DEPARTMENT OF HUMAN SERVICES

Crisis Response Final Report

March 2023

Prepared for Minnesota Department of Human Services by

strategic consulting & coaching
creating new paths for growth & success

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Executive Summary

Strategic Consulting & Coaching, LLC was contracted to conduct stakeholder research on the behavioral health crisis response in MN. The overwhelming conclusion of this stakeholder research is that additional capacity is needed in MN to adequately respond to people experiencing a mental health crisis.

According to SAMHSA guidance:

> **"Crisis systems must work within the larger system of care to address the needs of community members. The true test of whether there is adequate capacity to meet the needs of the community is whether individuals are able to access needed services in a timely manner. Psychiatric boarding in emergency departments and an over-representation of people with mental health and substance use challenges within the justice systems would suggest insufficient capacity within that community; warranting further analysis of flow within that system."**[1]

Utilizing these criteria in evaluating the data gathered in our research leads conclusively to the finding that additional capacity should be added to the system.

> **MN ranks 50th in the nation for the number of psychiatric beds per capita and fails to meet the minimum standards dismally, with only 7% of the recommended number of beds.**[2]

1 National Guideline for Behavioral Health Crisis Care Best Practice Toolkit. Substance Abuse and Mental Health Services Administration (SAMHSA).2020.

2 Engler, Jordan (2022) "Boarding Mental Health Patients in Minnesota Emergency Departments--The Unintended Consequence of an Inadequate Mental Health System," Mitchell Hamline Law Review: Vol. 48: Iss. 4, Article 3. Available at: https://open.mitchellhamline.edu/mhlr/vol48/iss4/3

This causes backlogs, with many people stuck at the wrong level of care for weeks or months on end and people in crisis with no place to go but the ER. Many of them also end up incarcerated.

In 2017, a Department of Justice study classified 55% of the country's state prison population as mentally ill, and 73% of all female inmates as such.

However, this is not uniform across the state, as some local jurisdictions have taken matters into their own hands and injected resources, leveraged resources through collaboration, and significantly grown their capacity. Geographic disparities in capacity are large, and some communities have added a great deal of capacity with additional infusions of local funding and leveraged resources effectively by collaboration among the key players – Dakota County is an exemplary case. However, many mobile crisis teams are underfunded and without local funding, they are constrained by the definitions imposed by third party reimbursement by MA. A number of communities have developed alternative responses, often co-responder models based in law enforcement. While these are felt to be more effective in responding to behavioral health crises than law enforcement alone, they are widely variable and there are many new implementations.

Travis's Law was meant to divert 911 mental health calls to the mobile crisis teams, but its implementation has been uneven so far, and there are numerous factors that contribute to the predominantly law-enforcement only responses to 911 crisis calls. The original intent of the sponsor was to shift "the primary response eventually to be done with mental health crisis teams with the biggest goal to end the police-only responses."

Our stakeholder research backs up the recommendations of the numerous MN-based groups that have worked on this issue and produced reports and recommendations over the past several years, including the MN Association of Police Chiefs, the MN Chapter of NAMI, Communities United Against Police Brutality (CUAPB in Minneapolis), East Metro/North Metro/South Metro Provider Connect groups, and the Rural Health Advisory Committee (RHAC) workgroup to assessment of mental health in rural MN with a focus on mobile crisis work. We are indebted to their work.

The firsthand experiences reported by the participants in our survey, focus groups, and interviews speak to the incredible work that goes on every day in communities across the state to help families and individuals in great distress, but also provides a backdrop of urgency to comprehensive reform.

Key recommendations in response to these findings include:

- Provide additional funding for mobile crisis teams;
- Expand the number of crisis beds and psychiatric beds;
- Expand options for crisis transportation through additional resources;
- Support the development of collaboration through funding, trainings, and dissemination of best practices;
- Support the expansion of co-responder models;
- Support the implementation of Travis's Law and 988 with guidance for dispatch and mobile crisis teams from both DPS and DHS; and
- Expand the role of LGSWs in mobile crisis teams to alleviate workforce shortages and burnout.

Methodology

Literature Review

We conducted a literature review to collect information on best practices and reviewed research and reporting on crisis response services from a variety of perspectives. For a full list of reports and articles reviewed, see “Appendix B: Literature Review” on page 56.

Surveys

We conducted two surveys, one aimed primarily at providers and a second one for people with lived experience. We recognized that there is some overlap between the two groups and asked about lived experience in the provider survey. We received 133 responses to the provider survey and a total of 13 to the Lived Experience survey. The surveys were distributed across a broad geographic area of the state via e-mail and web-based communications. Respondents represent a wide variety of professionals and para-professionals, including people with lived experience, covering many aspects of the mental health crisis continuum. Most respondents indicated that they had been working in the mental health field for over eight years.

The survey design was reviewed by NAMI, as well as by MN DHS staff. To appropriately disaggregate results, we asked for the following categories of information:

- The county or group of counties the respondent is residing or providing services in
- Whether the area is primarily urban, suburban, or rural
- The area of professional practice of the respondent
- The race and ethnicity of the respondent
- Whether or not the respondent has lived experience

Using those groups as a framework, we asked about strengths, areas of improvement, barriers to sustainability and growth, elements of the crisis continuum of care (as defined by SAMHSA), and which areas were a priority for capacity building efforts. For each area, respondents had both the opportunity to select multiple areas and an additional opportunity to respond with narrative.

Most respondents in our surveys and focus groups were from organizations and teams that serve rural areas (59%) with a particularly robust response (n=26) from Itasca County. Although the Itasca area was overrepresented, its responses did not skew responses overall (tested by removing them from the data analysis) and were not analyzed separately. Responses from urban and suburban areas were equal at 18%.

Racially, the respondents identified as White (88%), Black (3%), Asian (4%), and American Indian (4%). Intensive outreach was done to increase participation of BIPOC communities and those who focus on serving them, but unfortunately these fell short.

Focus Groups

We conducted three focus groups over Zoom. Two of these groups were comprised of people who signed up via a website link to participate. They included mental health providers, mobile mental health crisis team members, peer specialists, and law enforcement (LE). The participants were from 12 counties across MN including Itasca, Brown, Blue Earth, Beltrami, Ramsey, Polk, Becker, Winona, Hennepin, Otter Tail, Clay, and Wilkin. The third group was a listening session with 911/988 dispatchers from across the state.

The focus group script included questions focused on the strengths and gaps of mental health crisis services in MN; recommendations for significant change; working collaboratively with law enforcement; impacts of Travis's law and new 988 call-centers; how mental health crises were triaged, and how they evaluate their mental health program's effectiveness.

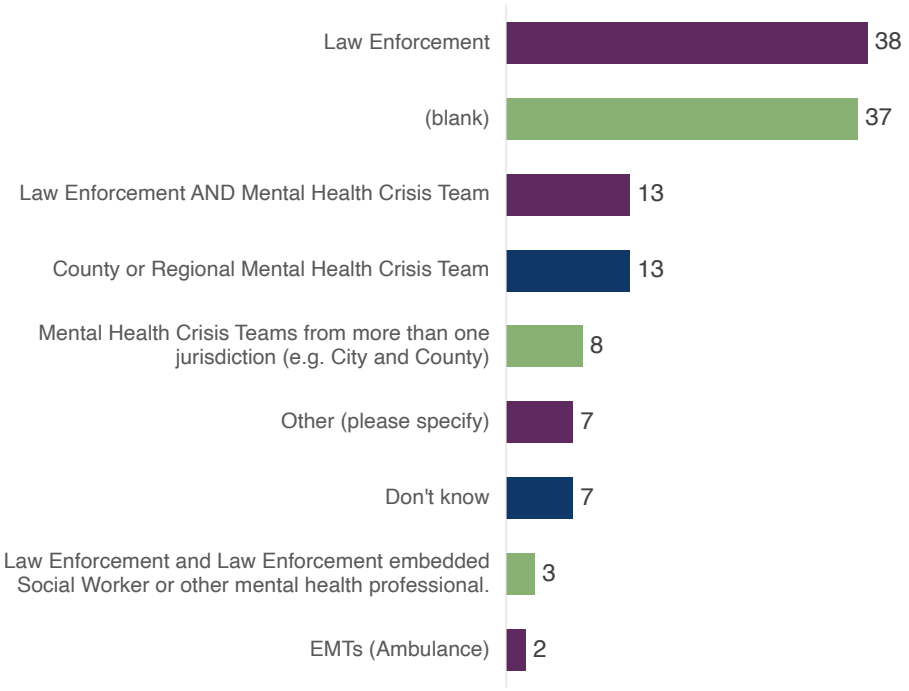
Key Informant Interviews

We conducted 18 key informant interviews with stakeholders working in mental health crisis from across the state. We spoke with seasoned experts including Executive Directors of Mental Health and Peer Support Organizations, Sheriffs, Police Chiefs, County Directors of Behavioral Health departments, citizen groups, DHS Directors, as well as co-responders and collaborators with LE in the field and individuals who specifically work with or represent BIPOC Communities.

Findings

Who currently responds to mental health crises in the community?

For most mental health crises in our area, the first response is:



Thirty percent (n=128) of respondents to our survey indicated that law enforcement alone are the first responders to mental health crisis calls in their community. A nearly equivalent number left the question blank and 5% indicated they didn't know.

This is consistent with state and national surveys where the majority of responders identify police as the first responders.[3] However, examining our survey results further indicates that there is a lack of clarity on the local level about who the primary first responders are unless there has been an intentional and comprehensive effort to collaborate. For example, in Itasca County, seven respondents indicated that LE was the first response, but five indicated that it was the county or regional mental health crisis team, and eight respondents said they didn't know. We recognize that first responders can vary based on individual circumstances, and it may very well be both at different times, depending upon the situation, but currently there is no comprehensive way to track the disposition of the responses statewide. On the local level, tracking is inconsistent.

According to our survey, county or regional mental health crisis teams (10%) or a unified response from both police and mental health mobile teams (10%) come in second for the most likely first responders. Objective data on this topic is largely lacking. Law enforcement tracks person-in-crisis calls (PIC), but many calls that are mental health related are classified under other categories in call logs. Additional information is not recorded unless the call results in an arrest. Diffusion of data across the various sources of assistance and confusion by the public on who best to call when facing a behavioral health crisis means that a thorough understanding of the scope, acuity, and geographical distribution of people experiencing a mental health crisis, or the outcomes of the service provided is impossible to discern on a statewide level.

Some estimates hold that between 6%-10% of all police calls involve someone with a serious mental illness.

However, the full range of behavioral health-related calls is likely much higher. Unfortunately, in 2015, it is estimated that 23% of these calls ended in police killing someone living with mental illness.[4]

> **"As of now, there are no agreed-upon metrics for identifying when a community needs more crisis response resources, or modifications to its existing plan for delivering services."**[5]

The SAMHSA Best Practice Toolkit, explains how communities – at the county level – (supported by state infrastructure), can estimate their crisis system resource needs, the number of persons

3 Best Practices in Law Enforcement Responses to Mental Health Crises – League of MN Cities, MN Chiefs of Police Association, MN Sheriffs Association & the Best Practices Working Group.2022.

4 Best Practices in Law Enforcement Responses to Mental Health Crises – League of MN Cities, MN Chiefs of Police Association, MN Sheriffs Association & the Best Practices Working Group.2022.

