Supplemental Mental Health Scenarios (Legislative Recommendation #7)
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Scenario 1- A residential facility located in rural Swift County and licensed through the Department of Corrections serves girls ages 11-21 who have been ordered into placement. The program focus includes a mental health component which is optional for some but mandatory for many as part of their Individual Education Plans. Mental health services are contracted to another agency, and if those services do not happen (end of contract, unavailability of clinician) those children are likely to be pulled from the facility by the referring county due to the unmet need for mental health. Many of the primary staff have worked for years at the facility and have degrees in disciplines related to behavioral health (psychology, counseling, social work). They work closely with the residents daily, implement and execute behavior plans, staff cases regularly, and work in tandem with the school and other collateral providers. Many times it is the primary counselors who know the girls best, and are very familiar with their behaviors and what interventions work best to be supportive or deescalate crises. If these staff could receive ongoing supervision by a LICSW, LMFT or LP comparable to what Mental Health Practitioners receive now (monthly face to face case review with clinical supervisor, review of treatment plan every 90 days or earlier if needed, 2x monthly group case consultation) as a means of supplanting the requirement of 2000 clinically supervised hours of mental health service, the benefits would be tangible and meaningful. Staff would be able to access MA/PMAP coverage for CTSS, which would relieve the burden on the facility budget for staff which is currently a blending of per diem county pay and foundation/fundraising money. Staff would be able to implement interventions in a more clinically consistent manner, utilizing strategies and working towards objectives directly cited in the Individual Treatment Plan. Lastly and most importantly, the capacity for on-site mental health services as needed would be of great benefit to the girls who reside at this facility, and may experience periods of crisis or exacerbated symptoms during times when presently mental health services are not available.

Scenario 2- A county in the far western edge of the state is looking to contract with a mental health provider for county referred children's mental health services. The in-home family counseling model utilizes a Licensed QMHP>Non-Licensed MHP model, where the licensed clinician provides the diagnostic assessment, individual treatment plan, clinical supervision, individual and family therapy as needed and the MHP provides individual, family and group skills. In an area where the local mental health services are limited to outpatient only at the regional hospital (which has a limited number of licensed therapy staff available, booked out for a period of 3 months, as well as no child psychiatric services), the in-home model is essential for children and families in crisis. Potential staff-pediatric nurses, educators, child and family advocates, people in "related fields"-could receive the above mentioned training and supervision and hit the ground running as opposed to having to obtain 2000 clinically supervised hours prior to being able to bill MA/PMAP for services. This would ease the county budget for mandated mental health services to children and families by accessing 3rd party insurance, continue to retain people in communities that are experiencing large scale layoffs, would develop the local mental health services infrastructure, and assist staff who would be able to provide mental health services to begin developing their career towards a licensed therapeutic track should they so choose.

Food for thought- There is a provision for Mental Health Behavioral Aid Services in chapter 16 of the Minnesota Health Care Provider manual. MHBA standards include a high school diploma and a 40 hour CTSS/Mental Health training period to be eligible to bill MA for services. If such an initial training were available for MHP development, this training-along with ongoing supervision-may be a model that would assist in the development and retention of mental health staff in rural areas of Minnesota while also satisfying the need and requirement for orientation to mental health and CTSS skill delivery.