Regional Needs Assessment: Phase Two

ARROWHEAD BEHAVIORAL HEALTH INITIATIVE REGION 3

UNIVERSITY OF WISCONSIN-SUPERIOR | CENTER FOR RESEARCH & EVALUATION SERVICES

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Introduction of Overall Project

The overall goal of our work is to conduct an in-depth assessment of the current behavioral health landscape in NE Minnesota to identify critical improvements to existing services, new opportunities for investment, and important policy recommendations. This intentional systematic examination will identify improvements and opportunities that will positively impact the health and well-being of persons seeking or needing behavioral health support; by creating a feedback loop with the decision makers, planners and funders of services.

The focus area for this assessment is the Arrowhead Behavioral Health Initiative's Region: Minnesota Counties and Lake Superior Chippewa Bands of Bois Forte, Carlton, Cook, Fond du Lac, Grand Portage, Itasca, Koochiching, Lake and St. Louis.

Phase One Overview

The goal of phase one was to identify and analyze existing relevant data to provide a national, state, and regional context and to determine what additional data and perspectives were needed for the complete assessment. Phase one included an extensive review of the literature, connecting with numerous partners to learn about their data collection and use in decision-making, development of an understanding of current systemic changes in Region 3, the creation of a model for organizing the known barriers for accessing and utilizing behavioral health care, and an analysis of regional secondary data situated in the national and state context.

Ideal Continuum of Care

As we embarked on this work, we recognized it was important to establish a conceptualization of an ideal continuum of care and to create a framework for organizing the known barriers for accessing and utilizing the behavioral health care continuum and potential strategies to address behavioral health. We believe that the existence of a clear theoretical framework is critical for guiding intervention development and measurement. The proposed ideal continuum of care (below) was as an analysis tool during phase one and two to help guide our consideration of barriers, opportunities, and potential recommendations.

Prevention/ Pre-emption			Interventions and Treatment				Recovery
Well-being/ health promotion	Prevention	Early intervention	Basic clinical services	Community services and support	Crisis response	Inpatient & Hospitalization, Residential Treatment	Recovery & 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.*

Phase Two Overview

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. In this report, we use the models and information from phase one to analyze the primary data collected. To do that, the report is divided into four main parts:

1. **Description of Primary Data Sources:** Provides an overview of the regional and demographic makeup of the primary data collected.
2. **Applying Data to Barriers:** In this section we introduce the main barriers to behavioral health and well-being, as identified by the respondents. We mapped these barriers by using the barriers table identified in phase one, revealing the barriers that are more and less prominent in Region 3 as compared to the literature and previous regional data. A few stories were included to provide a more nuanced understanding of the data.
3. **Applying Intervention Ideas to the Continuum of Care:** In this section we mapped the main interventions identified by respondents and summarized by the researchers along the continuum of care. This mapping clarifies the parts of the continuum that need more attention in the Region and the parts that are functioning well. We also included some additional themes that do not align across the Continuum. Based on our findings, we modified the proposed continuum to emphasize the centrality of basic need support throughout the continuum.
4. **Priority Recommendations for Phase Three Development**: Based on the results from phase one and phase two, we included our suggestions for topics for Region 3's consideration for further focus in phase three of strategy development using profiles to highlight these recommendations.

Due to the timeline of data collection this report includes only limited information from youth or K-12 school-based behavioral health supports. We anticipate finishing collecting this data in early Fall and will submit an amendment to the phase two report by the end of October 2024.

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. Three of the focus groups were conducted with crisis response providers, representing multiple counties, which is one of the reasons the 'regional' category is larger than anticipated.

Table 1 below shows the individuals interviewed and/or participated in focus groups by county. 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. For notes from these focus groups and interviews by county see Appendix A.

Table 1

Interview and Focus Group Geographic & Perspective Representation									
	Carlton	**Cook**	**Itasca**	**Koochiching**	**Lake**	**S St. Louis**	**N St. Louis**	**Regional**	**Total**
Consumer	5	4	7	9	5	18	19	-	67
Provider	4	7	9	17	5	26	8	33	109

Additionally, researchers solicited input from both individuals with lived experience and providers through online surveys. The online survey was open from May to August 2024 via Qualtrics. Table 2 shows the count of online respondents by county for both consumers and providers. For full survey responses, see Appendix B and C.

Table 2

Online Survey Geographic & Perspective Representation										
	Atkin	**Carlton**	**Cook**	**Itasca**	**Koochiching**	**Lake**	**St. Louis North**	**St. Louis South**	**Other**	**Total**
Consumer	0	0	4	2	0	2	7	6	1	**22**
*Provider	0	3	2	1	0	4	2	4	0	**16**

**Duplicated counts due to providers working in multiple counties; unduplicated count is 14*

Additional Sources of Secondary Data or Current Assessments

During our work on phase two of the project, we became aware of reports that we weren't aware of during phase one of our work as well as multiple assessments completed simultaneously. We reviewed each of the sources of secondary data in order to compare the findings with the framework of barriers we have already completed. Therefore, we thought it was important to share this list. We also wanted to provide a list of current assessments we are aware of which are being conducted so that we can coordinate the sharing of insights with those completing the work. It is important to expand the sharing of data, build on our knowledge gathering, and reduce duplication or efforts.

Additional Sources of Secondary Data

- Arrowhead Behavioral Health Initiative Children's Cabinet. *Early Childhood Mental Health Report*. May 12, 2020.
- Consulting Perks. *Community Needs and Recommendations: Community & Family Resource Network St. Louis County Assessment and Exploration*.
- Ingraham, C. *Suicide ticks down, remains more common in Greater Minnesota*. August 2, 2024. Minnesota Reformer
- MacDougall, H.; Peterson, B.; Neufeld, J. *Meeting Behavioral Health Workforce Challenges in Rural Minnesota*. Presentation at MN Rural Health Conference, Duluth. June 18, 2024.
- More Resilient Minnesota. *Community Conversation-Duluth Report*. April 3, 2024.
- *Northern St. Louis County LAC Forum Report*. October 19, 2023.
- Peterson, B.; Stigen, L. *Meeting the Rural Workforce Challenge: Academic and Clinic Partnerships.* Presentation at MN Rural Health Conference, Duluth. June 18, 2024.
- Serafin, M.; Petersen, A.; Robinson, M.; Thao, A. Wilder Research. *Needs Assessment of Youth Mental Health and Well-being in Northeast Minnesota: Prepared for United Way of Northeast Minnesota*. December 2023.
- Wilder Research. July 15, 2024. *Transfer and Discharge Delays for Behavioral Health Patients at Minnesota Hospitals: Results from the 2023 Health Behavioral Health Data Collection.* Minnesota Department of Health.

- Wilder Research. *Minnesota System of Care Expansion Grant: Carlton County Final Summary.* September 2022.

Current Regional or County-Specific Behavioral Health Assessments

- Behavioral Health Assessment conducted for St. Louis County, 2024.
- Wilderness Health Listening Sessions, 2024.
- NAMI Minnesota Listening Sessions, 2024.

Applying Data to Barriers

Building off of the work and research conducted in phase one, the table below incorporates the main barriers to behavioral health and wellbeing, as identified by the respondents in the second phase. The third column highlights the barriers that are more and less prominent in Region 3 in 2024.

Attitudinal Barriers (AB):

Attitudinal Barriers	General data and MN (including other regions)	Previous data from Region 3	2024 Region 3 data
Public Stigma: Perceived Public Stigma	Mental health stigma is often considered the main obstacle to help-seeking (11). This is also the main barrier identified by persons experiencing behavioral health issues in Region 4 (48%) (7). There are "gender differences in perceived stigma, where men may experience elevated stress regarding disclosing mental health issues in comparison to women" (19).	"Unfortunately, the denser social networks in rural communities, where everyone seems to "know each other's business," can also inhibit individuals, making them hesitant to seek mental health services and increasing the perceived level of stigma in their community" (15). When the patients feel that primary care physicians are not comfortable with behavioral health conditions, it "further perpetuates the shame that they feel, and they are not likely to bring it up for discussion or consultation" (6).	In the surveys, both providers and people with lived experience identified social stigma and stigma in the community as impacting the ability of patients to seek and receive care.
Public Stigma: Structural Stigma	Between 60-80% of people who live with serious mental health issues are unemployed (8).	While suicide rates have declined among individuals who identify as white, "there was a sharp increase among people of color and other marginalized populations (LGBTQ+, people with disabilities), a fact important to keep in mind since the primary population growth in Minnesota over the next fifty years is expected to be in communities of color" (15).	Stigma continues to exist within the care systems. The language used by care providers and some law enforcement personnel further stigmatizes persons and exacerbates distress or crisis. This was recognized by many individuals, including providers, who recognize stigma among law enforcement and first respondents as a barrier for seeking and receiving care.