5 Best Practices in Law Enforcement Responses to Mental Health Crises – League of MN Cities, MN Chiefs of Police Association, MN Sheriffs Association & the Best Practices Working Group.2022.

served within their system, the cost services, and the workforce demands of implementation.[6]

According to SAMHSA guidance:

> **"Crisis systems must work within the larger system of care to address the needs of community members. The true test of whether there is adequate capacity to meet the needs of the community is whether individuals are able to access needed services in a timely manner. Psychiatric boarding in emergency departments and an over-representation of people with mental health and substance use challenges within the justice systems would suggest insufficient capacity within that community; warranting further analysis of flow within that system."**[7]

Utilizing these criteria in evaluating the data gathered in our research strongly suggests that additional capacity should be added to the system. However, this is not a uniform across the state, as some local jurisdictions have taken matters into their own hands and injected resources, leveraged resources through collaboration, and significantly grown their capacity.

Understanding the need and how well current responses are working, as well as developing a set of metrics for improvement, are important tools for communities to make progress in developing an adequate and effective response to individuals experiencing behavioral health crises.

The issue of understanding the magnitude of police response to mental health is summed up well in the Communities Unite Against Police Brutality (CUAPB) White Paper:

> **"The number of police calls for service involving mental illness is certainly large and yet difficult to pinpoint with precision. Many such calls are hidden under call descriptors having nothing to do with mental illness. This problem with police record management and dispatch systems was first described by CSGJC in 2002 and remains unaddressed. Thus, there is little value in the call tally estimates based on call descriptors that suggest only 7%-11% of calls have a mental health aspect. Newer estimates, created when officials explore the call records in minute detail, reveal the real scope. For example, the St. Paul Police Department (SPPD) demonstrated that the number of calls "hidden" in non-related call descriptors in 2016 was greater than the number of calls for service recorded under mental health-related call descriptors. Notably, the SPPD's total tally of mental health-related calls in 2016 was 21,049. This was 33% of the total number of calls for service."**[8]

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6 National Guideline for Behavioral Health Crisis Care Best Practice Toolkit. Substance Abuse and Mental Health Services Administration (SAMHSA).2020.

7 National Guideline for Behavioral Health Crisis Care Best Practice Toolkit. Substance Abuse and Mental Health Services Administration (SAMHSA).2020.

8 Dispatch Triage, Alternative Responders, and Co-Response: Ending Police-only Response to Mental Health 911 Calls. Communities United Against Police Brutality.2020.

Law enforcement as the primary response to mental health crises has evolved over time, but dates back to the rapid deinstitutionalization of people held in mental institutions without the development of a viable alternative, the changing role of peace officers and their ability to force the implementation of a transfer hold, and increasing numbers of crisis calls to 911 over the last five years with an unclear crisis response system.[9]

Of the small sample of people (n=12) with lived experience who responded to our survey, 70% had called 911 and had law enforcement come to their location. Most of them were neutral on the question of whether the police were effective in their response, primarily because the response itself wasn't substantive:

"One time they did nothing and went home. Another time they just transported to the ER."

"Twice did nothing."

Stakeholder feedback on who should be responding to crisis

Stakeholders – including police, mental health providers, and people with lived experience who responded to our data gathering overwhelmingly believe that crisis responses are more effective when trained mental health professionals or para-professionals can augment or replace police as the first response:

"A young man with mental health concerns who is also a person of color was having a mental health crisis and ended up being arrested. Workers or volunteers at the shelter had no other way to respond than by calling law enforcement."

"[A gap is] police and service agencies not having sufficient training and resources to help someone in the middle of a mental health crisis."

"Lack of a response team, first-responder coordination and lack of first responder education, especially amongst law enforcement is problematic."

In identifying priorities for change, respondents almost always included expansion of mental health expertise and capacity in the ER, on the mobile crisis teams, in dispatch, and for co-responders with police:

"Grow the size of a mobile [crisis team] that can go out 24/7."

9 Dispatch Triage, Alternative Responders, and Co-Response: Ending Police-only Response to Mental Health 911 Calls. Communities United Against Police Brutality.2020.

"Increase funding crisis response and develop funding for co-response models."

"Expand ER to include a mental health area and an in-patient psych unit."

"It [crisis response] would be county operated and there would be mental health professionals at each access point (911 dispatch, with LE in field, in the jail, etc.)."

Dispatch is a critical link

In MN there are 40 different mental health crisis phone numbers and one central number.

**CRISIS, the statewide universal number to be connected to mobile crisis teams, is still not well known, only works on cell phones, and does not reliably work across the state. Most people call 911. In MN, when a call for help comes to 911 dispatch, the police have a professional and ethical responsibility to respond, whereas mental health mobile crisis teams and others can choose not to respond for various reasons including safety concerns, lack of capacity, or transportation.

When someone is experiencing a mental health crisis or someone calls on their behalf, 911 is often called first. Dispatchers screen the call and utilize decision making trees to determine if the call needs a law enforcement response or should be referred to the mental health mobile crisis team. This happens to varying degrees and with varying guidance across the state.

The link between 911 dispatch and the mobile crisis teams is relatively new and has not been fully implemented. In 2018, Travis Jordan, who was experiencing a mental health crisis, was killed by two police officers. Through the advocacy of CUAPB, in 2021, "Travis's Law" was passed, requiring 911 dispatchers to refer mental health crisis calls that do not contain threats to public or personal safety directly to mobile crisis teams.[10]

According to focus group participants and key informant interviewees, for a variety of reasons, mental health calls continue to be routed to police, despite implementation of Travis's Law.

In some cases, this is due to the limited capacity of mobile crisis teams across the state. For example, some teams operate in multiple counties over hundreds of square miles and cannot always reach clients in time to provide an emergency response. Staffing is often limited due to workforce shortages and constraints on who can serve in these roles. Our data shows that despite Travis's Law being a statutory requirement, implementation varies greatly across

10 Understanding Travis's Law.

counties.

Through our focus groups we spoke to providers directly about their use of, and experience with, 988 and 911. We also spoke with dispatchers who work at 988 call centers and 911 dispatches. In 2020, Congress designated as 988 the new National Suicide Prevention line. In July 2022, 988 was available for use in MN. There are currently four statewide call centers that each work in specific catchment areas throughout the state. They provide resources to persons in crisis. If immediate assistance is needed, they connect the caller to a local mobile crisis team or 911.

> **"988 still feels like a brand-new baby. So much work that still needs to happen. Just getting started with it, think it's being used a little bit, still educating people about what it is for and what will happen if you do call."**

Dispatch can play a key role in collaboration

From the perspective of those working in 988 call centers and 911 dispatch centers, several strengths were identified:

St. Louis County:

> **"We have quarterly meetings with different groups, including mobile crisis teams. Have completed sit-a-longs with their mobile dispatch and they can develop relationships and see things from the 911 perspective. They can ask questions and just get to meet them. All mobile crisis teams have radios as well, and they are trained by dispatch."**

Mental health workers can be co-located with dispatch operations and respond to callers directly

Ramsey County:

> **"We have initiatives regarding appropriate responses, part of that is enhancing their internal social services process. Embedded social workers work on the dispatch floor and with telecommunicators. They have the ability to do co-response with law enforcement and social services. They have the ability to dispatch them out as an immediate response, as opposed to delayed response. Depends on the situation. [We also can do a] warm transfer to the Ramsey County crisis line that has a juvenile or mental health component [for calls] that are nonviolent."**

1,700 calls a year that are transferred.

Carver County and McCloud Crisis Program:

> **"Have social workers that complete the phone calls and triage. They are co-located with dispatch. Can give background information and can dispatch the mobile crisis team. Dispatched out with law enforcement. When they don't have a social worker in dispatch, then the dispatchers are calling and transferring calls. Sheriff's office has funded a full-time co-responder therapist: managed and supervised through the crisis team (not duplicating infrastructure). This individual co-responds with law enforcement officers."**

Mobile mental health crisis teams have limited capacity

> **"The volume of mental health crisis is SO FAR beyond the capacity of crisis response. There are ALSO really insufficient numbers of beds and openings in crisis residences."**

Best practices indicate that mental health mobile crisis teams are essential for an "effective, modern, and comprehensive crisis care system."[11] In MN, there are 31 mobile crisis teams covering 78 counties. These teams are funded by the MN Department of Human Services. The 2023 and 2024 state mobile crisis grant contracts were $41.2 million, however, the amount requested by mobile crisis exceeded the amount available by $23.2 million which caused delays in contract disbursements.[12] This works out to approximately $7.22 per capita (based on 2021 MN population of ~5.7 million).

Data on additional expenditures via MA reimbursements, direct county and other community contributions was sought, but is not tracked in any central place, and the extensive outreach needed to collect this information was outside the scope of this research. Collecting such data, along with data on the real number of crisis calls and the responses to them across sectors is essential to a true understanding of the policy issues around crisis response.

Generally speaking, mobile crisis teams are a cost-effective use of public dollars:

> **Scott (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was $1,520 for mobile crisis program services, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23% lower average cost per case. In another study analyzing the cost impact of mobile crisis intervention, Bengelsdorf et al., (1987) found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79% in a six-month follow-up period after the crisis episode.**

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11 National Guideline for Behavioral Health Crisis Care Best Practice Toolkit. Substance Abuse and Mental Health Services Administration (SAMHSA).2020.

12 Department of Human Services. Letter to Mobile Crisis Provider for State of MN.2023.

In comparison, according to data from the U.S. Census Bureau, state and local spending on police protection totaled $2.4 billion in Minnesota in 2020, or about $423 per resident, the 10th highest per capita spending among the 50 states. In 2021, there were 2.9 million calls to 911 in MN.[13] According to an analysis of 911 data from nine cities, an average of 19% of 911 calls could be answered by unarmed crisis responders.[14] In MN this would be approximately 551,000 calls. Clearly, mental health crisis providers need more resources to tackle the challenges they are seeing in the field.

At the same time, on an individual level, despite the lack of resources, teams are doing critical work in communities, with many families and individuals given invaluable and life-changing assistance:

> **"The mobile crisis team in Duluth is great. I have talked to them on the phone and they have met with my adult child. I also had to call 911 for the Duluth area last year and was lucky that one of the officers responding was trained in mental health."**

But significant gaps persist:

> **"No in-person response from the pediatric mobile response team has ever been available when I have called during my child's mental health crisis. I have ended up calling 911 after speaking with the crisis line so that someone would come help us."**

Co-responder models

The co-responder model is a police-based intervention that "typically involves a specially trained team, including one police officer and one mental health professional, that jointly respond to calls for service in which a behavioral health crisis is likely involved."[15] The aim of the model is to improve the experience of the person in crisis by providing effective de-escalation, diversion from the criminal justice system, and connection to the appropriate behavioral health service. These models vary in terms of type of support and can be defined as "ride along, ride separate, or remote support," and hours of operation, size, and professionals involved.

> **Based on the International Association of Chief of Police's (IACP) review of research on first responder models, they found that no matter the variation in models, "co-responder teams were perceived to de-escalate crisis incidents more effectively, avoid unnecessary distress for service users, and reduce the**

13 https://www.911.gov/issues/911-stats-and-data

14 https://www.vera.org/downloads/publications/911-analysis-civilian-crisis-responders.pdf

15 Assessing the Impact of Co-Responder Team Programs: A Review of Research. Academic Training to Inform Police Response Best Practice Guide. IACP/University of Cincinnati Center for Police Research and Policy.2020.

stigma associated with and/or criminalization of these incidents.

Many cities and counties across the US, including MN, are using co-responder models as another layer to service those in behavioral health crises, in addition to county or regional mobile health crisis teams. What our data highlights is the growing interest in MN regarding co-response models for a person in crisis over law enforcement-only responses. When asked what respondents want to build capacity in or for, 54% stated, "funding and technical assistance to develop a co-responder model."

