Arrowhead Behavioral Health Initiative Region 3 Assessment

FINAL REPORT

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Introduction of the Project

The goal of this project was to assess the behavioral health landscape in Northeast Minnesota (Region 3) in order to identify critical improvements to existing services, new opportunities for investment, and important policy recommendations. The focus area for this assessment was the Arrowhead Behavioral Health Initiative's (ABHI) region. The region includes the following Minnesota counties: Carlton, Cook, Fond du Lac, Grand Portage, Itasca, Koochiching, Lake, and St. Louis. It also includes the Lake Superior Chippewa Bands of Bois Forte.

This systematic examination identified improvements and opportunities that will positively impact the health and well-being of persons seeking or in need of behavioral health support. The project included a multi-phased research approach designed by the UW-Superior Center for Research and Evaluation Services. The research team utilized mixed methods including a literature and research review, secondary data analysis, primary data collection and analysis including surveys, focus groups, and interviews. Finally, the team helped prioritize the recommendations rendered by the primary and secondary data analysis conducted and investigated considerations for implementing each recommendation. The final product was a compilation of 20 strategy consideration documents.

Researchers and Approach

The research team consisted of: Laurel Eaton, Dr. Lynn Goerdt, Dr. Daniela Mansbach, Emily Neumann, and Dr. Alisa Von Hagel.

The project team conducted the work following the guiding principles and strategies outlined below.

- Prioritized wisdom from lived experience, with a focus on populations vulnerable to behavioral health distress and crisis and those who are underserved or overserved by behavioral health services.
- Sought to understand specific and unique challenges certain populations are experiencing such as: youth, justice involved individuals, individuals with co-occurring disorders, etc.
- Utilized dual continuum of mental health and mental illness as guiding framework.
- Engaged with each region's Local Advisory Council (LAC) to incorporate their knowledge and expertise.
- Utilized systems thinking and analysis as framework for understanding patterns, clarifying problems rather than symptoms, and clarifying additional perspectives needed for data gathering.
- Considered the extent that strategies utilized during COVID-19 (i.e. Telehealth) were helpful for meeting and expanding access.
- Examined resource models or strategies utilized outside the region to inform the recommendations.

Executive Summary

Between January and December 2024, the needs assessment was completed in three phases:

1. **Phase One:** In-depth analysis of the research on barriers to accessing and utilizing behavioral health care. An analysis of secondary data was provided to help establish the relevance of the data to the regional context. An ideal continuum of care was also established as a framework to organize our work.
2. **Phase Two:** Collection of primary data through online surveys, focus groups, and interviews, totaling 213 people. The work completed in Phase One informed the questions that were asked in Phase Two. This step concluded with the establishment of 40 recommendations for improvement. During this phase, researchers also became aware of additional reports as well as multiple assessments completed simultaneously which were reviewed to compare the findings with the framework of barriers.
3. **Phase Three:** Prioritization of recommendations and further development of prioritized recommendations. This stage started with collaborative work with ABHI to prioritize 20 of the recommendations presented in Phase Two. Following this process, the chosen recommendations were researched to identify how to address and develop these areas, including identifying next steps. The recommendations included an analysis of best practices, effective existing models, and resources.

This assessment resulted in a number of findings. These findings include:

- The identification and mapping of three general categories of barriers to accessing behavioral healthcare: attitudinal barriers, structural barriers, and mental health literacy.
- The identification of barriers to accessing behavioral healthcare specific to Region 3. Overall, the top barriers to accessing care were basic needs supports, and in particular, the lack of secure and affordable housing and transportation options. These were noted by providers of care as well as by persons who access care.
- The identification of 40 total recommendations and 20 priorities as they are situated on the continuum of care. These recommendations are mapped by the following categories:
    - Basic needs supports
    - Prevention and preemption
    - More acute interventions
    - Recovery, healing, and resilience
    - Organizational change and capacity building

For full results and information from these phases, please see the full reports from Phase One, Phase Two, and Phase Three.