Public Stigma: Cultural Stigma	"Race and gender appear to intersect with mental health-related stigma, influencing its severity" (19).	Rural residents "experience higher rates of mental health symptoms. Negative attitudes toward mental health issues in some rural communities and the challenges that long distances to services create all compound the problem of unmet need in rural communities" (15).	BIPOC and Queer persons with lived experience mentioned they often avoid seeking care outside their personal identity support group.
Personal Stigma: Perceived Need for, and Effectiveness of, Behavioral Health Services	7% of the population in developed countries believe that mental illness could be overcome (1). 20% of persons experiencing behavioral health issues who did not access mental health services in the last two years, and 6% of those who did, do not think the services will help (3).	Of the 16.7% who delayed mental health care, 35.3% stated they felt their need "was not serious enough" (2). "Rural communities, which have a history of self-reliance, are much less likely to seek out assistance from outside the community, instead preferring to rely on family or others in their social circles" (15).	While not ranked very high, persons with lived experience identified their negative experience when seeking care as a barrier for not seeking care later.
Personal Stigma: Attitude toward Help Seeking	63% of respondents who did not receive treatment, but recognized the need reported "wanting to handle the problem on their own" (12). Cultural factors – such as race, ethnicity and religion – influence help-seeking, especially among groups that are culturally and linguistically diverse (10).		We have not found much evidence for this type of stigma among the individuals we surveyed and interviewed.
Personal Stigma: Self-Stigma	18% are worried about how they would be seen (3).	Of the 16.7% who delayed mental health care, 26.3% stated they were too embarrassed to seek help (2).	In the surveys, both providers and persons with lived experience identified self-stigma as impacting the ability of patients to seek and receive care.

Structural Barriers (SB):

Structural Barriers	General data and MN (including other regions)	Previous data from Region 3	2024 Region 3 Data
Cost	"Living in poverty has the most measurable effect on the rates of mental Illness" (14). 23% of persons experiencing behavioral health issues said they did not access services due to cost (3).	Cost is a significant barrier for accessing mental health services, even for those with insurance that covers mental health care (9). Cost was also a barrier for medication (even a co-pay that is as small as $3) (6). While around 31% of individuals earning more than 200% of the guidelines reported experiencing mental health conditions, almost 50% of individuals earning less than 200% reported experiencing mental health conditions (2).	In the interviews, many persons with lived experience identified their inability to afford co-pays for medications as preventing them from taking required medication or taking less than prescribed. In the surveys, cost and access to insurance were not identified as central barriers for seeking and receiving care.
Reimbursement	"Reimbursement rates from private insurance and Medicaid for mental health treatment services are significantly lower than other physical conditions" (14).		Surveyed providers identified insurance reimbursement as the barrier that least impacts their ability to provide services. Providers identified the rigidity of insurance requirements as negatively impacting their ability to provide care and derive satisfaction from their work.
Workforce Challenges	Minnesota is already experiencing a severe shortage of psychiatrists in most parts of the state, and about half of Minnesota's psychiatrists are over age 55 and thus are likely to retire in the next 10 years, further exacerbating the	"While the behavioral health workforce has always been challenging to maintain, the treatment gap between those who need care and those who are trained to provide it has never been larger than right now, especially for residents in Greater Minnesota's communities" (15).	Providers emphasized lack of searches and open positions, despite long wait times and shortage of therapists. In cases when organizations were recruiting, providers cited the challenge of fulfilling said positions.

	shortage. Similar shortages are felt in most other occupational categories as well" (14)	"While in metropolitan areas there is one licensed mental health provider for every 197 residents, that ratio goes up as the population density goes down, with 741 residents for every one provider in the most rural areas... In the past decade, the number of hospitals with outpatient psychiatric and detoxification services in rural Minnesota has declined 11%.... Of those professionals who serve Greater Minnesota, the median age is 63, compared to 56 for those practicing in urban settings" (15).	In the survey, providers identified retention of staff and burnout as their main barriers for providing services.
Access: Transportation	27% of service providers identified transportation services as the biggest barrier for accessing mental health services in their area, and 72% mentioned their patients encountered this barrier (3).	In addition to inconsistent transportation within and between communities, persons in communities close to Duluth are expected to travel to Duluth for certain services (4). "Mental health centers are sparser in rural regions than in urban and suburban communities, leading to longer driving distances, which can be especially troublesome for people with limited ability to travel, whether because of their finances (they don't own a car or can't drive themselves, for example) or the severity of their symptoms makes long-distance travel difficult" (15). Rural residents frequently must travel longer distances to see providers, with weather and road issues creating further challenges" (16).	Transportation was almost universally identified as a top barrier for accessing care, both daily and in times of crisis. Transportation is needed to access care in regional hub communities, even if Telehealth and community-based care in rural communities is expanded. The current model of dial-a-ride and fitting transportation needs within the existing network of rides is not working.
Access: Limited care options	The two main barriers identified by persons experiencing behavioral health issues for assessing services are available services and wait time (3). For	Persons experiencing behavioral health issues described challenges accessing services during evenings and weekends (6), and convenient times (9).	In the surveys, both persons with lived experience and providers identified limited hours, wait times and lack of needed services as a main barrier to care. Many

	providers, it was lack of providers or available appointments (7).		respondents called for increased access to community-based therapy. Limited care options are especially impactful in rural communities, where parents described a 6 month wait for kids experiencing suicidal ideation. One result of limited care options is the need to wait in high-cost settings such as jail, the ER or other inpatient options, which negatively impacts behavioral health. Interviewees also identified the need for increased access to psychiatry care, psychological assessments, and medication changes. Assessment wait times are exacerbating people's symptoms. This is especially concerning for youth in need of support while in school. Rural communities are especially suffering from the lack of care options. Assessments for inpatient care are typically done by an ER physician who may or may not be comfortable assessing psychiatric risk or through a virtual assessment team (i.e. DECK). This results in local providers feeling undervalued, often leading to people being sent home while in crisis.

			In most communities, there is not enough ongoing recovery support for people who are transitioning from inpatient care back into the community. This lack of community support impacts the success of treatment and can lead to the misidentification of the treatment's failure. Almost every community identified the need for follow-up care. Designated care coordinators or community health workers focused on follow up with people discharged from treatment are needed to assist in patient's community-based transition. There is inconsistent access to mobile crisis response teams. Some parts of the region are not served by a viable crisis response team (i.e. Cook County). In other areas, such as Northern St. Louis County, it has been difficult to get the mobile crisis team come on-site to respond.
Access: Crisis Care for dependents and pets	While research identifies the positive impact of pets on the well-being of owners, 25% of them state that they will prevent seeking care if it impacts their ability to take care of their pets (26)	"Peers on our council report that they are reluctant to get the treatment they often need because they cannot find care for their pets" (20).	Caregiving responsibilities were identified by some persons with lived experience as somewhat of a barrier for seeking care.
Housing	Of the patients experiencing homelessness and being treated for overdose or substance use, 87% had a history of at least one	Of the persons who were unhoused and unsheltered, approximately 50% identify as having a serious and persistent mental illness	Affordable housing options, like board and lodging or homeless shelters, have reduced in scope or closed. While providers often do not have a positive view of these facilities,

	mental health disorder. This is in comparison to 75% in the non-homeless population (13).	and 30% experiencing substance use disorder (22). Persons seeking DETOX support, which medically assisted detoxification from alcohol or other drugs, doubled between 2022 to 2023. Of those seeking care, the vast majority are single, unhoused, men aged 25-44 (23).	their removal exacerbates the need for affordable shelter. Currently, some services like detox and crisis stabilization programs are used as a shelter to access food, bed and a bathroom. This reduces their availability that is needed by others. Individuals living in a shelter often have some type of mental illness and/or substance use issues. They need supports prior to moving into housing with services. In the survey, providers identified the lack of basic needs, including housing, as central barriers for accessing care. Persons with lived experience ranked this as a lower barrier than others.
Responsive to Identity and Culture	"Structural racism, intergenerational trauma, and genocide have lasting effects on people and cultures, leading to disparities that are reproduced generation to generation" (14). Diverse cultural communities "experience more risk factors, but they also can find it difficult to engage in mental health treatment when the provider does not understand their language cultural values, or	31% of persons experiencing behavioral health issues said that finding a mental health provider they felt comfortable with regarding diversity has been a barrier for accessing care (9). Both persons experiencing behavioral health issues and providers describe the lack of culturally relevant and appropriate care in the American Indian community as a significant barrier (4).	When asked about the relevancy of care to persons' culture, identity and experience, both persons with lived experience and providers identified the care as the least relevant to people's religion and spiritualty. Both persons with lived experience and providers ranked identity and cultural consideration as a minimal barrier for seeking care. We recognize that this may be a result of the identity of individuals who participated in this research.