Crisis receiving and stabilization facilities

Another essential element to a robust mental health crisis system is receiving facilities. The first responder, be it police or mobile crisis team, will make a determination as to whether the person in crisis needs immediate stabilization services. Depending on the situation, and the first responder, stabilization could be a local jail, emergency department, or other crisis stabilization site if available.

The overwhelming majority of those in crisis are brought to hospital emergency rooms. Unless an individual is medically unstable, emergency rooms are not appropriate placement for those experiencing a mental health crisis.

These settings are loud, highly stimulating, and often do not have staff with mental health expertise readily available. Additionally, emergency departments are overwhelmed and short staffed and often rely on crisis teams to intervene while the person is in the emergency room. This issue is further compounded by the lack of available crisis beds, especially for children in MN, which results in children or adults living in emergency rooms for months at a time, a terrible situation for all involved.

Eighty-four percent of respondents stated that emergency rooms were available in their area and this is where clients are taken if alternative stabilization centers do not exist.

Respondents also identified that their areas had crisis homes/beds (49%), partial or day-treatment mental health facilities (35%), and hospital-based Emergency Psychiatric Assessment, Treatment, and Healing (EmPath) units.

"Crisis stabilization units are available somewhat locally but accessing them is very difficult due to them being full; to meet an immediate crisis need, individuals are either transferred outside of the community to a behavioral health hospital or released with voluntary supports to help bridge the gap until providers can be established."

“A majority of these services are only for adults. The ones that do accept children do not accept the children we are seeing in crisis due to eligibility. PHPs and day-treatment programs are not accepting children with high needs due to behavioral escalations and/or inability to engage in all-day programming.”

“State statute states that law enforcement can only transport a client on a “transportation hold” to a “treating facility” which is primarily defined as an Emergency Department. This language will need to be changed if we want to make progress in developing alternative assessment and stabilization units.”

Outcomes of Service

Existing Strengths of MN Mental Health Crisis Response

Our survey results identify a multitude of strengths within the MN crisis response continuum. However, the percentages among the top three results demonstrate there was not strong agreement on what exactly the primary strengths of the system were.

Top Six Strengths in Crisis Response Selected in Survey

Strength: Crisis response team member skills

Forty-five respondents (n=90) indicated that the skills of crisis response team members were the system's greatest strength. The strengths of the teams included individuals who worked for county and tribal services, community-based organizations, law enforcement, hospitals, and state agencies. The roles the individual who identified as crisis team responder included licensed mental health professions, healthcare providers, peer specialists, mental health coordinators, supervisor, executive director, social worker, community advocate and/or tribal case manager. Focus group discussion participants emphasized that the system's strength and success relied on "committed, passionate, flexible, and dedicated mental health team members."

Those working in mental health crisis response are committed, creative, knowledgeable problem solvers who know what they need to do this work and do it well.

Strength: Appropriate and prompt response of mental health crisis team as first responder in response to a crisis call line or 988 call

Per our survey, 38 respondents identified that when either the crisis team was contacted directly or 988 referred callers to mobile crisis teams or warmlines they received appropriate and prompt response of the mental health crisis team. Per recent 988 dispatch information provided by MDH, since implementation, 95% of calls are resolved over the phone with no need for immediate referral to 911 or mobile crisis.

When mobile crisis teams are contacted directly or when individuals are appropriately referred from a 911 dispatcher, they have access to a crisis member who has extensive mental health training and skills to work with someone experiencing a crisis. These teams are available 24/7 and often include certified peer specialists. The mobile team can connect with the person in crisis via phone and as needed come to meet the person to assist with de-escalation and develop a safety or stabilization plan with the individual and/or family members.

> **"The crisis team consists of the staff at human services so we are able to make a follow up plan if necessary."**

During our focus groups, we asked crisis providers how they determine acuity of calls. For example, how it is determined whether to intervene in person or provide assistance over the phone. Mobile team members shared that they used a screening tool sheet and decision-making tree (these are not standardized – all teams use something different). The crisis line assessor will notify the mental health provider after the screening tool is complete and they make a decision whether LE needs to be called or if a mental health professional is going to respond. Per one respondent,

"If someone is in a crisis, they don't want to bombard them with questions, but staff makes it a conversation. The client directs the conversation. The screening tool has questions which assess safety, who is in the house, whether the individual has a history of substance use, if they seem agitated on the phone, and/or have used in 24 hours."

Per respondents, some callers just want to stay on the phone and talk while others may want assistance finding a crisis bed.

"St. Paul Non-Emergency Police are familiar with our situation, respond quickly and appropriately, and we have received the best care possible by calling Non-Emergency Police when necessary. St. Paul Non-Emergency Police are miracle workers along with EMTs, psychologists, and other doctors, nurses, social workers, counselors, and therapists at Regions Hospital in St. Paul when it comes to assessing, diagnosing, and treating a dual diagnosis with patients who have suffered from medical illnesses, including schizophrenia and substance use disorder."

Strength: Multiagency coordination and collaboration

Thirty-eight survey respondents stated coordination between entities (law enforcement, hospitals, community-based mental health providers, cities, counties, and medical providers) was a strength of the system in their area. Focus groups were clear that working collaboratively across the mental health system (outpatient, peer groups, community mental health clinics, hospital systems, jails and with LE) was a reason behind the success of programs and response. Additionally, easy access to information was a key strength noted within communities where multi-agency Release of Information (ROIs) were utilized.

However, it should be noted that this type of collaboration is not happening universally across the board but in select areas.

Examples of successful multiagency collaborations

Alluma Mobile Crisis (Polk County) formed a Community Assessment Team (CAT) in collaboration with LE and the local hospital ER:

"We identified problems such as an individual who ends up at the ER via a police officer and after a 40-mile ride, and now is stuck at the hospital without being able to find a way home. The CAT team is looking at getting ahead of those types of issues and figuring out what inerventions can be completed prior to taking someone to the ER. "Multiagency releases (law enforcement, social worker, ER, shelters, VA, etc.) have been such a big help. Hard to get someone to buy into signing this paper so they can talk to law enforcement."

Horizon Homes (mobile crisis and residential program covers 10 counties):

> **"We have a solid team throughout the region – works well, pulls in human services, law enforcement, and hospitals. We are all in contact with each other due to ongoing meetings with each other. We view it as more than what is Horizon Home doing—what are the counties doing, what are the emergency departments doing? How are we working together to best meet the needs of the clients that we have? We have a good working relationship with law enforcement and flexible teams. Some parts of the region include co-response with law enforcement. Another part has a rural hospital that does not have social workers or staff who know the resources and therefore they work out of that hospital to provide the best care."**

The East Metro Crisis Alliance, runs monthly **"Provider Connect"** meetings for local workers focused on mental health crisis issues, including frontline crisis team managers, police departments, and community providers like People Incorporated. They share updates and trends. Likewise, there is a South Metro Crisis Alliance and a North Metro Crisis Alliance.

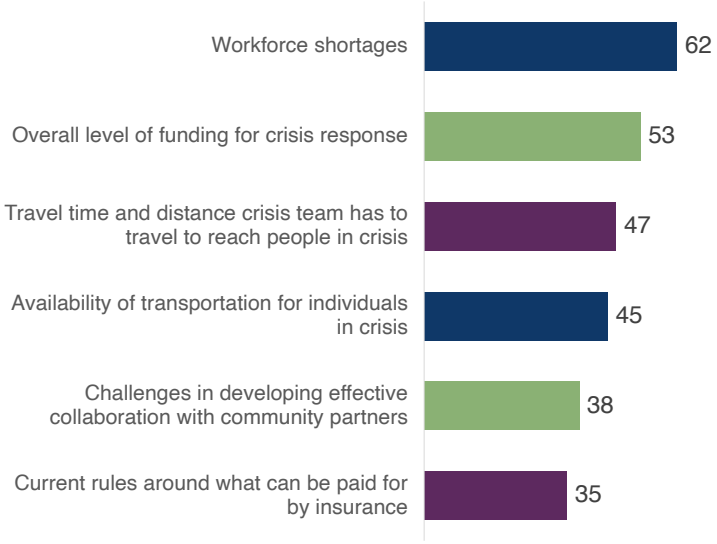
Dakota County leaders are working in close partnership with public service systems including police, EMS, fire, and 911 as well as with mental health providers; healthcare systems; community partners; justice system partners; and people with diverse lived experiences. This approach focuses on bringing everyone together to tackle the issue — because mental health and addiction impact everyone. Dakota County's dispatch referral program launched around September, in partnership with several local agencies. As of February, 78% of the county's crisis calls were routed to county social workers. Dakota County, through additional funding, has implemented a "firehouse model", which means county responds to everyone who calls experiencing a mental health crisis, just like a fire department responds to everyone with a concern about fire. One of the key factors in being able to accomplish this is removing third party reimbursement from the initial response of screening and assessment. Only after the individual is assessed as needing stabilization and/or treatment do they tap into third party reimbursement.

Committed multi-agency collaborations are the key to success. Throughout our research we came across numerous examples of agencies doing the hard work of understanding one another's roles and responsibilities, learning from one another, and figuring out a way to move forward to serve those living with mental illness. And for those counties, cities and/or communities that are struggling to bring everyone to the table, they are willing and would like more leadership, resources, and examples of best practices.

Barriers

Barriers to Operating a Sustainable Response System

Top Six Barriers to Sustainability & Responsiveness of Crisis Response: # of Survey Respondents Indicating Issue



Barrier: Workforce shortages and staffing

Workforce shortages were overwhelmingly reported as the primary barrier to sustainability of crisis response. When examining workforce shortages, specifically Licensed Clinical Social Workers (LICSWs), the most prominent role in mobile crisis response, the issue is not that there are not enough of them: "According to the U.S. Department of Health and Human Services Administration (HRSA), in MN in 2016 there were 800 more social workers than jobs to employ them. By 2030, MN is predicted to have 8,350 licensed social workers."[16] The issue is not "shortage of LICSWs," but lack of adequate pay, on-call hours, and burnout. This was clearly articulated in our research:

> **"You know, staffing is a real concern in crisis services, people get burnt out quickly. And so how do we nurture the staff that are doing this type of work? How do we make it a sustainable program where we're paying individuals for their availability and their time, because this is a program that requires 24/7 access and availability to work with any person who walks through your door or that asks for you to come and see them or talk to them on the phone."**

> **"Our region is served by the only team that is willing to provide mobile crisis services. They struggle with staffing consistency, clinical skills, and have limited use in the community due to shrinking referrals."**

Respondents indicated on-call pay and stagnant salary without adjustments to inflation are stretching their workforce very thin.

> **"We have four social workers who are embedded with law enforcement to respond to mental health calls. However, they are not staffed to be able to provide 24-hour coverage; we have a need to provide 24-hour coverage."**

> **"[We] need more trained people in all communities and in rural areas. I see more and more people living with mental health illnesses. One of the times I needed help for my adult child while they were with me in my rural area, I learned that I would have to take them to the local ER and the wait to be seen would be many hours long. It was suggested to take them to the ER in Duluth which is two hours away."**

Increased salaries, on-call pay, and use of additional non-licensed support like certified peer specialists could greatly support mental health professionals.

16 HRSA: State-Level Projections of Supply and Demand of Behavioral Health Occupations: 2016-2030. September 2018.

Barrier: Funding

Fifty-three survey respondents and many focus group participants identified the overall level of funding as a significant barrier to success.

Crisis teams are underfunded. With the goal of shifting crisis response from law enforcement to mental health professionals, this issue needs to be addressed.