Ideal Continuum of Care

This project is based on the conceptualization of an ideal continuum of care, which is helpful for organizing the barriers for accessing and utilizing behavioral health care. The continuum is also helpful for developing potential strategies to address behavioral health. We believe that the existence of a clear theoretical framework is critical for guiding the development and measurement

of behavioral health interventions. The proposed ideal continuum of care (below) served as an analytical tool during all three phases as it helped guide our consideration of barriers, opportunities, and recommendations.

Prevention & Preemption			**More Acute Intervention**				**Recovery**
Well-being/ health promotion	Prevention	Early intervention	Basic clinical services	Community services and support	Crisis response	Inpatient & Hospitalization, Residential Treatment	Recovery, Healing & Resilience
Universal efforts to promote healthy lifestyles & emotional literacy.	*Universal efforts to expand learning and use of skills to navigate distress.*	*Strategic efforts to ensure training & access to early interventions.*	*Universally accessible clinical supports for behavior health maintenance.*	*Universally accessible supports to reduce acuity and prevent crisis*	*Accessible crisis response to triage evidenced-based need.*	*Evidenced-based treatment for highest levels of behavioral health needs.*	*Intentional recovery coaching & support with peer wisdom at forefront.*
Basic Needs Support *Access to safe, stable and affordable housing; transportation, economic viability, healthy food, medication, childcare.*							

Phase One

The goal of Phase One was to identify existing relevant data on behavioral health care, and to determine what additional data and perspectives were needed to complete the assessment of Region 3's behavioral health services and care.

This phase included the following steps:

- An extensive review of the literature, including published articles, recently published books, and publicly available reports with the purpose of mapping the barriers to care. This process also includes the development of an ideal continuum of care, and the placement of the identified barriers along this continuum.
- Discussion with numerous partners in the ABHI to learn about their data collection and understand how they use the data in decision making or planning.
- Identification of the current systemic challenges in Region 3 which impact the delivery of behavioral care services.
- Creation of a model for organizing the known barriers for accessing and utilizing behavioral health care.
- Linking national, state, and regional secondary data with the barriers.
- Creation of a continuum of care and mapping of the identified barriers along the continuum.
- Analysis of regional secondary data.
- Establishment of suggested focal areas for Phase Two.

Following the initial data collection efforts, the research team drafted an ideal continuum of care and analyzed the barriers for accessing and utilizing behavioral health care found at the national, state, and regional levels. The analysis identified three categories of barriers:

- **Attitudinal barriers**, which include cognition and emotions that prevent individuals from seeking help. Examples of attitudinal barriers include stigma and personal attitudes toward mental healthcare.
- **Structural barriers**, which include problems with the cost of, reimbursement for, and access to services as well as workforce challenges and service fragmentation.
- **Mental health literacy**, which includes limited knowledge of health conditions and the mental health system, and limited comfort with the Telehealth system.

The barriers to behavioral health care were mapped onto the ideal continuum of care to assist in the identification of focal areas for Phase Two. The areas of focus identified for Phase Two included:

- **Telehealth:** Explore factors that obstruct the use of telehealth and understand the experience of users and providers.
- **Workforce challenges:** Explore the unique recruitment and retention challenges for a qualified workforce to support the desired continuum of care, including a focus on effective use of telehealth.
- **Use of data for decision-making:** Explore the extent that data generated by service providers can be used more effectively, both internally and externally, in decision-making to improve the effectiveness of care.
- **Continuum of care:** Examine prevention/preemption and recovery ends of the continuum of care to understand if they are resourced and accessible.
- **Effectiveness of recent changes to crisis response strategies:** Examine the impact of the recent expansion of crisis response, triage crisis calls, and mobile crisis response.
- **Factors impacting positive or negative outcomes**: Use case studies to develop an understanding of the risk and protective factors that impact positive or negative outcomes, focusing on groups at-risk.

For full results and findings from Phase One, please see the Phase One report.

Phase Two

This phase of the project was based on Phase One's results and consisted of quantitative and qualitative data collection including surveys, focus groups, and interviews. The models and information from Phase One were used to analyze the primary data collected.

Description of Primary Data Sources

Over four months, researchers conducted 21 focus groups and 44 interviews to hear from individuals with lived experience and providers throughout the region, reaching a total of 175 people. Participants were from each county in the region.