	perspectives on mental health" (14). Nearly all respondents of the national Trans Survey (94%) who lived at least some of the time in a different gender than the one they were assigned at birth ("gender transition") reported that they were either "a lot more satisfied" (79%) or "a little more satisfied" (15%) with their life. (28)		An interview with BIPOC community members described not feeling as if they were listened to by providers and encouraged the recruiting and hiring of more providers of color. They described perceptions of distress as different if someone is White versus Black.
Service Fragmentation: Lack of integration for co-occurrence	Persons experiencing behavioral health issues found mental health services especially helpful when providers were empathetic, caring and knowledgeable (7). 18% of persons experiencing behavioral health issues stated that the services they received were not very, or not at all, helpful, in facilitating further access to mental health services (3).	Persons experiencing behavioral health issues who typically go to the emergency room during a mental health crisis describe the experience as scary, demoralizing and unhelpful. They also described being judged and misunderstood, especially by emergency room personnel and in some communities, by law enforcement (6). 2023 crisis call data from Region III's First Call for Help shows that 6% of calls involve chemical dependency issues and 14% are from individuals needing detox (25). Veterans, who sometimes are hesitant to use the V.A. system to access mental health services, face difficulties accessing private services (4).	Alcohol or other substance abuse is so pervasive and impacts it should be reframed as a public health issue. More attention should be directed towards identifying the harmful effects of substance use by adults. Many people identified the problem of high functioning alcoholics for family and community health.

		In 2023, 12% of callers to Region III's First Call for Help needed mental health resources and referrals (25).	
Service Fragmentation: Lack of Integration with Primary Care	The majority of persons experiencing behavioral health issues feel their primary care providers are knowledgeable of mental health services and respectful toward them when discussing mental health issues (3).		Many who were surveyed and interviewed identified the integration and coordination of care as improving. Coordination between care and basic needs, including housing, is still lacking. The lack of care integration undermines the effectiveness of expensive services. Lack of transition care means that after treatment, people return to their community with limited support options. Respondents identified the role of care coordination and case management in the ER as invaluable. These positions, however, are often overworked or depend on specific grant funding, thus are eliminated when the grant ends. The shortage of therapists is exacerbated by the lack of integrated care, requiring therapists to spend time for tasks outside of their primary role, such as assisting with access to shelter or other basic needs.
Service Fragmentation: Fragmentation of planning and funding		"Rural Minnesota's small employers are less likely to provide health insurance for their employees contribute to the greater use of Medicare, Medicaid, and MinnesotaCare in rural areas" (15).	A lack of planning and coordination of assessments was identified. Various individuals and organizations collect repetitive data, with little sharing or use.

		Both patients and providers identified state and insurance regulations as barriers, including billing practices, data sharing rules and housing regulations (6).	Interviewees recognized the lack of sustainable funding as preventing the development of continuous care and coordination.

Mental Health Literacy (MHL):

Mental Health Literacy	General data and MN (including other regions)	Previous data from Region 3	2024 Region 3 Data
Limited knowledge of mental health conditions	Low perceived need is the main barrier for treatment in many cases, including cases of moderate and serious mental health disorders. It is also more common among men and older respondents (12).	Of the people who "wanted to talk with or seek help from a health professional about mental health concerns," 35.3% delayed or did not do it because they believed their need was "not serious enough" (2).	Respondents did not identify limited knowledge as a central barrier for accessing care. They instead focused on lack of needed services, long wait times, etc.
Limited knowledge of the mental health system	21% of persons experiencing behavioral health issues mentioned they do not know what mental health services are available as barriers to accessing care (3).	All respondents, including those with lived experience, identify lack of knowledge about available services and resources as the most significant barrier for accessing care (9). Both providers and persons experiencing behavioral health issues spoke of lack of awareness of services, particularly those related to crisis prevention and stabilization, and community-support services (4). "29% of survey respondents weren't sure what mental health care services or resources were available to them in SLC" (9).	Respondents discussed the lack of awareness and underutilization of services as interconnected issues. For providers, lack of connections is impacting their awareness of available services.

Telehealth: Equipment and services	34% of persons experiencing behavioral health issues said they lack the ability to access remote services (no smartphone, no Wi-Fi connection etc.) (7).	"While Telehealth is a promising solution in some cases, it is not appropriate for all situations, and lack of adequate broadband coverage in some rural areas is a barrier to using this mode at all" (16).	Respondents did not identify this as a barrier.
Telehealth: Location		As of now, we were unable to find data that examines whether the lack of safe or private location impacts the willingness of persons to engage in Telehealth. We would like to explore this barrier further, especially in the context of behavioral health care.	Providers mentioned the lack of safe and secure place for Telehealth services as a barrier, including kids whose parents are listening outside the door and safety of patients who are in their car or are driving during treatment. Some persons with lived experience mentioned their home as safer and more privates place for treatment
Telehealth: Individual and cultural barriers	64% of persons experiencing behavioral health issues said that Telehealth services were always or sometimes less helpful than in-person services (7).	"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 percent moving to this mode of practice within the first six months of the pandemic" (16).	Some persons with lived experience mentioned they are not sure that Telehealth services are effective.
Telehealth: service providers	"Clinicians agreed that they felt as comfortable with video visits as in-person visits and comfortable with video for both established and new patients. There was relatively less agreement regarding the efficiency of video visits, with 66 (58.9%) who agreed or completely agreed that video was more efficient than in-person visits" (21).	"Providers responding to the workforce survey reported that unreliable internet access limited how helpful Telehealth could be in treating patients in rural areas" (16).	Providers stated feeling comfortable using Telehealth services and encountering fewer cancellations.

Care Access Story: Experience Navigating Eating Disorder

One person shared their story navigating care for an eating disorder whose care was hindered by seemingly inattentive primary care physician and stringent health insurance rules. Thankfully, they are in a healthier place, but their journey was longer, scarier and more challenging than it needed to be.

Initially, their physician was made aware of specific eating disorder symptoms which were recorded into their medical records but not brought up in connection with their health check-ups. This included the sharing of 'night eating' which is a common symptom of brain starvation. The provider, however, did prescribe a new medication for their ADHD with a known side effect to suppress eating. This is unfortunately what they experienced. It was their close family who recommended they seek help to due concerns of significant weight loss from their eating disorder and exacerbated eating suppression. They discussed this with a therapist who recommended treatment.

Approximately 5 weeks after the initial screening, they were admitted into an inpatient treatment program in the Twin Cities for avoidant restrictive food disorder. They were fortunate to have a supportive employer and family, which allowed them to take a leave of absence and attend the program. However, after only 1.5 weeks into the program, their health insurance determined that recent changes in their BMI indicated inpatient treatment was no longer needed. So, despite the professional assessment for inpatient care, they were transitioned to outpatient intensive treatment and needed to secure housing for about 3 weeks in order to continue. After 3 weeks, they returned to Duluth for all-day Zoom sessions. Until this point, they described their care as "life changing".

After two weeks, they transitioned to ½ day Zoom sessions where they found the facilitator of those sessions to be poorly trained and information basic and unhelpful. So, they discontinued their participation and felt like a "fragile newborn" who was navigating their life with new insights about themselves and challenges with navigating their new relationship with food.

The treatment program did not offer any follow-up care, so they received support from friends and family. Their primary care physician did change their diagnosis but otherwise did not inquire about their health and well-being related to the disorder. They wished that the physician was more knowledgeable on the impact of eating disorders on health and that the nursing staff were more compassionate (especially when logging their weight) in their interactions with patients who experience eating disorders. As they noted, eating disorders are common and have a high mortality rate for a mental illness diagnosis.

They now interact with others who are diagnosed and undiagnosed with eating disorders, many who are women or marginalized populations who are often impacted by body-related judgments. They feel like there is a large population of underserved or unrecognized persons in NE Minnesota who need support.

Their ideas for improving care for persons experiencing eating disorders includes:

- Judgement-free education with K-12 schools and students about symptoms and causes.
- Primary care physicians knowledgeable on impacts both physical and mental health.
- Decoupling BMI from indicators of health.
- More community-based discussions and peer groups on eating disorders.
- Financial assistance for persons entering inpatient treatment.
- Ensure that virtual support group facilitators are well-trained to maximize impact.
- Apply the language of recovery to eating disorders, similar to substance use.