While crisis teams can bill some services to insurance including Medicaid, MN Care, and private insurance, they do so with minimal return that does not cover costs for teams. By investing in mobile mental health teams, the state can save money.

> **According to one cost-benefit analysis report by MN management study, "each participant engaged in mobile crisis response had a $1,280 return on investment by avoiding hospitalization or criminal justice involvement."**[17]

> **"I think the things I would say to DHS would be that we need funding for a system that's really going to work. I will say that if the city hadn't kicked in, and then if, like, we wouldn't pay for the social worker, I mean, none of this would happen. And the grant funding doesn't work. I mean, we do these great things, and then the funding goes away. And then you know, we were expecting, we were hoping for more funding with crisis response and we did not really get that. So, it was really . . . it was very disappointing. I'll just say that."**

As was cited earlier in this report, the 2023 and 2024 state mobile crisis grant contracts were $41.2 million, however, the amount requested by mobile crisis exceeded the amount available by $23.2 million which caused delays in contract disbursements.[18] This works out to approximately $7.22 per capita (based on 2021 MN population of ~5.7 million). In comparison, according to data from the U.S. Census Bureau, state and local spending on police protection totaled $2.4 billion in Minnesota in 2020, or about $423 per resident, the 10th highest per capita spending among the 50 states.

> **"Huge area needs more funding to ensure entire county is covered with services."**

> **"Streamlining the funding – FMAP funding hasn't received a contract, hasn't started anything because of the delay in the funding. Can't do the expansion because the contracted funds haven't come."**

> **"Mental health professionals are too stretched to run a program 24/7. Everyone is in-house for three**

17 MN National Alliance on Mental Illness (NAMI) Workgroup Letter.2022.

18 Department of Human Services. Letter to Mobile Crisis Provider for State of MN.2023.

hours out of the 24 hours. Not enough of them to go around. MHP working 40 hours a week (ha, ha) and in addition, completing on-call and every other weekend, three nights a week."

Barrier: Travel time and distance

Many survey respondents as well as focus group participants identified the travel time and distance as a significant barrier to sustainability and overall responsiveness to those experiencing a mental health crisis. In 2019, the Rural Health Advisory Committee (RHAC) formed a workgroup to assess mental health in rural MN with a focus on mobile crisis work. Rural crisis teams face a unique set of challenges due to the distances they have to travel. This can often result in delayed time or ability to meet face to face with an individual in crisis. RHAC highly recommended increasing funding to more staff to cover larger areas. Additionally, rural teams noted that there are occasions where the locations they need to travel to are so remote that safety is a concern.[19]

"Our team covers a six-county area so with the geographic distance and the number of partners (law enforcement agencies, hospitals, etc.) it can be difficult to be responsive and have adequate staffing sustainability to the entire region."

Barrier: Availability of transportation for individuals in crisis

There are numerous barriers that make it difficult to provide appropriate and secure transportation to clients who need a higher level of care, especially in rural areas:

"I'm the Team Lead for Mobile Crisis with Sanford which services Region 2 for adults and youth only in Beltrami County. We often run into barriers with transporting patients who are needing a higher level of care safely and securely to the appropriate level of care. Often, transporting by LE or ambulance is not an option, such as in LOW County they have limited LE and only an on-call ambulance service with one ambulance for the county. When a client has been assessed and identified needing acute psychiatric hospitalization it becomes a challenge to get the individual there safely."

"Roughly for the past seven years we provided mental health transport for individuals who are needing acute psychiatric hospitalization as the closest inpatient unit is just over 90-122 miles away (from Bemidji, or Baudette). With language changes in the statute and through our most recent audit, we learned this is no longer allowable through crisis, which poses a significant barrier for individuals in crisis."

19 Recommendations on Strengthening Mental Health Care in Rural Minnesota. MN Department of Health. Workgroup of the Rural Health Advisory Committee. 2021.

Transportation for crisis services is a reimbursable service. However, it requires two drivers or a driver and a service provider for rides over 100 miles which costs double. MN DHS has protected transportation providers who are contracted to provide this transportation for individuals covered under MA, but the service is under-utilized.

Barrier: Systemic racism

Many factors suggest that depression goes undiagnosed and untreated at disproportionately greater rates in majority Black and Hispanic communities, causing disproportionate suffering among individuals and family members. The Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health found that while rates of depression are about the same among various racial and ethnic groups, more Black and Hispanic individuals reported a moderate to severe impact from depression on their lives, including their ability to manage at home, work and close relationships, compared to White respondents. The reasons for these inequities include structural racism in the healthcare system, social stigma around mental health issues in BIPOC communities, and a greater distrust in the health system overall in these populations. The lack of BIPOC mental health providers is another key driver: research shows that Black and Hispanic individuals are more likely to want a mental health provider of the same race and ethnicity or cultural background with similar life experiences. Finally, a lack of access to mental health care contributes to these disparities - according to the most recent Blue Cross Blue Shield Health Across America report, in communities with greater access to mental health care the rate of diagnoses increased significantly.

Historical, generational, institutional, and present-day trauma have been identified as major contributors to mental illness in communities of color. According to Sue Abderholden, Executive Director of National Alliance on Mental Illness Minnesota, "One in five people suffer from mental illness, but communities of color face more risk factors, including poverty. In 2015, only 1% of Minnesota's licensed social workers identified as Latino and 2% as Black on the state's mental health workforce."[20]

When asked specific questions around cultural competency, respondents had this to say:

> **"It isn't enough to have culturally competent teams; what's essential or critical is to have teams that reflect the communities served. If the mental health crisis is in the Black community, a team of Black mental health practitioners should be dispatched. The same for Somali, Hmong, Latin, LGBTQ+..."**

> **"Law enforcement in Itasca County, and especially Grand Rapids, MN, are rude, brutal, and traumatizing in their reactions, (NOT responses), to people in a mental health crisis. They also are**

20 Sapong, Emma (2017)."Minnesota struggles to catch up as minority mental health needs grow." MPR News August 3, 2017. Accessed on March 2023; https://www.mprnews.org/story/2017/08/03/mn-slow-to-respond-as-minority-mental-health-needs-grow

extremely deficient in cultural competency regarding Indigenous, Black, and Brown community members, as well as LGBTQ+ community members!!!!"

BIPOC are less likely to receive mental health services compared to those who are White, due to a variety of systematic barriers – racism and a culturally incompetent healthcare system. At the same time, their risk factors for trauma and mental health issues are significantly higher.[21]

"A young Black male was attempting suicide. My partner was called and went to check on the young man and realized he had a gun. My partner was not concerned about his own safety because he has a chronic mental illness, is a peer support specialist, and understood the young man's mentality. He was trying to save the young man's life. He called me and asked me to call 911, alert them to the situation, and ask them to refrain from using sirens. It took three calls and over 45 minutes for responders/police to come. When they (several squad cars) arrived, they manhandled the young man by throwing him on the ground, handcuffing him, and taking him to the police station."

"Increase the number of Black mental health professionals in Minnesota – especially in areas with the largest Black communities. Make all mental health medication affordable (either subsidy or price cap). No one should have to pay $300-$1,200 for a 30-day supply of meds that help them manage mental healthcare."

MN needs to continue to make a significant investment in culturally competent mental health care. With the passing of the bipartisan bill HF 970, which allows pathways for funding to increase the number of clinical supervisors from BIPOC and underrepresented communities, set standards for cultural competency continued education, and have cultural diversity standards for licensing boards, MN is on the right path.[22] Other models of diverse care like Canopy Roots Health Counseling in Richfield, a Black-owned counseling agency with providers who are predominately from BIPOC and/or LGBTQI communities is a wonderful example of inclusive care. Furthermore, the City of Minneapolis recently contracted with them to provide mental mobile health crisis response. These types of models need to be replicated throughout MN.

Cultural integration challenges between police and mental-health/ human services professionals embedded in the PDs:

Co-responder models appear to be a useful model that augment law enforcement and in some locales, the mobile crisis team's capacity to respond to behavioral health crises effectively. Because these interventions are not built on a third-party reimbursement model and are not

21 NAMI. Accessed on March 9, 2023; https://www.nami.org/Advocacy/Policy-Priorities/Supporting-Community-Inclusion-and-Non-Discrimination/Mental-Health-Inequities-Racism-and-Racial-Discrimination

22 Wilder Foundation. Accessed March 9, 2023. https://www.wilder.org/articles/building-stronger-more-diverse-mental-health-workforce

regulated by statute, there is more flexibility for communities to expand their response to individuals in crisis in this manner.

However, in practice, there can be challenges. We interviewed one co-responder, a woman of color, a social worker, placed in a suburban Twin Cities PD:

> **"Other things that I noticed and experience is this concept that I was supposed to assimilate to this blue world and kind of fall in line and do whatever they thought I was supposed to do. I encouraged that there could be this . . . more of an idea that we kind of bridge together. Just as it is important for me to understand this blue world, you [law enforcement] have to understand the world of social services and mental health. And by that I also mean diversity and equity inclusion is a huge part of it. We can't say you know, as a city, XXXX rejects racism when you really . . . when you don't. I think there could be specific training that could be made available and again, not expecting one group to assimilate or the other, but we can work together and understand both roles.**
>
> **"Right, [co-responder models] sound like a good idea. And right, let's go do this. But then they don't really think it out and how it's going to be most effective and how can we work collaboratively? I feel like for myself, I don't come from a family of police officers or even military, right so this was a whole other world for me, but I felt like I made significant efforts to ensure that I could immerse myself or try to understand. I met with different embedded teams, different chiefs of police, and went to this training, spent time meeting with this person, so I feel like I really tried to, again it's my responsibility. I can't just come into their space and then expect them to operate in the way that social services would and vice versa. But I did that.**
>
> **"What are they specifically doing? Like I'm saying to understand the role of a social worker and even our ethics and our values. I know that there's quite a few people that don't believe that social workers should be embedded specifically within the department. Can they still partner and collaborate? Absolutely. And that's my questioning too. You know, it could work different for each department. But like I said, I felt like I could have still been in my role and been quite successful. Whether I was specifically within the department or within this city office."**

She explained an incident where her approach and the approach of officers were at odds. When following up on calls from the night before, she would often go out with an armed law enforcement officer, although sometimes she would go by herself. The response in general varied among community members:

> **"We would ride in an unmarked police vehicle – there's like a van that we would ride in together. So sometimes we would do like door knocks. Sometimes I would do them by myself and just leave information. The response that we got from the community was mixed: sometimes it would be like, 'oh my gosh, the police are here what's going on?' And other times people are so excited to hear about this community action team that exists."**

Responding to a situation involving racialized trauma proved problematic:

> **"Where some of the concerns arose is anything that seemed to be regarding race. I can give you an example. There was a particular family that had a neighbor who was calling the police over and over and over again. And if you read the police report, one would say like, 'I wonder if Karen lives next door and Karen is calling' because the things that would be in the police report—do people call the police for that? And so when I went out to meet with the family, me and my partner went out together, it was a family of color. She's like, 'Oh my gosh, like what are you guys doing here? So there's already been like three police officers to my house this week.' And we said 'Oh, you know, like this, we didn't know that. This is our first time coming out, we can explain our role.' She had described having an uncomfortable experience with a police officer the previous day. I didn't necessarily know all the police officers at that time but I would say, I was just trying to validate her information, explain my role and say, you know, I can come back out and I don't have to bring my partner, it's not a safety issue. I can provide some supports. I had asked my partner so well, you know, in the future if people have concerns, interactions with police officers, how do they make a complaint, like how does it go? I know in other departments, the citizen could just probably go online and make a report if they felt like something unsatisfactory had happened. He said he didn't know.**
>
> **"I think it was some days later, I was approached by a lieutenant that pulled me aside in his office and his mannerisms and how he interacted with me—I felt that he was trying to demonstrate that he's in a position of power, right, like he's over me and to kind of remind me what my role is or isn't. And he didn't explain that he was the officer that responded, but I could tell from the dialogue that he essentially was. He said 'Oh, I heard someone's trying to play the race card. You know, you can watch my body cam footage or whatever. And you can see that this didn't happen.' And I was like, 'Well, you know, do you understand that even you just showing up in your uniform, how triggering that could be especially for a person of color? It doesn't matter if you're a police officer in City X, or Y or wherever. You're wearing the same uniform essentially. And that creates a lot of hyper vigilance.' And so I tried to provide some education around that. And I tried, I talked with Ramsey County about it and they're going to handle it you know, that situation that happened.**
>
> **"I was going out to respond to the family of color. I asked the family you know, 'Do you want me to come out with my [law enforcement] partner?' But I was told 'no' multiple times by this family. 'No, I don't want any more police on my house.' I said that's fine. I received a lot of pushback from the police department saying that they needed to go out. And as well why would this particular family be an issue? You don't always go out with me. There's no safety concern. I can tell you that there's trauma here. And then also can we even understand like the historical trauma piece of why like it might be actually more helpful in repairing relationship not to go."**

This story, disturbing as it is, points to a variety of potential pitfalls in the co-responder model: First, the different culture and expectations of functioning within a police force when it comes to chain of command and when an officer should defer to the judgement of the mental health

professional. A chain of command approach is necessary in police work, but is antithetical to the more collaborative management style that is characteristic of mental health and human services. In a different conversation, we heard from law enforcement personnel that while people entering law enforcement do so with the expectation that they will be a first responder, people entering mental health or human services professions do not. These are two different orientations. Policies and procedures need to be clear, and reporting relationships should be explicitly laid out.

In this case, the unwillingness of the LE officers to acknowledge the role of racial trauma in the family's response to officers coming to their door and their reluctance to engage with police is striking. Further, the LE officer's refusal to allow the social worker to acknowledge this trauma and work with the family without LE assistance when no threat to safety was identified appears inexplicable (although we did not hear the story from the LE officers involved). While it is tempting to attribute this to the individual officer involved, there is a wide acknowledgement of the racist history and culture of police nationwide. Many individuals, disproportionately BIPOC, tragically have had frightening and fatal interactions with police. On balance, co-responder responses are found to be less traumatizing:

> **Eight studies reported on the views of those who had experienced a co-response intervention [12, 14, 15, 25, 26, 30, 33, 35]. In five studies, participants reported that previous interactions with the police were traumatic [12, 14, 15, 30, 35] and in four how their illness had been treated as a criminal matter rather than a mental health one [12, 15, 30, 35]. In comparison, co-response models were better at de-escalation, less threatening, and less stigmatizing [12, 14, 15, 25, 26, 30, 35]. Service users in one study suggested that the use of unmarked police cars and non-uniformed officers would further reduce distress and embarrassment [15].**[23]

The same authors conclude that:

> **Preliminary evidence suggests that co-response models of mental health police triage may reduce the use of police powers of detention on people with mental illness and be more acceptable to service users than a standard response. However, there remains a lack of quality of reporting in studies, few controlled studies investigating the effectiveness of co-response triage, and a lack of focus on the characteristics and outcomes of service users.**
>
> **There are many unanswered questions about the effectiveness of police mental health triage. Is a police response the most appropriate response for people in mental health crisis? Alternatively, would an ambulance-based mental health crisis response be more effective, and more acceptable,**

23 Puntis S, Perfect D, Kirubarajan A, Bolton S, Davies F, Hayes A, Harriss E, Molodynski A. A systematic review of co-responder models of police mental health 'street' triage. BMC Psychiatry. 2018 Aug 15;18(1):256. doi: 10.1186/s12888-018-1836-2. PMID: 30111302; PMCID: PMC6094921. Accessed 3.10.23 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6094921/

than a police response? Is the perceived increased need for police mental health intervention due to a lack of appropriate mental health support elsewhere in the healthcare system? How can we better care for those who repeatedly make use of the triage service, for their benefit and for other users who need access?

Given the considerable recent investment of resources by police and mental health services, thoughtful evaluation of triage services should lead to the development of models rather than be left as an afterthought. Rigorous data on outcomes, both immediate and long-term, following a triage intervention is needed. We also need further exploration of service users and their carers' experience of triage, and their participation in the design of these services. Finally, we need to move toward better model description and evaluation, with the aim of creating fidelity indicators linked to good practice and good outcomes.[24]

24 Puntis S, Perfect D, Kirubarajan A, Bolton S, Davies F, Hayes A, Harriss E, Molodynski A. A systematic review of co-responder models of police mental health 'street' triage. BMC Psychiatry. 2018 Aug 15;18(1):256. doi: 10.1186/s12888-018-1836-2. PMID: 30111302; PMCID: PMC6094921. Accessed 3.10.23 from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6094921/

Improvements Needed

Top Areas for Improvement

Top Six Areas of Improvement: # of Survey Respondents Indicating Issue

Improvement: Availability of appropriate transportation options

Aligned with the section on barriers to sustainability, participants chose the availability of appropriate transportation options as their top area for improvement.

Experiencing restraint and police transport can be disturbing and difficult:

> **"I was having a mental health crisis and hyperventilating. My mother called 911 and an ambulance took me to the hospital. I was in a place where I didn't care anymore if I lived or died. One person came in the room to speak to me, and I expressed what I was feeling and it was decided for me to be inpatient at a mental health facility. I was handcuffed and placed into the back of a police car and transported to the facility. Being handcuffed was extremely disturbing to me and made me feel more worthless. I've never been handcuffed before or rode in the back of a police car ever! I didn't even get to talk to my mom before I left the hospital."**

Law enforcement must place individuals who ride in the back of their vehicles in handcuffs. This is the law and is used to protect the individual from harming themselves or others. In some cases, this causes un-needed embarrassment and shame for someone in a mental health crisis, as in the example above. However, there are times when someone is actively psychotic and has been assessed to be dangerous to themselves or others and a transportation hold has been placed and force is needed (only done by police) to put the person in the squad car to be transported to an ER or stabilization unit.

One area of improvement that LE respondents identified that would be helpful is clarity on who and/or expansion of who can write a transportation hold. Currently, only LICSWs, psychiatric nurses, providers, and LE can write transportation holds. One LE stated, "LGSWs clearly have more mental health knowledge than police officers. If they could write holds, this would take pressure around liability off of the police officers." And conversely, LICSW respondents expressed frustration when LE does not honor their assessment or transportation hold:

> **"[LICSW] My biggest struggle is getting LE to honor our holds when someone is wildly psychotic. Their definition of imminent risk is much more raw."**

Clearly, improved communication, role definition, and the honoring of evaluations done by mental health assessors would be a good first step in lessening the burdens involved in these critical situations.

Improvement: Coordination between entities

This area is critical. When coordination is present, it is viewed as a key strength, and when it is not, it is perceived as a barrier and an area for improvement. Notable collaborations include:

Dakota County Crisis Response

In 2020, Dakota County set forth an ambitious plan to evaluate and recreate their crisis response model. Using County data from 2018 onward, they identified areas that needed improvement and utilized the SAMHSA Best Practice toolkit as their guide. They started with a multiagency approach including County-based services, community mental health nonprofits, and LE. Their goal included: increase capacity for phone and mobile crisis response; develop alternatives for mental health crisis transportation; modernize access to crisis triage, short-term and residential support; and expand crisis follow-up with an embedded social worker model. Over the last few years they have hired nine social workers (unheard of in other counties) who are embedded in 911 triage centers and within police departments. They have stated distinct goals to "breakdown service silos," and they have been successful.[25]

Per one of their six-month client follow-up surveys, "Seventy-three percent of clients responded that they were satisfied or very satisfied with the coordinated response teams." Additionally, they have built resources for CIT training and have approval for building a Residential Crisis Center for the community in partnership with Guild Services.

Much of their success was built on shared memorandums of understanding and operating procedures with partners and having social workers hired as county employees, which gives them easier access to larger social service information. As stated in the executive summary, this model is an exemplary one for other counties in MN.

25 Dakota County, Community Services Committee of the Whole, Crisis Follow up Services PowerPoint. Accessed on 3/1/23 https://www.co.dakota.mn.us/Government/BoardMeetings/CSCommittee/CSCommitteeMtgMaterials/Mental%20Health%20Crisis%20Follow-up%20Services%20Oct%202021.pdf

The Yellow Line Project in Blue Earth County

https://www.yellowlineproject.com/

Prevention-focused projects like The Yellow Line Project are designed to **provide an early response** to individuals with acute or chronic mental or chemical health problems who have become involved with law enforcement and are not a risk to the community.[26]

> **"The underlying systemic goal is to streamline the decision-making between law enforcement, human services, and community-based care providers so the most cost-effective services are provided and less incarcerations are needed."**

The Yellow Line Project has been highly successful. Their website offers step-by-step instructions as well as an operational toolkit for all communities to utilize.

Revolutionary Emergency Partners (REP) Twin Cities

https://www.repformn.org/

This is a grassroots organization responding to trauma and crisis through strong communities and networks. Two of their guiding principles are – Black love and liberation. Their work began in 2020 when core members where doing crisis work during the uprising. They saw a need to make crisis more sustainable and grounded in community work. The model is similar to the Crisis Assistance Helping Out On The Streets (CAHOOTS) model.

REP provides emergency care to community members via secure hotline. They can offer the caller to be connected with a community resource trained in mental health first aid and de-escalation; or send a response team to provide immediate support. As they begin rolling out, they are focusing on 80% of 911 calls that involve non-violent calls – noise, mental health support, neighbor complaints, referrals, and some "welfare checks."

Models like REP are an important layer in the crisis response and can assist by addressing non-violent crisis calls avoiding LE.

26 https://www.yellowlineproject.com/

Improvement: Receiving and using feedback from people with lived experience of mental illness and/or substance abuse

People who live with mental illness have a wealth of experience and information to share. Those with lived experience are at the core of understanding an appropriate and effective crisis response. MN has recognized the role of peers in mental health and recovery for quite some time through DHS's Certified Peer Specialist Program.

> **"Since 2009, DHS has funded ~ $150,000 every two years for mental health peer training and support. Thus far, ~1,300 peers have been trained. Unfortunately, only 300 are currently working."**[27]

An Executive Director of a mental health peer-run organization that operates "warm lines," states:

> **"The underutilization of peers is a significant issue in our mental health crisis response. It takes patience and support but I have 50 employees and a 95% retention rate. We have a workforce shortage and we have all these people out there with lived experience."**

Additionally, many counties and contractors to counties operating mobile health crisis teams, such as Canvas Health and others have certified peer specialists on staff. They can sit with clients in crisis, empathize with what they might be experiencing, and skillfully offer assistance, resources, and support.

