through what is called a dual-commitment. Currently, state-operated services mostly provide intensive support in locked facilities. NAMI will work on the following issues:

- **Carve out DCT:** It is a conflict of interest for DHS to license, fund, and operate the DCT program. From time to time, State-Operated programs at St. Peter and the AMRTC have faced scrutiny from Federal and state regulators about patient safety and quality of care. It is time to create a separate agency to operate state-operated services.
- **Community Competency Restoration:** Due to the increase in the number of people deemed incompetent to stand trial, most of the people being sent to the Anoka Metro Regional Treatment Center (AMRTC) are coming from the jails in order to receive treatment and competency restoration services. NAMI Minnesota supports efforts to develop community-based competency restoration programs, thereby preserving scarce resources at the AMRTC to support people with the most acute mental health needs.
- **Move IRTS to Community Providers:** Due to budget shortfalls, NAMI Minnesota supports recent proposals by the Department of Human Services to engage community partners to run the remaining state-run IRTS facilities. Community providers can offer the same level of care and are better connected to the rest of the community-based mental health system.

Suicide Prevention

Suicide is one of the leading causes of death for Minnesotans and has become a public health crisis, with close to 800 people a year dying by suicide. With the COVID-19 pandemic, even more people are seriously considering suicide. We need to tackle this public health problem like the opioid crisis with improved coordination and additional resources.

In the last biennium, the legislature made a significant investment in suicide prevention efforts including the implementation of the zero-suicide model, increasing grant funding for suicide prevention efforts at the local level, and funding access to suicide prevention training for school staff. With increasing needs, Minnesota cannot afford to go backwards and undo these crucial investments. NAMI will work on the following issues:

- **Kognito:** In the previous biennium, the legislature appropriated money to the Departments of Health and Education to make the Kognito suicide prevention training available to all school-staff in Minnesota. This is an online, evidence-based training where the teacher or school staff member navigates a series of role-playing scenarios in order to recognize the signs of a mental health crisis and how to effectively engage a student who is at risk of suicide. NAMI Minnesota supports sustaining the funding for this vital resource to ensure that all teachers and staff have access to evidence-based suicide prevention training.
- **Minnesota Suicide Taskforce:** NAMI Minnesota supports implementing the recommendations of the suicide taskforce, many of which do not have a fiscal impact. These changes include:
 - Promote effective programs and practices that increase protection from suicide risk.
 - Provide training on suicide prevention to community groups that have a role in the prevention of suicide and related behaviors.
 - Provide care and support to individuals affected by suicide deaths and attempts in order to promote healing and implement community strategies to help prevent more suicides.
 - Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible gun ownership.
 - Increase the capacity of communities to use evidence-informed programs and strategies to respond to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.
 - Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.
 - Promote continuity of care and the safety and well-being of all patients treated for suicide risk in health care settings such as emergency department or hospital inpatient units.
 - Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate and to promote rapid follow up after discharge.
 - Improve the usefulness and quality of suicide-related data.
 - Improve and expand the state, tribal and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.
 - Increase the number and quality of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors, suicidal behaviors, related risk factors, and exposure to suicide.

- **Prevention Funding:** During the COVID-19 pandemic, more people are experiencing acute mental health symptoms, and many are at risk of suicide. The legislature must not cut recent investments in suicide prevention given the rising rates of suicide, particularly during the pandemic.
- **Student IDs:** NAMI Minnesota worked with MDE and schools last spring to have the suicide helplines voluntarily printed on the back of student IDs. Unfortunately, few districts opted into this program so NAMI Minnesota supports making this mandatory.

Voter Registration

Current Minnesota election law allows for employees of residential treatment programs to vouch for the client's residency in order to cast a ballot. NAMI will work on the following issues:

- NAMI proposes clarifying that the definition of residential program includes residential mental health treatment programs.
- Partner with the Second Chance Coalition to continue to advocate for voter rights.

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