Region 3 Profile: Experience of family trying to get help for mental illness & addiction

One person shared their story attempting to navigate care for their partner and child's substance use over a span of about 5 years, unfortunately resulting in tragedy. Their experience highlights the fragility of a family with untreated mental illness and addiction, and the legacy of feeling that the health care system has failed them.

Their close family was living a successful life by many measures; pursuing education, career oriented, and active in sports; all while one parent experienced episodic struggles with alcohol. At the time, the episodes with alcohol struggles felt manageable. However, when one of their teenage children experienced a depression and began using substances after a sport-related injury, the family's ability to navigate the additional stress became extremely challenging and escalated the alcoholism.

When their child turned 18, the parents witnessed them quickly unraveling and decided to seek emergency care for what they observed as seriously escalating behaviors. They were admitted at a local hospital on a 72-hour hold but since they were 18, the parents were unable to get any information from the care provider. The next thing they know, their child was transported to a facility in North Dakota and then released within 24 hours from that hospital, angry, scared and feeling betrayed by both family and the medical system. The experience was traumatizing for the entire family and left a deep level of mistrust while also exacerbating their struggles. They have wondered if the extent that their young adult child was educated and articulate influenced an inaccurate assessment of mental illness.

The family's cohesion quickly unraveled. In the few years that followed, the parent's alcoholism became debilitating and initiated many desperate attempts for help. They began attending AA meetings and entered both inpatient and outpatient treatment approximately 7-8 times. They eventually found an AA sponsor they felt was relatable and finally a sense of hope. However, when their young adult child's struggles became more intense, the alcohol use of the parent spiraled, and they tragically died at age 59 from "alcohol related issues". The day before their death, they sought to secure a bed at a local detox facility but unable to stay since they were at capacity. Their last phone calls were to alcohol treatment providers and supports.

The remaining parent continues to experience significant loss and sense that health care systems and regulations either failed their family initially or gave up on them. They are grieving the loss of their life partner while trying to navigate care for a young adult in active addiction with little sense of hope or support.

Support Group Profile: NAMI Support Group

At a recent visit to a NAMI support group in Duluth, it was evident that the group was immensely valuable to the 12 people who attended on a weeknight. They seemed to appreciate and benefit from the structure, familiarity with the group norms, snacks and comfortable space. Most people seemed to know each other but there were a few new attendees. Some arrived from a neighboring IRSS facility. The group was diverse in age, gender, and ethnicity. One person indicated that they were 'glad to be back'.

The time together was primarily a check-in to see how people were doing, and support was offered as it seemed to be welcomed and helpful. One person offered a DBT skill they found especially useful. When someone became agitated, the facilitator gently helped them to de-escalate and continue their participation in the group. It was an impressive demonstration of compassion and facilitation skills.

There were many smiles, laughter and support shared and received within the hour. The group seemed validating, respectful and critical to the well-being of many who attended.

Applying Intervention Ideas to the Continuum of Care

Through interviews, focus groups, and survey responses the research team solicited input from community members regarding what is working, what has been helpful, and what needs more investment. In order to help consider these potentials we have mapped these interventions across the continuum of care developed in phase one of the project.

After reviewing all of the input, we concluded that basic needs support is at the basis of all of the continuum of care categories, rather than under only one category (like prevention). As such, we have modified the continuum of care to reflect this overarching need for basic needs support. Overall, the feedback we received about the continuum as a model was extremely positive and many people described it as helpful to their work.

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.*							

Basic Needs Supports

- **Identify Collaboration Options on Permanent, Temporary & Shelter Housing.** Identify ways for more collaboration around housing, shelter beds, boarding houses, including Board and lodging facilities have closed in multiple counties, including Itasca and Lake. They were often not described favorably by providers but the removal of this level of housing still exacerbates need for affordable shelter. Temporary and supportive housing providers, like community housing with supports, shelters, and board and lodging do not appear to be viewed as partners for crisis response although they are meeting (or attempting to meet) a critical community need.

- **Investigate Innovative Transportation Options.** Investigate transportation models, including those that utilize the latest ride-share technology and driverless vehicles, to contribute to more effective and efficient transportation between communities, counties and across the region.
- **Expand Support for Basic Needs Gaps.** Identify ways to expand flexibility in ways that providers can respond or help consumers of care, even if it is expanding a "flex fund" of support. There seem to be low-cost barriers that can have a significant impact on people's well-being (assist with medication co-pays, purchase of equipment, etc.).
- **Investigate Consistent Use of Basic Needs Tracking.** The role of care coordination and community health work appears to be expanding but requires access to information about the extent that people receiving care have access to their basic needs. The use of Z-codes is a relatively new tool for health care systems but knowledge or use in the region appears to be minimal.

Prevention & Preemption

Well-being/Health Promotion

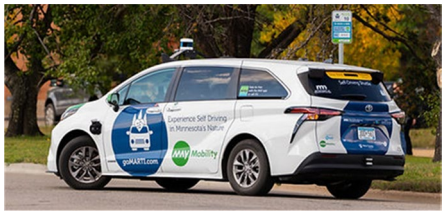
- **Expand in-school emotional literacy efforts.** In-school prevention efforts were almost universally identified as necessary, especially to focus on emotional literacy and learning about the brain.
- **Expand opportunities for connection.** Provide opportunities for connectivity and social interaction within communities.
- **Expand access to natural supports.** Expand access to natural supports like the outdoors and social support which is abundant in rural communities. This includes safe and free places to socialize and interact, regardless of therapy or other services available there.
- **Expand drop-in center availability and model options.** The extent that drop-in centers or clubhouses were functional and meeting the needs of persons who used them differed significantly across the region. What was apparent, however, was the immense value of having a space where people who share relatable behavioral health experiences can socialize and support each other. The centers with a clear sense of purpose and opportunities for the attendees to have a voice and involvement appeared to be the ones with the most participation and satisfaction. Despite their importance, many centers were closed or had significantly reduced hours. The

Transportation Strategy Profile: goMARTI

Minnesota's Autonomous Rural Transit Initiative is a pilot shuttle service project focused on "increasing accessibility and transportation options for residents and visitors in Grand Rapids" (www.gomarti.com). The rides are free, requested either through an app or by calling First Call 211 and can be for medical or non-medical purposes. The vehicles are staffed with an autonomous vehicle operator on board at all times.

The hours range from 2pm-10pm Tuesday-Friday, Saturday 10am-10pm and Sunday 8am-2pm and recently extended the service area to include Coleraine. Two focus group participants described using the service regularly and described it working well, mostly on time and easy to access.

The key partners have included MN Department of Transportation, City of Grand Rapids. The PLUM Catalyst, May Mobility, Department of Iron Range Resources and Rehabilitation, Itasca County, Via, University of Minnesota, Arrowhead Transit, Mobility Mania and others.



goal would be to identify options that could work for different communities and be sustainable in their functioning and impact**.**

Prevention

- **Invest in and elevate prevention.** Find sustainable sources of funding for prevention work; not just grant funding that can end. Additionally, invest in the staff that provide prevention to lower turnover as these positions due to salary.
- **Promote emotional regulation skills knowledge and use.** Many people identified specific DBT skills as lifesaving and helpful in their ability to manage distress. One person even referenced the DEAR MAN skill during a peer support group as something that has been extremely helpful for them.
- **Expand effective peer support utilization.** Identify ways to expand the role of peer support for mental health and addiction recovery. Peer support was identified as one of the most helpful types of care, both within crisis stabilization as well as in the community. Peer support specialists focus on trust, establishing connection, and meeting people where they are at, emotionally and often physically.
- **Expand supports to parents.** Parents described needing more education about mental health, substance use, and strategies to help their children.

Early Intervention

- **Develop more intentional transition of support for young adults.** Provide supports for the transition from high school into adulthood which is when many symptoms first present themselves.

More Acute Interventions

Basic Clinical Services

- **Coordinate therapy access in k-12 schools.** Dedicate space in k-12 schools for in-school supports including Telehealth and therapy.
- **Support therapists to transition off therapy for those who are ready, to increase access.** There was an almost universal call to increase access to community-based therapy while also increasing the flexibility of therapists to partner with care coordination. There was also the acknowledgement that some people stay

Drop-in Center Profile: Kiesler Wellness Center

The Kiesler Wellness Center is friendly, beautiful and vibrant. Everything about the Grand Rapids located peer-driven community support program feels welcoming, including the signage, front desk staff, and the variety of activities that take place during the week.