Best practices dictate certified peer specialists should be utilized throughout the mental health crisis continuum – be it a peer specialist on a mobile crisis team, an advocate in the emergency room, a warmline responder, or crisis worker. When we asked DHS staff responsible for peer programs why they thought more peers were not employed they said,

> **"To be successful, they need to be paid more, guaranteed hours, and have more support and training on the job." People with lived experience do not want to be used as tokens. They have significant experience and skills which need to be tapped."**

> **"As a peer, I feel it is vital we have more peers on the team. I also feel that peers need to be allowed to have more engagement and do our job instead of being the "paper person." We have a lived experience, some of us over 20 years of navigating the recovery system, and our input is valid. Not to mention, we really do need more funding so that we can have competitive salaries."**

In our Lived Experience Survey, those living with a mental illness, or family members with a loved one with a mental illness, had this to say:

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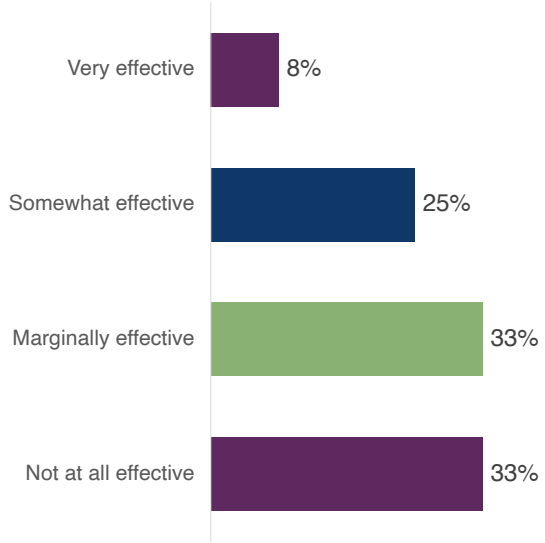
27 DHS Behavioral Health, Family and Peer Policy Expert. On November 29, 2022.

“Really, really listen to the patients and families.”

From your perspective, how effective is crisis response in providing the assistance you or your family need?



Improvements: Availability of resources for referral, ability to prevent future crises, and ability of crisis team members to follow up and ensure clients have received what they needed

These three are grouped together and all stem from the scarcity of mental health resources, especially crisis and psychiatric beds. Since the 1950s, inpatient psychiatric bed capacity across the nation has shrunk by over 90%, relegating many individuals with severe mental illnesses to emergency rooms, jails, or the streets. Lack of beds leads to repeated crisis calls by the same individuals—from home or the ER, and/or jails.

Unfortunately, ERs have become the most common entry point for a psychiatric crisis, and on average it takes 3.5 days for a hospital bed to become available, and often much longer for children and adolescents. In MN, there are 202 psychiatric hospital beds for youth and 590 adult beds. However, Minnesota ranks 50th out of all states on having the fewest number of psychiatric beds per capita (3.5 beds per 100,000). The recommendation by health policy experts is 40-60 mental health beds for every 100,000 people.[28]

> **Increasing the number of crisis beds was clearly indicated as an area for improvement across our data gathering. Crisis beds for children in MN was specifically identified as a need.**

Here's what respondents had to say:

Children need specialized care

> **"The ER staff placed my child in a solitary confinement room and locked me in there with him upon my arrival just behind his ambulance. The ER staff confiscated our belongings and rarely appeared to check on him/us during the many hours we waited there. The staff could not find an inpatient room for him, so they changed the recommended LOC from Inpatient to Home. He was discharged with no changes to his care plan, in spite of my insistence that his behavior is a safety risk to himself and our family."**

> **"We come across the same barriers as providers state-wide regarding children with significant aggression and a lack of resources. Many children end up going to the ER which is not appropriate but is also the only immediate option. Crisis beds are not available for months at a time. PRTFs and Rule 5 Residentials also have extremely long waiting lists in addition to the quality of services as RTCs. Many therapists and in-home supports will not accept children with the level of behaviors and**

28 Archbold, Todd (2021). Facing a Psychiatric Bed Crisis: When demand exceeds supply. Minnesota Physician Journal. March 2021 Volume XXXXIV, Number 12. Accessed 2023. https://www.mnphy.com/MP_0321_S1_Todd_Archbold

mental illness we have been seeing for the last 5-10 years. This number is only increasing."

"Our community lacks access for holds/stabilization and 35-day evaluations for children, pre-teens, and teens. Often a parent waits in the local ER for days so they can find a bed. The child and parent are left waiting in an ER exam room for days. It is not a calming, comforting, or caring environment. They do not have things like toothbrushes for the child to use. I have experienced the ER staff not ordering and giving my child their mental health medication in the morning when I had to leave for a while—even after I inquired on this. My child has waited in the ER for three days and not been able to even shower. We often had to ask to order food, too. My child has been hospitalized three times. The only time she was treated with care and reassurance was when we ended up in an ER located in a different town. The staff was even caring to me. We had one experience when hospitalization was good."

"I'm probably a broken record. Everybody would say this, but bed space and availability, and housing, everything from long-term housing to short-term housing are the biggest challenges. Right now, two or three times this week, we've needed to bring people to the hospital for evaluation. And we've been facing up to four-hour wait times. So, we actually then bring them to the hospital in St. Peter, which is about 10 or 15 minutes north of us. We also have a great deal of mental health patients on commitment that are really stuck in our emergency department. Speaking on behalf of the hospital, I know that this taxes their staff and is very stressful. But then we (LE) are then also called up there to help with challenging patients' rights. We're being called up there to help stand by while medications are being administered and restraints are being done. It puts everybody in a situation that is not beneficial for anyone. It's not that the police officers want to go and have to use force. Somebody on a commitment—the hospital staff aren't trained and don't want to but then for the individual themselves . . . it's not a good situation for them either. And so, really, our hospitals and our emergency departments have become de facto inpatient units, short term, or long-term care, and they're just not equipped to be able to do that. So, I can think back, I've been doing this—I'll be starting my 24th year here in May. When beds in the community-based hospitals were getting closed, I think that was really the start of it. We have a behavioral health unit in our hospital here in Tallinn, but I don't think it's got more than 10 beds in it. It probably could have 30 or 40 beds and still have a waitlist."

It is commonly known that reimbursement for mental health services is at least 20% less than the rest of health care.[29]

29 Archbold, Todd (2021). Facing a Psychiatric Bed Crisis: When demand exceeds supply. Minnesota Physician Journal. March 2021 Volume XXXXIV, Number 12. Accessed 2023. https://www.mnphy.com/MP_0321_S1_Todd_Archbold

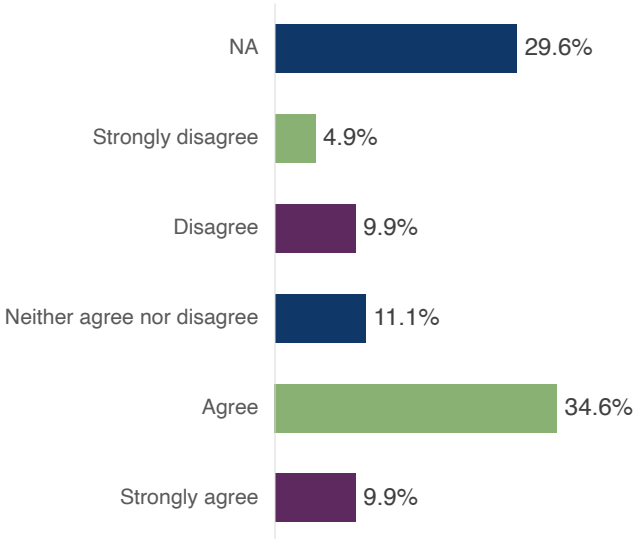
Improvement: Address and treat co-occurring disorders of mental health and substance use

Those living with mental illness often have a co-occurring substance abuse disorder as well. According to SAMHSA, approximately 9.2 million adults in the United States have a co-occurring disorder.[30]

Substances like alcohol, marijuana, and/or meth are often used by individuals to dull or treat symptoms of a mental illness. During a mental health crisis, individuals may also be under the influence of substances. These are both medical problems that need to be addressed. Yet we found in our survey that many responders feel underequipped on how to handle co-occurring mental illness and substance use.

> **"Local ER lacks care and willingness to help those going through alcohol withdrawal. Ambulance has refused to take an individual that was going through seizures, stopped breathing several times, and needed help. Patient and family was told there was nothing they could do and to keep an eye on this person. I have sat in the local ER and heard the doctors and nurses talk about patients and incoming patients. This is a breach of privacy laws."**
>
> **"Our regional crisis team does not respond to people under the influence."**
>
> **"They [mobile health crisis team] specifically state they DO NOT respond to persons under the influence of substances."**

As a responder, I have effective tools/strategies to determine whether substance use is involved in the crises:



30 SAMHSA. Co-occurring Disorders and other Health Disorders. Accessed on 3/9/2023. https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/co-occurring-disorders

Unfortunately, there can be deadly consequences (especially when not treating or assessing for alcohol or other substance withdrawal) for individuals living with mental illness and substance use disorder.

> **"I had a family member that struggled with alcohol addiction. There was a time this individual's parent brought them into the only local ER due to dangers and high risk from alcohol detox. The ER gave this person fluids and medication to stop the vomiting and shaking. After about two hours the individual was discharged. Once arriving home (about a 20-minute drive) this individual started having seizures and stopped breathing. The mother did CPR and called 911. The 911 call went through another county dispatch. This dispatch person knew the individual and shared this information with other family members. When the ambulance arrived, the mother was told that there was nothing they could do to help because he was going through detox and they refused to take him to the ER. The ambulance was called twice that night and they refused care both times."**

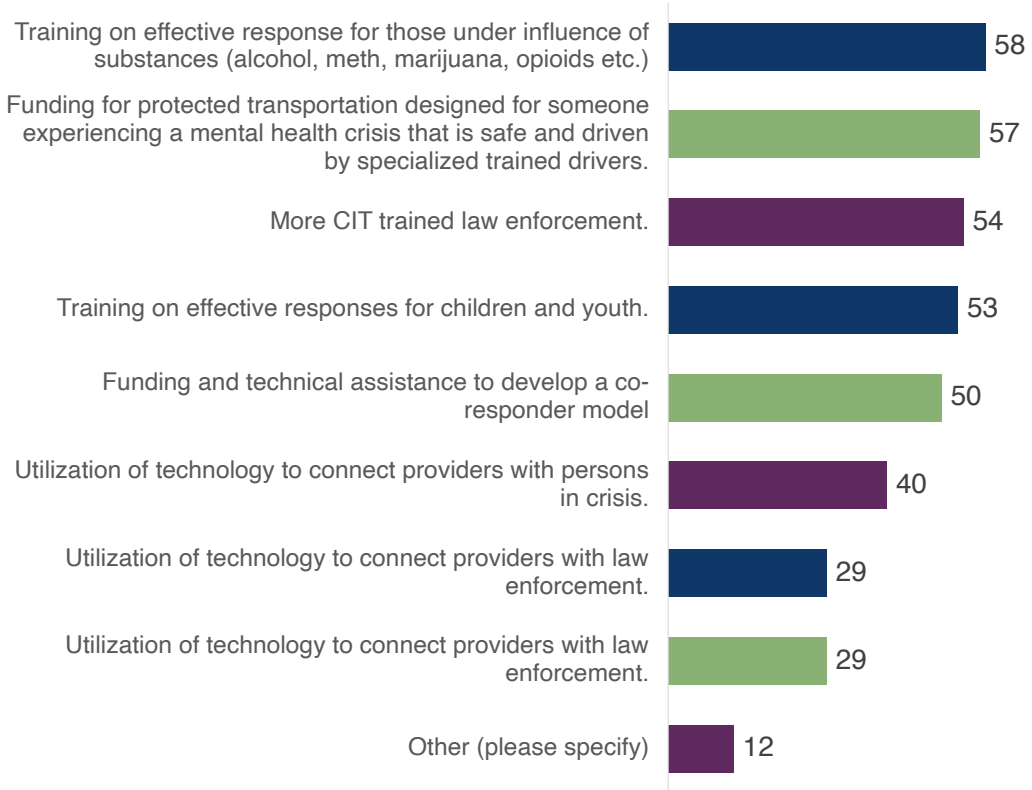
Substance abuse and mental health services can no longer exists in silos. Crisis providers need tools like screening and referral processes for co-occurring mental health and substance use disorders. This is a great opportunity to bolster crisis teams with peer recovery specialists and licensed alcohol and drug counselors (LADC). All hospital emergency rooms have protocols in place to medically monitor those who are actively using substances and those who may be going through withdrawal. This needs to be followed and enforced. Additionally, there needs to be a cultural mind shift to treat individuals who are living with both addiction and/or mental illness in the same way we treat any other medical illness, with skill, compassion, and without judgement.