The providers include representatives from K-12 schools, crisis response, community mental

health, hospitals/clinics, corrections, first responders, community substance use treatment, county human services, public health, administration, tribal behavioral health, and veterans' services. Additionally, researchers solicited input both from individuals with lived experience accessing behavioral healthcare and providers through online surveys. The online surveys were conducted from May to August 2024 via Qualtrics. Participation in the survey was quite limited, resulting in 22 consumers of care and 16 providers.

Recommendations

This is a full list of the Phase Two recommendations, organized primarily by the continuum of care. These recommendations are based upon the areas of focus first identified from the literature in Phase One and found in the primary data collected during Phase Two.

Basic Needs Supports

- Identify collaboration options on permanent, temporary and shelter housing.
- Investigate innovative transportation options.
- Expand support for basic needs gaps.
- Investigate consistent use of basic needs tracking.

Prevention & Preemption

Well-being/Health Promotion

- Expand in-school emotional literacy efforts.
- Expand opportunities for connection.
- Expand access to natural supports (i.e. the outdoors and social support).
- Expand drop-in center availability and model options.

Prevention

- Invest in and elevate prevention.
- Promote emotional regulation skills knowledge and use.
- Expand effective peer support utilization.
- Expand support to parents.

Early Intervention

- Develop more intentional transition of support for young adults.

More Acute Interventions

Basic Clinical Services

- Coordinate therapy access in schools, including Telehealth and therapy.
- Support therapists to transition patients off therapy when ready, to increase access.
- Invest in diagnostic testing training and capacity for professionals.

Community Services & Supports

- Expand diversion programs.
- Expand access to behavioral health support in jails across the region.
- Expand integrated and coordinated care.

Crisis Response

- Develop plan for youth crisis stabilization option in Northeast Minnesota.
- Continue to prioritize rapid access to psychiatry.
- Ensure access to mobile crisis response in every part of region.

Inpatient & Hospitalization, Residential Treatment

- Work with DHS to further modify 72-hour hold and commitment requirements and protocols.
- Work with regional health systems to improve emergency room crisis assessments.

Recovery, Healing & Resilience

- Expand culturally relevant and religiously inclusive recovery options.
- Provide more opportunities for people to share their stories about struggle, healing & resilience.
- Expand opportunities for healing practices, such as trauma-informed yoga.
- Expand transition to maintenance care.
- Improve transition from in-patient care into the community.
- Implement system of follow-up care.
- Investigate intermediary care options between shelter and in-patient care.

Organizational Change and Capacity Building Recommendations

Workforce Challenges

During the primary data collection, we focused on the unique recruitment and retention challenges for a qualified workforce along the continuum of care. Below are the themes and recommendations that emerged surrounding this area.

- Identify untapped workforce potential.
- Identify regional workforce recruitment strategies.
- Identify regional workforce retention strategies.
- Identify regional training opportunities and partnerships.
- Invest in dual licensing of staff.
- Investigate ways to expand flexibility in how professionals engage in their work.

Use of Accurate Data for Decision Making

During the secondary data gathering, researchers recognized challenges experienced by organizations in terms of analyzing and reporting their data in a format usable for the regional context and limited learning from shared assessments for decision making. This influenced some of the provider questions in Phase Two, resulting in the following recommendations.

- Be intentional about combining assessments to maximize learning and expedite action.
- Invest in data analysis capacity building for regional use of data.
- Reduce the spread of misinformation by intentionally verifying critical details.

Limitations of Phase Two

We recognize that this report was intended to include the perspective of youth. To achieve this goal, the researchers conducted the following steps:

- Submission of additional documentation and questionnaires to the university's Institutional Review Board for approval of including minors in the research.
- Creation of a unique process for the approval of participation of youth by parents or guardians.
- Creation of recruitment materials to distribute in schools and other youth organizations.
- Contact with schools and other organizations to schedule focus groups with youth.

Despite these efforts, the input from youth was extremely limited. During the process of conducting the research, we identified two factors that may have impacted our need and ability to successfully recruit youth to participate, and led us to adjust our goals:

- First, in 2022-2023 the Wilder Foundation conducted a needs assessment of youth mental health and well-being in Northeast Minnesota. The report includes many findings and recommendations that are relevant to the questions and goals identified by ABHI for the youth-centered part of the project.
- Second, the lack of a youth-centered system in Region 3 introduced challenges for accessing youth and engaging them with this project. We are thus very excited about the next project with ABHI, which focuses on youth and an attempt to design a comprehensive system that focuses on youth behavioral health in our region. We see that project as complementing the results of the Wilder report, and as helping ABHI to develop a more youth centered approach and services.