At a recent visit, participants gave a tour to share the chicken coop, outside patio, craft room and wood shop space. People can become members of the wellness center and benefit from the extensive programming, lunch, and social opportunities. Members are expected to volunteer each week to contribute to the support and maintenance needs of the center.

The space includes a living room area, commercial kitchen and dining area where members of the support program, Northland Counseling staff, and community members often share a meal together.

It is apparent that people enjoy their time together, appreciate the opportunities to socialize, and have a genuine relationship with each other. The center feels well taken care of and critical to people's sense of belonging and community.

https://www.kieslerwellnesscenter.org/

on therapy beyond what may be recommended due to their concern about the wait list. This reduces access for others but needs to be navigated carefully.

- **Invest in diagnostic testing training and capacity for professionals.** The gap for access to diagnostic testing was identified by many as a significant barrier to care but the cost and time for assessment training is a barrier for professionals. The wait for assessments for things like ADHD is exacerbating people's symptoms and inability to get relief. This is especially concerning for youth who need support in school.

Community Services & Supports

- **Expand diversion programs.** Drug court was identified as helpful because of the intensive support and incentive for persons to access treatment and recovery supports. This same philosophy could be used for others who may not interact with corrections but who are in dire need of help.
- **Expand access to behavioral health support in jails across the region.** Behavioral health care provided or offered by jail staff is inconsistent across the region.
- **Expand integrated and coordinated care.** Integrated and coordinated care is improving, especially if the providers are meeting across the spectrum. Consider simpler consent forms to be used across providers in the county and identify other avenues for information sharing and notification of providers working with individuals across the continuum. Examine impact of care coordination and community health worker models.

Crisis Response

- **Develop plan for youth crisis stabilization option in NE Minnesota.** Must have crisis stabilization option for youth in Northeast Minnesota, if not one in each county. The state needs to finalize funding rates for this type of service.
- **Continue to prioritize rapid access to psychiatry.** Increase access to psychiatry and psychological assessments, and the number of people eligible to provide them.
- **Ensure access to mobile crisis response in every part of region.** Work with mobile crisis response providers to implement system of response to entire region. Innovations with technology will likely be needed to facilitate communication.

Inpatient & Hospitalization, Residential Treatment

- **Work with DHS to further modify 72-hour hold and commitment requirements and protocols.** The system of a 72-hour hold and commitment determination and placement is not effective. Many identified the hold as not long enough to adequately assess someone's needs or risks related to commitment. Once someone has been identified as needing commitment, they are often waiting for six months or longer for appropriate placement into psychiatric or forensic state facilities (Anoka or St. Peter). While waiting, they are kept in a hospital setting that can lead to their deterioration due to limited access to visitors, fresh air, etc.
- **Work with regional health systems to improve emergency room crisis assessments.** There was almost universal concern over the large health systems not meeting the expectations of the rural communities' in being a location where people desperate for life-saving care related to mental health or substance use could get help. The assessment for inpatient care is typically done by attending ER physician who may or may not be comfortable assessing psychiatric risk or using a virtual assessment team from the metro area (i.e. DECK). This often results in local providers feeling undervalued in the assessment process and fewer people in the region being

served by local hospitals. This also results in people being sent home with self or loved one in crisis and can be terrifying or tragic in outcome.

Recovery, Healing & Resilience

- **Expand culturally relevant and religiously inclusive recovery options.** Traditional models such as AA aren't relatable to a broad section of the community. Recovery Alliance Duluth, Sober squad and apps like Reframe were identified as helpful and an alternative to AA and NA but need support and facilitator training.
- **Provide more opportunities for people to share their stories about struggle, healing & resilience.** At the conclusion of most interviews and focus groups with persons with lived experience, they expressed gratitude for the opportunity to talk about their experiences, ideas, and to tell their story. Many described the process as "cathartic".
- **Expand opportunities for healing practices, such as trauma-informed yoga**. There are practices used in the region, which have been demonstrated as critical to mind-body healing and can take place in the community and outside of a clinical care setting. The impact can be generational while cost efficient.
- **Expand transition to maintenance care.** Providers identified the need to transition some individuals from care to a more maintenance level, but there are limited incentives for both parties to do that. The waiting list for therapy could be reduced if there was less access from people who need a lesser maintenance level of care.
- **Improve transition from in-patient care into the community.** In most communities, need support or who are transitioning from in-patient care back into the community. The lack of recovery and transition support impacts the extent that treatment is successful. Therefore, the treatment is often identified as not successful, when it could be the lack of community support that impacts the success.
- **Implement system of follow-up care.** The need for follow-up care was also identified almost every community. There needs to be designated care coordinators or community health workers who are focused on following up with people discharged from hospital or treatment to assist in their community-based transition.
- **Investigate intermediary care option between shelter and in-patient care.** Need care option that exists between shelter and in-patient care. A rehab center for people with significant mental illness and/or substance use disorders but who are starting a recovery journey (may want to focus on 40+ age group).

Organizational Change and Capacity Building Recommendations

Workforce Challenges

One of the specific areas asked about during the primary data collection was the unique recruitment and retention challenges for a qualified workforce along the continuum of care. Below are the themes and recommendations that emerge surrounding this area.

- **Identify untapped workforce potential.** Numerous ideas were already shared for accessing persons who already serve in a helping but unpaid role with persons accessing behavioral health care, many who also describe being lonely and isolated. This may include, but are not limited to, persons who receive Social Security Disability, and may be supported in a part-time paid role.

- **Identify regional workforce recruitment strategies.** There are numerous recruitment strategies already used in the region and state. These can be built upon and expanded for regional workforce development, including existing professional roles that would be appropriate 'stepping stone' for upper-level positions. This could also include examining models of non-specialized roles.
- **Identify regional workforce retention strategies.** There are numerous workforce retention strategies, already being used in the region. We can collate those ideas and expand the list to promote more learning, coaching and practice of strategies to improve the well-being of the workforce.
- **Identify regional training opportunities and partnerships.** There are numerous institutions of higher education in the region that could be partners in providing training and skill development for behavioral health professionals. Numerous ideas were already shared in the data gathering for specific skill, modality and assessments gaps that could be the focus of regional training efforts. Incentivize first year therapists in their practice and additional training. This will improve the quality of their therapy.
- **Invest in dual licensing of staff.** Most people acknowledged the extent that most people experiencing substance use disorder had significant underlying mental health issues but the care they received was typically focused on one or other, not both. There was a call to encourage dual licensing agency investment so staff could be better trained or at least the agency could be better prepared to address mental health and substance use for every consumer of care.

Region 3 Profile: County Workforce Resilience Initiatives

St. Louis County Public Health and Human Services received a workforce resilience grant, providing an opportunity for innovative strategies to enhance the wellbeing of the workforce. The strategies were provided for their own employees as well as those in community-based partner agencies, including:

- Accelerated Resolution Therapy (ART) certification for 12 therapists and worked with NuVantage for SLC PHHS employees and community partners.
- Compassion Cultivation Training for 18 people and their respective organizations.
- Writing to Wholeness facilitation training was conducted for 7 professionals to offer this workshop at their respective workplaces and in the community.
- Search Inside Yourself Leadership Institute 2-day training and half-day training for community partners and PHHS employees.
- Ten community partners received micro-grants to customize employee wellbeing and resilience support.
- Selah Center for Grief provided Becoming Grief Conscious training for SLC Behavioral Health division (north and south).
- Gallup Q12 Engagement Champion training and tests to improve employee engagement at SLC PHHS.
- Mental Health First Aid training and workbooks for adults and youth.

The projects concluded due to the ending of the grant funding, but they are hoping this investment will have a ripple effect on the well-being and resilience of the workforce for their own benefit as well as to help the persons they serve.

- **Investigate ways to expand flexibility in how professionals engage in their work.** Having the ability to support people in ways that they need appeared to be directly tied to job satisfaction and retention. Persons whose positions offered the most flexibility and less dictated by health insurance rules, were the most satisfied in their work, even in positions with high rates of consumer overdose and suicide.

Use of Accurate Data for Decision Making

- **Be intentional about combining assessments to maximize learning and expedite action.** Researchers heard from many people that were concerned with the level of assessment and investment in data gathering and less investment in new ideas. At the time the researchers were gathering data, there were at least five other assessments which were recently or currently being completed. There was a level of frustration with this.
- **Invest in data analysis capacity building for regional use of data.** Many agencies identified the generation of immense amounts of data which primarily was sent to MN DHS but not used for care improvement or planning purposes. The reasons noted were lack of time and limited or no staff with data analysis training.
- **Reduce spread of misinformation by intentionally verifying critical details.** There were many instances where information shared between care providers during focus groups that was unintentionally inaccurate. This seems to be unavoidable but could be reduced with intentionally checking critical information, particularly regarding eligibility, admissions criteria, or payment options.