Solutions

Solutions to identified barriers for providing or expanding crisis response services

Respondents were asked to identify areas where they want to build greater capacity in their geographic areas that focus on strengthening their mental health crisis response system. They identified the following areas:

Capacity building strategies or program models you believe would be helpful in your service area:



These areas continue to be identified by providers and community members as evidenced by multiple previous reports, listening sessions conducted by DHS and MDH, law enforcement best practices, the white paper by CUAPB, NAMI, and dozens of community mental health providers in the field. These solutions can be achieved by using the following recommendations.

Solution: Address issues with transportation

Those experiencing a mental health crisis should be entitled to safe, confidential transportation as opposed to being handcuffed and placed in a police vehicle or ambulance. NAMI and other mental health provider and advocacy groups have long recognized this need. Since 2015, protected transport, which is designed for someone experiencing a mental health crisis, has been available but is rarely used due to the complicated authorization and billing for Medicaid.[31] Protected transportation also requires that two people (one driver and one attendant) be present for transportation over 100 miles.[32] These distances are common in rural areas, but often two people are not available. Furthermore, in rural areas, LE and ambulance services are not always abundant or available for transporting higher acuity patients. In some situations, this has left mental health providers as transporters which is both unsafe and costly.

According to the Rural Health Advisory Committee:

> **"Protected transport providers must be certified by the Minnesota Department of Transportation and have a protected vehicle that meets the criteria for the service and is not an ambulance or police car. Some counties shared they were considering contracting with protected transport services that could transport patients to facilities outside their region. While some areas considered this a potential solution, other regions chose not to pursue this option as they did not have the volume necessary for a transport company to create a hub. We recommended the counties explore other uses for protected transport that would increase volume and allow this solution to be viable."**

Another recommendation by this workgroup that we support is:

> **"Regional coalitions creating a discretionary fund that can be used for transportation One issue raised frequently was the cost of transportation. People experiencing a mental health crisis in rural areas often have to travel farther for treatment, which costs the person or party responsible for the transport more time and money. One regional coalition shared that they have worked to ease this burden by using grant funding to create discretionary funds that can be used for transportation costs."** [33]

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31 MN NAMI Mental Crisis Response Workgroup.2020.

32 DHS. Protected Transportation. https://www.dhs.state.mn.us/main/idcplg/Dental-Services-Overview.doc?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-288176

33 MDH. Recommendation of Strengthening Mental Health Care in Rural Minnesota: Workgroup of the rural health advisory committee.2021.

We also suggest exploring why protected transportation is not being utilized, alter the system, and address Medicaid reimbursement concerns. For a robust and functional mental health crisis system, low barrier transportation needs to be available 24/7.

Solution: Provide leadership and support for multi-agency collaboration and coordination by following SAMHSA best practice guidelines

In 2020, SAMHSA produced, "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit." The toolkit identifies core services and best practices which include 1) Regional Call Center; 2) Crisis Mobile Team Response and 3) Crisis Receiving and Stabilization Facilities. These core services are all available in MN. However, they need strengthening in the form of coordination, collaboration, role definition, funding, and expansion of services and staff. We heard from key informants, including Dakota County and members of the East Metro Crisis Alliance, that in building their county's successful mental health crisis system they relied heavily on this SAMHSA toolkit.

SAMHSA asserts that mobile crisis team care is one of three essential elements of a well-integrated crisis system of care. To maximize effectiveness, the availability of mobile crisis services should match needs in the area/region they serve on a 24/7/365 basis and should be deployed and monitored by an air traffic control (ATC)-capable regional call center. Essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;
- Peer support;
- Coordination with medical and behavioral health services; and
- Crisis planning and follow-up.

Currently, crisis teams are deployed on a county-by-county basis, with potential access via 911, 988, or the direct crisis line number for that county. Teams cover both the phone screening, decisions about dispatch, and all interventions and follow-up. Peer support is not consistently available.

In MN, as in some other states, a comprehensive statewide response is hampered by the fact that different aspects of the response are governed and funded by different state agencies, with different missions. Law enforcement is multi-jurisdictional, with funding at the state and local level, both city and county, and the Department of Public Safety is the applicable state agency. The Department of Human Services oversees the contracts for the county-based mobile crisis teams. Dispatch response is overseen by the Emergency Communication Networks division of the MN Department of Public Safety.

Our research found that in communities where multi-agency collaborations between LE, mobile crisis, hospital systems, and the behavioral health division were occurring having a multi-agency release of information (ROIs) for an individual they all worked with in addition to memorandums of understanding (MOUs) were critical. This shared understanding allowed those in crisis to be served faster and with better quality of care. Crisis system collaboration and coordination is also outlined as a best practice:

> **"Agency-to-agency collaboration is essential and may manifest through personal relationships of leaders, memorandums of understanding (MOUs), shared protocols, or more advanced high-tech solutions such as real-time bed registries, shared GPS-enabled communication to support dispatch, and outpatient appointment setting through the call center hub."** [34]

Throughout the other focus groups, providers were asking for direct input and leadership on building multi-agency collaborations. While many providers and counties are finding the time to create this collaboration on their own, others lack the resources and time to do so and need leadership. Toolkits on best practices are wanted and needed across many communities.

Collaboratively provide education and address concerns around the implementation of Travis's Law and 988 utilization

Given the relatively new implementation of Travis's Law and 988 call centers, more resources need to be given to providers and LE regarding the implementation of the law and defining roles. Respondents we spoke with made it very clear with regard to Travis's Law that this looked very different at each "local level," with some communities using, understanding, and implementing and others unable or unwilling to do so.

Travis's Law was sponsored by Representative Jessica Hanson, DFL-Burnsville and drafted through the MN state's Public Safety and Criminal Justice Reform Finance and Policy committee. As Rep. Hanson, CUAPB, and other providers acknowledge, there is still much work to be done for the law to fulfill its purpose. We encountered numerous misunderstandings and reports of misunderstandings of the law, affecting to what extent and how it is being put into practice. During our data collection process, several mental health crisis providers asked for clarification from DHS regarding this statute. They were especially interested in a definition of their role, particularly in cases where LE interpreted this law to mean that mental health providers were to be the first responders without police presence at all. When asked, DHS made it clear they were not involved or consulted in the drafting or implementation of the statute, and therefore were unable to provide clarity.

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34 National Guideline for Behavioral Health Crisis Care Best Practice Toolkit. Substance Abuse and Mental Health Services Administration (SAMHSA).2020.

Rep. Hanson stated that the bill she introduced was changed in the Senate – "the one signed into law — placed the dispatch of mental health teams in a second paragraph and called it an additional step." She further stated, "It leaves it open to interpretation," allowing Minneapolis and other jurisdictions to avoid using a co-response model in situations when violence is threatened. She said she wants the primary response eventually to be done with mental health crisis teams with the biggest goal to end the police-only responses."[35]

Some crisis providers were concerned that this vague language could lead them to be solely responsible for crisis response when they are short staffed and burnt out and without the safety back up of or in coordination with law enforcement. In one northern county, a respondent stated this in regard to implementation of Travis's Law and 911 dispatch centers:

> **"I'm hearing from call center staff that it isn't that way in every county, and there are some police departments that are not willing to respond in person due to George Floyd and new laws. It has made police feel unsafe in responding to those situations."**

This misinformation needs to be clearly addressed in order for LE and mobile crisis responders to understand roles and responsibilities. This should come jointly from DHS, MDH, and LE leadership who all overlap in terms of guidance on mental health crisis response in MN.

With the advent of the newly implemented 988 line and call centers in MN, MDH has been holding monthly meetings as well as Stakeholder Engagement Sessions for the community to gather gaps and strengths. From both sides this is still a work in progress. According to a community feedback session on 988, communities stated the center must have a mechanism to be aware of availability and feasibility of local crisis mobile response, and if immediate response is not feasible there needs to be infrastructure in place to handle that situation. Community members also stated they preferred technology and infrastructure that would allow three-way calls to ensure warm handoffs between call centers and crisis mobile teams and warmlines. During our focus group with 911 and 988 dispatchers, overseen by the Minnesota Department of Health (MDH), there were clear "asks" from participants on that call to have DHS mobile crisis responders included in their regular meetings. This requires coordination and buy in from DHS leadership to orchestrate.

One key informant stated that they are continuing to tell community members to use their local crisis number due to issues with 988 geolocation:

> **"We've been having a lot of conversations around 988 and the geolocation not working. I was just talking to the call center about a situation where they had a person whose area code is a Minnesota**

35 Furst, Randy (2021). "Would Travis's Law have helped Travis Jordan in 2018? Maybe not some say." Minneapolis Star and Tribune. December 3, 2021. Accessed on March 9, 2023. https://www.startribune.com/would-traviss-law-have-helped-travis-jordan-maybe-not/600123567/

area code, but the person is in Arizona, and they're in a Walmart parking lot, and they're actively saying that they're going to end their life and then the Minnesota call center here trying to find out which Walmart parking lot they are at in Arizona. How do I get responders to this person? And knowing that that could have gone really, really bad, because they've had a couple of other calls like that where they had a youth who committed suicide on the phone who had a Minnesota area code on their cell phone, but they were no longer in the state. So, I'm just hearing things like that. That's really concerning."

For 988 to work effectively and to have community members use 988 as intended—one easy central number for everyone to reach out to for help or referrals if in a crisis—geolocating technology needs to work.

A model crisis system should involve a multi-layered approach, including "co-responder" models

Our research identified at least 23 co-responder models in MN. As described in ""Appendix A: Co-Responder Models" on page 54, various types of co-responder models exist.

In MN, the predominate co-responder model is one where a social worker is embedded in a police department.

Other choices by cities and counties have included co-location of social workers in 911 dispatch centers and/or co-location of police and mobile health crisis teams. Having clinical workers on-scene during a crisis is powerful. It allows them to immediately evaluate the situation, provide quality care information, and have the ability to triage the individual to the appropriate level of care. Clinicians on the scene can provide clinician-to-clinician information allowing for continuity of care and smooth transition to stabilization services.

Additionally, co-responder models are not restricted by the statutory team requirements of mobile crisis teams on the qualifications of professionals involved. For example, in the Community Case Manager program in Northern Suburban Ramsey County, the case manager follows up on repeat callers referred by law enforcement and has a social services background. Most individuals he works with have multiple needs that are intertwined with mental health, but cannot be solved solely via mental health treatment – it requires a holistic view, including housing stability, food, employment, and health.