For full results and findings from Phase Two, please see the Phase Two report.

Phase Three

Out of the initial 40 recommendations, the researchers worked with the ABHI to identify 20 recommendations for additional investigation. This was done through a process of evaluating each recommendation by its potential impact and level of resources/effort needed. A strategy consideration document was developed for each of the 20 recommendations (listed below) and included: 1) Considerations for effectiveness, 2) Examples, 3) Next steps, and 4) Resources/references. These reports were presented to the ABHI in October and November.

Prioritized Recommendations by ABHI

Basic Needs Supports	Identify collaboration options on permanent, temporary & shelter housing. Investigate innovative transportation options. Expand support for basic needs gaps.
Prevention & Preemption	Expand in-school emotional literacy efforts. Expand drop-in center availability and model options. Promote emotional regulation skills knowledge and use.

	Expand effective peer support utilization. Develop more intentional transition of support for young adults.
More Acute Interventions	Expand access to behavioral health support in jails across the region. Expand integrated and coordinated care. Work with regional health systems to improve emergency room crisis assessments.
Recovery, Healing & Resilience	Provide more opportunities for people to share their stories about struggles, healing, and resilience. Improve transition from in-patient care into the community. Implement system of follow-up care.
Organizational Change & Capacity Building	Identify untapped workforce potential. Identify regional workforce recruitment strategies. Identify regional workforce retention strategies. Identify regional training opportunities and partnerships. Invest in dual licensing of staff. Be intentional about combining assessments to maximize learning and expedite action.

For further detail on these strategies, see the full strategy consideration documents provided in the Phase Three report.

Suggested Next Steps

We recognize that each of the 20 priority recommendations represent critical impact areas for improving behavioral healthcare. At the same time, not all the recommendations are realistic or feasible for the ABHI to lead. Therefore, we are suggesting a two-part plan for moving each of the recommendations forward and identifying which are feasible for investment and leadership from the ABHI. We recognize that some recommendations are more feasible for other organizations, counties, or collaboratives.

Step One: We recommend the ABHI Executive Committee review the list of recommendations and identify those which could most logically be assigned to another entity to lead. For example, the youth-focused recommendations likely make sense to be led by a youth-behavioral health task force. This could be completed prior to the January Regional Behavior Health Summit so that the entities in attendance can consider if the recommendations are aligned with their organization's responsibilities. It is likely that the summit is not representative of the entire region, but it represents an opportunity to connect with providers and county representatives.

Step Two: After the Summit, we suggest the ABHI create temporary task groups for the recommendations that are aligned with the mission of the ABHI, particularly those with no other logical leads. These include the more complex but regionally significant goals of transportation access and housing with supports. The goal of these task groups would be to work on individual or sets of recommendations, to review and consider the strategy report research, suggest next steps, clarify the optimal direction, and establish workplans for the next 12 months. The work of the task groups should be completed within the first few months of 2025 to maximize efficiency and reduce ongoing workload concerns.

By the April ABHI meeting, each of the task groups could complete these tasks:

1. Establish task group membership, convener, and meeting schedule.
2. Review the Recommendation Strategy Documents, clarify the optimal next steps based on the proposed best practices research, and review shared resources and expertise of committee members.
3. Suggest an implementation workplan for 2025 to address the recommendation in full or make significant progress towards implementation. To clarify the resources needed, the groups would need to consider the following questions:
    - Can the recommendation be addressed within an ABHI member organization with their existing capacity and funding? If so, clarify the ABHI member organization and the funding that could be designated for this purpose.
    - Can the recommendation be addressed within an ABHI member organization with additional capacity and funding? If so, clarify which organization, how much funding and the type of capacity (staff, expertise, etc.) that is necessary, and who would secure the funding.
    - If the recommendation cannot be addressed within an ABHI member organization, is there an organization or collaborative that could receive the recommendation from ABHI for their consideration?