Priority Recommendations for Phase Three Investigation

Based on our work thus far, these are our suggestions for topics to consider for further focus in phase three of strategy development. We suggest that these areas are the focus of further research to identify best practices and implementation considerations.

Basic Needs Supports

- Identify collaboration options on permanent, temporary & shelter housing
- Innovative transportation options
- Support for basic needs gaps
- Consistent Use of Basic Needs Tracking

Prevention & Preemption

- In-school (k-12) emotional literacy efforts
- Drop-in center availability and model options
- Emotional regulation skills knowledge and use
- Effective peer support utilization
- Develop more intentional transition of support for young adults

More Acute Interventions

- Diagnostic testing training and capacity for professionals
- Access to behavioral health support in jails across the region
- Expansion of integrated and coordinated care
- Work with regional health systems to improve emergency room crisis assessments

Recovery, Healing & Resilience

- Culturally relevant and religiously inclusive recovery options
- Transition to maintenance care
- Transition from in-patient care into the community
- System of follow-up care

Workforce Challenges

- Identify untapped workforce potential
- Identify regional workforce recruitment strategies
- Identify regional workforce retention strategies
- Identify regional training opportunities and partnerships
- Dual licensing of staff

Use of Accurate Data for Decision Making

- Combining or sharing of assessments to maximize learning and expedite action
- Data analysis capacity building for regional use of data.

Appendix

Appendix A: Regional Interview and Focus Group Responses

Appendix B: Region 3 Provider Survey Responses

Appendix C: Region 3 Consumer Survey Responses

Providers (33 people)

1. Rewards and impacts
    - We are saving lives – every day. Building hope for the future. (x3)
    - We have options other than ER. Rapid access to support.
    - Current stabilization and future stabilization.
    - We also are focusing on the health and well-being of staff, by holding workshops on self-care, retreats, and flexible work schedules.
    - Seeing people do well and no longer needing us. (x4)
    - When clients come back to say "hi" or "Thank you" after being in recovery to celebrate.
    - Connections and trust.
    - Helping kids understand how to reach out for help.
    - Resolution of long-standing family disfunction
    - When a "high flyer" isn't that any more
    - Positive response from law enforcement.
    - Public health is now known although COVID shed a light on our profession in ways that was very stressful.
    - If we do prevention well, we can eliminate the need for some of the crisis response care.
    - We focus on graduation and for kids to experience things that "normal kids have" which seems to be one of the keys to therapeutic success, like "I passed the swimming test".
    - Seeing kids in long-term residential treatment graduate from high school.
    - Seeing kids develop life-long skills to navigate their distress. (x2)
    - Families having more skills to manage and support their teens and their mental health concerns. (x2)
    - Medication management is a big part of a partial hospitalization program.
    - Education support so that kids can identify what skills work in the classroom when they return to school.
    - Community education is important and rewarding.
    - Harm reduction like San Marco is model that is wildly successful. They are kind, safe and the staff love the people who live there.
    - Community Intervention Group is model that brought community organizations together to create a list of people in the community who are known for usage, are ones who should be helped out even more for hopes of recovery.
    - Wellness in the Woods is very supportive of each other, resulting in higher rate of retention for peer staff. We also have positive relationship with MN DHS Peer Support Coordinator.
    - Warmline works and keeps people from calling crisis line.
    - Wellness in the Woods is contracted by Pine, Isanti and Kanabec Counties to provide peer support and recovery care to residents. They receive referrals directly from case managers. This has worked very well.

> *Northland Counseling talks to all 9th graders and together they call 988. They connect with First Call for Help first and walk through a call so that students are aware of what the interaction would be like. Calls in the weeks and month after increase from adolescents.*
>
> Regional provider

2. Greatest challenges

- Accessibility and Transportation:
    - Remoteness: Geographic isolation impacts patients' ability to access care.
    - Transportation Barriers: Lack of reliable medical and non-medical transportation and long travel distances, particularly for detox and crisis services.

- Service Gaps:
    - Closure of Facilities and 'affordable' housing options: Regional treatment centers, board and lodging, and day labor options have closed, leaving a void in available services and ways for people to have 'cheap' housing.
    - Lack of Affordable Housing: Contributes to instability and makes treatment access harder.

- High Needs and Emerging Trends:
    - Substance Use Trends: Increase in binge drinking, particularly among women, and a growing number of individuals needing treatment.
    - Voluntary Nature of Services: Many people do not follow up on or take advantage of available services.

- Need to connect with parents
    - Parent support: Parents need support but hard to connect with them.

- Staffing and Funding Challenges:
    - Staff Recruitment and Retention: High turnover and difficulty in hiring, particularly for public health nurses.
    - Funding and Sustainability: Limited funding for essential services and difficulties in maintaining consistent service provision.
    - Peer Support Services: Need for sustainable billing models and overcoming barriers to employment and training for peer support specialists.

- Systemic and Structural Barriers:
    - Insurance Limitations: Coverage issues, particularly for crisis services and outpatient therapy.
    - Fragmented Care: Lack of continuity and collaboration between services and providers.
    - Training and Stigma: Insufficient mental health training for providers, and pervasive stigma affecting both patients and providers.

- Legal and Law Enforcement Challenges:
    - Lack of Collaboration: Insufficient integration and coordination with law enforcement and crisis response teams.
    - Cross-State Issues: Problems with treating individuals across state lines.

- Community and Cultural Factors:
    - Mistrust and Stigma: Persistent stigma towards mental health and substance use issues, which impacts service uptake and effectiveness.

- Cultural Competence: Challenges in addressing the needs of diverse populations and overcoming barriers related to trust and stigma.

3. Greatest needs to become mentally healthy
   - Affordable and safe housing (x8)
   - Shelter beds (x3)
   - Transportation (x5)
   - Safe places to become healthy again; club house closed after COVID
   - Healthcare system silos mental health services
   - Recovery capital. Most people who recover from addiction don't go to treatment. They have "recovery capital" and are able to recover on their own. Detox and treatment facilities often work with people who have 'recovery deficit'.
   - Isolation, depression, anxiety, loneliness
   - Social support that is positive (x3)
   - The way that therapy is structured and promoted does not fit veterans and their view of what they need. The use of terms such as "heal", "help" etc isn't helpful
   - Access time, childcare, economic challenges.
   - Mental health prioritized like physical health (x2)
   - Leads to segmented / disconnected care
   - No action taken by health partners in system, with respect to mental health diagnosis, referral and/or treatment
   - Don't have necessary number of clinical services for county / service area
   - Must refer people out which leads to drop off in obtaining care (x3)
   - Poverty / other stressors – affect individuals across spectrum
   - Wait times – people in need of care 'drop off map'
   - crisis stabilization, lack of awareness of supports.
   - There is culture of independence and people tend to try to address crisis on their own without seeking help
   - Persons in crisis won't accept intervention
   - Different interpretations of imminent risk. Wish lack of willingness to identify absence of basic needs as an imminent risk
   - Self care.
   - Healthy relationships. What kids need more than anything else is a relationship.
   - Healthy food
   - Help to be parents. Kids need skills, families need skills
   - Less time on social media
   - Family stability
   - Kids suffering from eating disorders or substance use aren't able to get the help they need if they are medically unstable. This is a huge gap.

4. Impact on well-being from working in behavioral health care
    - Reflective practice is very helpful and should be available to everyone.
    - It is stressful but also very rewarding.
    - High burnout positions / lots of turnover (4 years max in high burnout positions)
    - Constantly working to find more supports for staff in most stressful positions
    - Have worked to spread out most difficult cases to a larger number of staff members

> *If we will only be focusing our attention on the people who are showing up in crisis or causing problems for others (those throwing bricks into windows) and not those who are quietly suffering.*
> Regional provider

    - Those in these positions often move to less stressful positions
    - Burnout / turnover – in large part attributed to the lack of resources / inability to fully or adequately support clients in need of care
    - I need to work to not see the pathology in all kids.
    - We need more community and networking opportunities between providers and staff and opportunities for shared training. There is a lot of pressure to do more with less which heightens the stress.
    - There is a lot of death, which is hard for us and others but it is a part of the work.
    - We are a tight team and keep each other strong. We try to do fun things as a team and attend conferences as we can. That is helpful and something we look forward to.
    - Depletes me and those around me. Emotionally drained. Struggle with how to replenish. (x2)
    - Reflective supports and supervision. Need their own therapist or crisis line for decompressing from stressful experiences and after hours calls. (x2)
    - In Cook County, the service providers tend to share same independence ethic as community, and don't reach out for support.
    - Recruitment and retention is a constant issue and leaves other staff overburdened. Seems to be a 5-year burnout. (x2)
    - Funding support for staff retention efforts has to come from other sources.
    - Continue to host retreats for crisis response staff. It was very beneficial. Make sure everyone can go (even in small staffs) (x2)

5. Telehealth observations and needs
    - Need access to stable Wi-Fi or often even phones (x2)
    - Need support for people to use the technology. (x2)
    - Seems like a 50/50 split between those who want telehealth as an option and those who don't but anticipate this will grow as the next generation is more comfortable with technology. (x2)
    - Often the video call turns into just audio due to technology issues.