Consider expanding the role of the LGSW in mobile crisis teams and transport holds

One focus group participant spoke clearly about the benefits of expanding the role of Licensed Graduate Social Workers (LGSWs), supervised by licensed clinical social workers (LICSWs), to take on-call hours and perform other duties, saying it would be extremely helpful. By expanding the role of LGSWs, it would help overworked and underpaid LICSWs to avoid occupational burnout as well as expand the pool of candidates available to fill mobile crisis team positions. This most likely would require a change in statute and/or DHS regulatory clarification regarding LGSWs:

> **"[Respondent] asked DHS to create an exception and expand the role of Licensed Graduate Social Workers (LGSWs) who are capable of taking on-call shifts, but they were told they cannot be on-call or do calls. It is frustrating, as LICSWs are still responsible for the LGSWs, but they still said no, that's not an option. This would be a good fit for their (LGSW) training and a learning opportunity. We even quoted the Board, because nothing was outside the scope of practice of the Board of SW, but they were told no. They have competent, capable people, but they are getting cut off because of how the statute is being enforced. It would keep the few mental health professionals they have from burning out."**

Solution: Increase and enforce CIT for law enforcement officers

In 2017, $12 million dollars was made available to police departments for conflict management and mediation, and recognizing community diversity and cultural differences, including implicit bias training. The training includes 16 hours over three years and includes some mental health content. However, current law does not specify how many hours must be dedicated to mental health training. Documentation of these hours needs to be recorded as well as developing training materials done in partnership with mental health providers, and evaluating training effectiveness. Lastly, MN needs to expand access to the full 40-hour Crisis Intervention Team Training, offering it to rural agencies that, in particular, need resources for CIT training, or at least online access.[36]

> **"I am concerned that law enforcement (in rural areas) be adequately trained to respond to mental health crises in a manner of de-escalation."**

This training is happening in urban areas. In 2021, Dakota County created the Safety and Mental Health Alternative Response Training Center for first responder training. The 35,000-square-foot facility is a permanent home for crisis response and de-escalation training

36 NAMI Mental Health Crisis workgroup Letter.2020.

that gives law enforcement officers and other first responders the "soft skills" to improve their interaction with people experiencing a mental health crisis. This is a great start and should be expanded.[37]

We know law enforcement (LE) is a key player in mental health crisis response. They play a critical role alongside of, or instead of, mental health response. In 2022, The Minnesota Chiefs of Police Association, the Minnesota Sheriffs Association, and the League of Minnesota Cities created "Best Practices in Law Enforcement Responses to Mental Health Crises."[38] This is an important tool which outlines why crisis IS a police matter; how to develop local approaches; and highlights successful examples used throughout Minnesota where LE, mental health, hospitals, and other city and county social services entities work to address the challenges faced by those living with a mental illness and the systems that support them. This is a guide which should be shared widely throughout MN.

Solution: Invest in alternatives to emergency departments and increase crisis bed availability

> **"I really would prefer an option to bypass the ER for in-patient crisis services or crisis bed facilities. Social workers or peer support specialists would be a welcomed addition."**

MN has a handful of specialized mental health crisis stabilization centers, many of which are based on successful national models. These are specialized all-in-one mental health centers that can provide 24-hour stabilization, walk-in assessments, and some crisis bed availability.

These innovative models include:

The Southeast Regional Crisis Center (SERCC) Rochester, MN

https://www.crisisresponsesoutheastmn.com/SERCC

SERCC, is a 24/7/365 walk-in mental health facility designed specifically for people experiencing a mental health crisis. SERCC provides immediate crisis services including a few short-term crisis beds as well as integrated safety plans for those returning to the community. They serve people of all ages in the 10-county region.[39] They accept referrals from hospitals and mobile crisis teams. SERCC operates on the 24-hour model, allowing individuals and their families to be with them for 24 hours. Then they can work on finding a crisis adult or youth bed. They have 16 residential beds at the back of the center where individuals can stay for up to 10 days.

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37 Nero, Charmaine. Kare 11. "Dakota County addressing growing need for mental health services. "May 3, 2022. Accessed on March 10, 2023. Dakota County expands mental health crisis assistance | kare11.com

38 League of MN Cities, Chief of Police Association and Sheriffs. Best Practices in Law Enforcement Response to Mental Health Crises. 2022.

39 https://www.crisisresponsesoutheastmn.com/SERCC

Clarity Center for Well-Being, Duluth, St. Louis County (Pending opening 2023/24)

https://www.stlouiscountymn.gov/departments-a-z/public-health-human-services/adult-services/clarity-project

The Clarity Project plans to provide a one-stop shop of services focused on those in crisis and living with a mental illness. This will be an outpatient facility operating from 10 a.m. - 10 p.m. Behavioral health and substance abuse services will work together to provide a continuum of care for those with co-occurring illness. A patient will walk in and/or a LE or crisis team will bring them there during the day. Clients will be assessed to determine the level of care needed. Crisis stabilization will be done immediately and they will develop an integrated plan of care – primary, mental health, and dental care.

EmPath Units

This is a new emergency mental healthcare model. These units are patient-centered and designed to assist a person in crisis while also building their skills for future challenges. These units have multidisciplinary providers including mental health specialists, psychiatrists, psychiatric nurses, and licensed therapists. The length of stay is 12-48 hours. They provide a calming and specialized space for those in mental health crisis.[40]

> **"EmPath units across the county have demonstrated that up to 80% of patients who utilize them are able to become stabilized within 24 hours due to the timely and patient-centric care provided. In addition, unnecessary inpatient hospitalizations have been reduced and limited inpatient beds are reserved for those individuals requiring more intensive levels of treatment."**[41]

Fairview Southdale

https://mhealthfairview.org/blog/minnesotas-first-empath-opens-march-29-at-m-health-fairview-southdale-hospital

The Southdale Hospital emergency department saw more than 2,000 adults experiencing a mental health or substance abuse issue. They report admitting 40% of people with a mental illness. Since the EmPath unit opened in 2022, that number has dropped to 16%.[42]

> **"The space itself is a vital part of the care. The open layout and calming atmosphere stand in contrast to hectic emergency departments."**

40 https://mhealthfairview.org/blog/minnesotas-first-empath-opens-march-29-at-m-health-fairview-southdale-hospital

41 https://www.centracare.com/blog/2021/august/taking-mental-health-emergencies-out-of-the-er-e/

42 https://mhealthfairview.org/blog/minnesotas-first-empath-opens-march-29-at-m-health-fairview-southdale-hospital

Sanford Health Bemidji Behavioral Crisis Center

https://www.eapc.net/project/sanford-bemidji-behavioral-health-crisis-center/

This behavioral health center offers a variety of mental health services. It has eight adult psychiatric inpatient beds, and EmPath Unit. The center works in close collaboration with social services, LE, and community schools.

CentraCare-St. Cloud Hospital EmPath

https://www.centracare.com/blog/2021/august/taking-mental-health-emergencies-out-of-the-er-e/

The St. Cloud Hospital Emergency Trauma Center, on average, sees more than 10 patients a day with mental health emergencies which equates to nearly 4,000 patients a year–making mental health emergencies the sixth most common reason for visiting the emergency department.[43] In 2021, Centra Care opened its EmPath unit in hopes to reduce this number and provide more appropriate patient-centered care with outpatient follow ups to reduce the ED revolving door and stabilize patients out in the community.

Solution: Increase utilization of technology through improved broadband capabilities and compatible telehealth platforms

As respondents clearly articulated throughout this project, distance poses significant challenges in providing mental health crisis care especially in rural areas.

A survey conducted by the Office of Rural Health and Primary Care showed that mental and behavioral health providers were the group most likely to transition to telemedicine, with over 60% moving to this mode of practice within the first six months of the pandemic. However, telehealth only works if recipients have a platform to use and access to broadband.

The work group recommended:

- Supporting policies that increase funding for broadband development, especially ones that recognize the need for increased and affordable broadband coverage in rural areas.
- Increasing access by supporting uniform or compatible telehealth platforms.[44]

We concur with this as a solution. Additionally, funding for the mobile crisis teams and LE to have tablets would make utilization of improved broadband coverage possible.

Some communities in MN are making innovative use of technology to improve communication

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43 https://www.centracare.com/blog/2021/august/taking-mental-health-emergencies-out-of-the-er-e/

44 MDH. Recommendation of Strengthening Mental Health Care in Rural Minnesota: Workgroup of the rural health advisory committee.2021.

between providers, services, and care. In one community, 40 iPads were deployed to law enforcement to give to clients to connect with crisis teams. In Rochester, SERCC has a direct telehealth link with Mayo Clinic, allowing them to conference with providers to get medication and treat minor things like UTIs. Finally, respondents reported some crisis team members having access to police radios to increase communication and provide more timely response to those in crisis.

Appendices

Appendix A: Co-Responder Models

City Models	Type of Co-Responder Model
Rochester Police Department	Social workers are embedded in the police department and will "co-respond" and/or provide follow up support to person in crisis.
City of Minneapolis	Behavioral Response Team – Canopy roots Culturally competent mental health responders co-respond with law enforcement.
Minneapolis Police Department	Community Outreach for Psychiatric Emergencies (COPE) * (This is also HC Mobile Crisis Team) LE and LICSW respond together
City of Virginia Police Department	Embedded social worker who will respond with LE, provide follow up and/or respond alone depending on situation.
City of Virginia Fire Department	Embedded social worker who will respond with LE, provide follow up and/or respond alone depending on situation.
St. Paul Police	Has a mental health unit which seperates co-reponder model from patrol work. LE works with LCSW (less strictive education qualifications then statue mandates for mobile health crisis response) who can perform Rule 25 assessment.
Gainesville	Partnered with local mental health service providers to create co-responder teams. Co-responder teams consist of an officer and clinician trained in crisis intervention.
Roseville	Uses the Community Action Team (CAT), a specialized team including one police sergeant, five police officers, two embedded social workers, one housing coordinator, and one mental health coordinator.
Columbia Heights	The Embedded Social Worker programs teams law enforcement officers with social workers and mental health professionals to respond collaboratively when police are called. This is a partnership with Canvas Health.
Woodbury	An embedded full-time social worker works in partnership with the Community Support Team.

City Models	Type of Co-Responder Model
Duluth	Mental Health Unit consisting of two dedicated police officers and two embedded social workers. Duluth PD also have an embedded registered nurse.
Richfield Police Department	An embedded social worker works side-by-side.
Maple Grove Police Department	Adding an embedded social worker in 2023.
Eden Prairie Police Department	Embedded social worker who will respond with LE, provide follow up and/or respond alone depending on situation.
Golden Valley City Dispatch	Embedded social worker who will respond with LE, provide follow up and/or respond alone depending on situation.
Brooklyn Center Police Department	Embedded social worker who will respond with LE, provide follow up and/or respond alone depending on situation.

County Models	Type of Co-Responder Model
Carver County and McCloud Crisis Program	Social workers are co-located with 911 dispatch. They will go out with law enforcement on crisis calls.
Scott County	Law enforcement officers and mental health mobile crisis team are co-located in the same physical space.
Dakota County	Social workers are located at 911 dispatch. Social workers and trained officers can respond to or follow up on crisis calls.
Washington County	Law enforcement officers and mental health mobile crisis team are co-located in the same physical space.
Blue Earth County	The Yellow Line Project is designed to provide an early response to individuals with acute or chronic mental or chemical health problems who have become involved with law enforcement and are not a risk to the community. Yellow Line Project

Appendix B: Literature Review

1. Minnesota Department of Health: *988 Listening Session Summary*
2. Minnesota Department of Health: *988 Planning – Tribal Listening Sessions;* March 24, 2022
3. Minnesota Department of Health: *MN Suicide Prevention – Community Engagement Share Back;* March 18, 2022
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