- Southern & Northern St. Louis - providers don't prefer it; missing things related to body language, connection
- There are cases where a patient should have gone in for treatment / care, but telehealth system didn't work, and they didn't go in for treatment
- There is room for growth in training of staff, increased broadband coverage and training of heath consumers in technology use.
- Northland Counseling never uses telehealth for a crisis response call, same with First Call for Help. Only with follow-up care.
- Cook could use more radio technology for rural communication and knowing how to use it. Could help with improved outreach
- Provider-to-provider telehealth could be improved to support folks providing rural behavior health care.

6. Data generation, analysis and use
    - Statewide data about kids (MN Student Survey) is misleading because it now doesn't ask about all of the ACES, only 8 of them (remove divorce and neglect). So, the students who show 4+ ACES is not reflective of the actual number. In 2020 the pandemic was identified as an adverse childhood experience by the National Institute of Health which has increased the percentage of youth with 4+ ACES to about 25%, which we can also use as a predictor of the high school drop-out rate. That is unacceptable and should be alarming and should be described as complex trauma, which is what it is.
    - We need to pay closer attention to ACES data and those which we can impact therapeutically. Three of the adverse childhood experiences are specific to abuse which we can impact therapeutically. The rest relate to neglect (not receiving something needed which others receive), which is not addressed with therapy. Neglect is addressed through the building of resilience skills and from kids knowing that people care.
    - We do CAFAS Assessments at the beginning, halfway and at the end which is a requirement for a 15-day program.
    - It would be interesting to get a follow-up but the data is very hard to get.
    - We do a parent and child survey at the end of treatment and use the results to make improvements.
    - We need to pay attention to the evidence about treatment modality effectiveness. For example, DBT is only evidence-based for one diagnosis but is used for all kids. Insurance companies often don't follow the evidence. There is 80 years of research on resilience strategies and a lot of research on trauma from past 20+ years. We need to pay close attention to this. I am also frustrated by the characterization of mindfulness as resilience.
    - Data is not getting collected or report in Cook County so it is not being used for planning, this is due to the fact that law enforcement and the hospital are the most likely responders rather than crisis team.
    - Northland Counseling analyzes data regularly and uses it for planning purposes.

- Range Mental Health Center needs support for summarizing data. They do not have someone whose responsibility is data analysis or sharing so they could use assistance with this.
- HDC does well gathering data but doesn't consistently have someone analyzing it for planning purposes.
- It would be helpful to have regional support for data analysis and use as well as more coordination between crisis response providers and law enforcement, hospitals and jails.
- Northern and Southern St Louis: monthly and quarterly reports are being generated.
- Carlton – utilizing data for jail collaborations and outreach; going really well
- the development of more services / services that are most likely to be used by the greatest number of patients
- lots of disparate groups involved in mobile crisis response
- no common form of reporting between response units (i.e. ambulance company, fire dept, hospitals, etc.)

7. Integration between mental health and substance use care
    - Substance use and mental health need to be treated together. It is important.
    - LICSWs are not as trained in substance use and visa versa. There is too much of a division.
    - Federal government messaging that we need a 'war on drugs' and 'drugs are bad' assists the stigma against substance use care. This stigma is embedded in our systems. This needs to stop. So many people are discouraged with cost of living and stressors. If life is discouraging, they are likely to use substances.
    - Range Mental Health Center: We are fortunate we are all under one umbrella.
    - Northland Counseling: As a CCBHC we are already integrated between mental health and substance use.
    - HDC: As a CCBHC we are already integrated but need community-based substance use crisis stabilization beds.
    - Cook County: Need more funding and resources to adequately address both issues, especially if there is psychosis related to substance use.
    - Range Mental Health Center: needs regular training on new substances for all providers; there are new substances every day; not everyone trained in it; so much to know
    - HDC – Carlton/St Louis: need IRT (Intensive Residential Treatment) center
    - There needs to be more substance use treatment for kids.
    - Substance use prevention and education. The legalization of marijuana has seemed to stop the education about what it does to developing brains. This is not OK. We have 11 and 12 year olds who smoke marijuana on a daily basis and bringing it to school.
    - We need therapists who are co-trained in CD and MH. They don't need to likely have an LADC but need training in substance use.
    - Seems like Nystrom had a nice model of providing mental health care to people in their treatment programs.

- Currently, healthcare system looks at patient in parts (i.e. address mental health separate from substance abuse separate from health)
- Need one place and/or person to serve the individual, as a whole A lot of overlap between mental health and substance use treatments
- Overlap is central place to treat both, simultaneously
- Closer connection between the medical providers and CADT or other substance use treatment.
- Share data with medical providers. Their perception of the problem is rarely actually reflected in the data.
- There is no addiction without a biomedical condition also.

8. Top ideas

- Preparation and Preemption:
    - Preparation and education: Focus on education to identify early signs of mental health issues and provide clear pathways for seeking help.
    - Need more prevention and education with schools and parents. Need a unified approach with kids and their substance use, not focusing on punishment.
    - Need more standardized behavioral health screenings but can't put this all on general practitioners. What if we had LICSWs to do regular behavioral health screenings for kids and young adults, like we do with annual check-ups.
    - Public Health Approach: Frame addiction as a public health issue and focus on educating both the public and professionals (e.g., bartenders, salon workers).
    - Community Support: Increase support for families, especially parents struggling with their children's behavior. Expand community-based support systems.
    - School and Family Support: Improve collaboration between schools, families, and mental health services. Support teachers with trauma-informed training and support parents with practical resources.
    - Dramatically increase our focus on kids and achievement and positive interactions, having every kids feel like they are good at something
    - Mobile shower units and laundry services
- Interventions:
    - Parallel Approaches: Implement comprehensive strategies including prevention, intervention, harm reduction, and law enforcement collaboration.
    - Consider re-creating the First Step program
    - Hire care navigator to work out of the ER department, at a shared expense across agencies.
    - Improve transition from treatment into community or natural settings. Kids often do really well in day treatment but don't do well when re-entering their classrooms. We often find that the school staff aren't doing what we have recommended, which isn't helpful for the schools or the students. The transition has to work.
    - "Full Court Press" Strategy: Employ a coordinated, all-encompassing approach to address mental health and substance use issues.

  - Harm Reduction: Promote harm reduction strategies to minimize risks and support recovery. Educate people about risks and the principles of harm reduction.
  - Continue to pursue a peer respite home in Northern MN. This could address a lack of crisis stabilization care.
  - Service Gaps: Expand access to crisis intervention, detox, and treatment options, particularly in underserved areas like Lake County and Cook County.
  - Crisis Response: Develop on-call crisis negotiators and enhance regional crisis response infrastructure.
  - Continuity of Care: Ensure smooth transitions from crisis intervention to ongoing treatment. Address gaps in follow-up care and integrate services more effectively.
  - Integrated Behavioral Healthcare: Advocate for an integrated model that includes mental health within overall healthcare services.
- Recovery and Healing:
  - Sober Housing and Support: Increase availability of sober housing and support services (beyond AA, ALANON), including sober living arrangements and recovery housing.
- Recruitment and Retention
  - Workforce Development: Address the need for more peer recovery specialists and ensure adequate training and support.
  - Identify one or two crisis response staff retreats for region, similar to the one in Hinckley. Consider having it somewhere in Region 3, although anonymity for staff was appreciated.
  - We need therapists who are co-trained in CD and MH. They don't need to likely have an LADC but need training in substance use.
- Addressing Stigma and Cultural Competence:
  - Reduce Stigma: Normalize mental health care and reduce stigma associated with seeking help. Promote culturally competent and LGBTQ+ inclusive care.
  - Veteran-Specific Support: Develop targeted support and treatment options for veterans, addressing their unique needs and challenges.

Region 3 Provider Survey

September 2024

Q1 - What county(s) do you work in/provide service (check all that apply)?

#	Answer	%	Count
1	Atkin	0.00%	0
2	Carlton	25.00%	5
3	Cook	10.00%	2
4	Itasca	5.00%	1
5	Koochiching	0.00%	0
6	Lake	20.00%	4
7	St. Louis North	10.00%	2
8	Other	0.00%	0
9	St. Louis South	30.00%	6
	Total	100%	20

Q2 - What is your main role at work?

#	Answer	%	Count
1	Parent support, education, screening, etc. (prevention)	0.00%	0
2	Home visiting, early childhood, mental health first aid, etc. (early intervention)	0.00%	0
3	Primary care, psychiatry, etc. (basic clinical services)	7.69%	2
4	Therapist, school-based mental health (community services & supports)	15.38%	4
5	Peer support, ARMHS, club houses (community services & supports)	11.54%	3
6	Case management, assertive community treatment (community services & supports)	15.38%	4
7	ER, inpatient, partial hospitalization, residential treatment, DETOX (hospitalization & residential treatment)	3.85%	1
8	Law enforcement, first responder (crisis prevention & response)	15.38%	4
9	Mobile crisis team, crisis calls (crisis prevention & response)	7.69%	2
10	Crisis stabilization (crisis response)	3.85%	1
11	Peer recovery facilitation, healing interventions (recovery & healing)	7.69%	2
12	Other	0.00%	0
13	Emotional-literacy, well-being (well-being & health promotion)	11.54%	3
	Total	100%	26

Q3 - How long have you been working in the field of behavioral health?

#	Answer	%	Count
1	Less than 5 years	38.89%	7
2	5-10 years	22.22%	4
3	11-20 years	22.22%	4
4	More than 20 years	16.67%	3
	Total	100%	18

Q4 - Which age groups do you serve at work (check all that apply)?

#	Answer	%	Count
1	Under 18	14.29%	10
2	18-29	22.86%	16
3	30-44	22.86%	16
4	45-54	20.00%	14
5	Older than 54	20.00%	14
	Total	100%	70

Q5 - All items on this list have been identified by experts as individual or community barriers to accessing care. To what extent are these barriers impacting the persons you serve?

#	Question	No impact		Some impact		Significant Impact		Total
1	Inadequate or no insurance	16.67%	3	61.11%	11	22.22%	4	18
2	Cultural or identity considerations	5.56%	1	83.33%	15	11.11%	2	18
3	Caregiving responsibilities (children, parents, pets)	5.88%	1	47.06%	8	47.06%	8	17
4	Instability of basic needs (including housing)	0.00%	0	38.89%	7	61.11%	11	18
5	Lack of access to transportation	0.00%	0	38.89%	7	61.11%	11	18
6	Lack of availability of type of care needed	0.00%	0	52.94%	9	47.06%	8	17
7	Long wait time for needed services	0.00%	0	22.22%	4	77.78%	14	18
8	Lack of knowledge of available care	5.88%	1	52.94%	9	41.18%	7	17
9	Limited access to telehealth because of broadband or limited technology	35.29%	6	47.06%	8	17.65%	3	17

Q6 - Which of the following barriers impact the ability of your organization/place of work to provide care?

#	Question	Not a barrier		Somewhat of a barrier		Significant Barrier		Total
1	Level of pay	23.53%	4	41.18%	7	35.29%	6	17
2	Insurance reimbursement	41.18%	7	35.29%	6	23.53%	4	17
3	Retention of staff	11.76%	2	29.41%	5	58.82%	10	17
4	Burnout	11.76%	2	35.29%	6	52.94%	9	17
5	Ongoing training	23.53%	4	47.06%	8	29.41%	5	17
6	Licensing supervision of new professionals	47.06%	8	29.41%	5	23.53%	4	17

Q7 - Do you offer telehealth services as a part of your work?

#	Answer	%	Count
1	No	22.22%	4
2	Yes	77.78%	14
	Total	100%	18

Q8 - Which of the following statements do you find to be accurate regarding telehealth services?

#	Question	This statement is not accurate for me		This statement is somewhat accurate for me		This statement is very accurate for me		Total
1	I need more training to be able to offer telehealth services	88.24%	15	11.76%	2	0.00%	0	17
2	I find the technology challenging	70.59%	12	17.65%	3	11.76%	2	17
3	I do not have a private place to offer such services	76.47%	13	11.76%	2	11.76%	2	17

#	Question	This statement is not accurate for me		This statement is somewhat accurate for me		This statement is very accurate for me		Total
4	My patients are not interested in telehealth services	37.50%	6	43.75%	7	18.75%	3	16
5	I am not sure that telehealth services are effective	55.56%	10	27.78%	5	16.67%	3	18
6	Other:	100.00%	3	0.00%	0	0.00%	0	3

Q9 - What do you think is the benefit to the provider for offering telehealth services?

More contact between provider and client Better attendance with clients
Ease of use, provides people more flexibility, as well as an ability to seek out more specialized and specific providers for certain care that wouldn't be available in their area
More accessibility for clients/patients and more flexibility for provider to see people if facing transportation issues, including lack of transportation and distance barriers
People may try this if they are unwilling to physically go to a facility.
It allows the client to meet in their own home and space.
my clients, children, are able to meet with me for regularly scheduled sessions despite often not having rides to appointments.
Many patients have transportation issues and telehealth can help but ONLY if they have a way to also connect. Some of our older patients are not technically savvy and are overwhelmed with technology. They become more isolated as they have trouble with abilities to walk and get transportation.
Benefit for clients that live in more rural areas, as well as benefit for clients that are full time parents, students, etc. Telehealth is also beneficial for clients that have agoraphobia.
Accessibility. Bus lines take forever, clients need to be able to access services without sacrificing 1-2 hours of their day.
My belief is that healthcare organizations have switched to telehealth due to the falling numbers of qualified personnel in rural settings, and the reluctance of other staff to perform an evaluation of a mental health crisis based upon liability.
Allows people to be more comfortable, reduces transportation barriers.
Transportation is no longer an issue, patients with social anxiety feel more comfortable. Access to psychiatry can be quicker.
I see no benefit to a provider conducting telehealth service

Q10 - Which of the following populations do you serve at work (check all that apply)?

#	Question	The majority of my work		Only sometimes		I do not work with this population or group		Total
1	Teenagers	23.53%	4	47.06%	8	29.41%	5	17
2	Indigenous youth	17.65%	3	58.82%	10	23.53%	4	17
3	Queer youth & young adults	17.65%	3	64.71%	11	17.65%	3	17
4	Young women	29.41%	5	58.82%	10	11.76%	2	17
5	Young to middle-aged men	33.33%	6	61.11%	11	5.56%	1	18
6	Single men	27.78%	5	66.67%	12	5.56%	1	18
7	Unhoused persons	11.76%	2	76.47%	13	11.76%	2	17
8	Older adults (75+)	17.65%	3	58.82%	10	23.53%	4	17
9	BIPOC	13.33%	2	73.33%	11	13.33%	2	15
10	Veterans	11.11%	2	66.67%	12	22.22%	4	18
11	Other	0.00%	0	0.00%	0	100.00%	2	2

Q11 - Stigma regarding mental and behavioral health care is one of the main barriers for accessing care. Based on your experience, in which setting, and by whom, does stigma limit people's ability to seek and receive care?

#	Question	No impact		Some impact		Significant impact		Total
8	Stigma among other behavior health providers	35.29%	6	47.06%	8	17.65%	3	17
7	Stigma among primary care or other healthcare providers	23.53%	4	52.94%	9	23.53%	4	17
6	Stigma among law enforcement and/or first responders	17.65%	3	35.29%	6	47.06%	8	17
4	Stigma at school	0.00%	0	58.82%	10	41.18%	7	17
3	Stigma among family/community	0.00%	0	58.82%	10	41.18%	7	17
2	Social stigma	0.00%	0	64.71%	11	35.29%	6	17
1	Individual/self stigma	5.88%	1	64.71%	11	29.41%	5	17
5	Stigma at work	6.25%	1	68.75%	11	25.00%	4	16
9	Other	100.00%	2	0.00%	0	0.00%	0	2

Q12 - Patients benefit from care that is relevant to their culture, identity and experience. Please tell us if the care you provide is relevant to the following culture, experiences or identities:

#	Question	The care I provide is not relevant		The care I provide is somewhat relevant		The care I provide is relevant		Total
1	Culture & Ethnicity	17.65%	3	35.29%	6	47.06%	8	17
2	Gender Identity	17.65%	3	23.53%	4	58.82%	10	17
3	Sexual Orientation	11.76%	2	23.53%	4	64.71%	11	17
4	Veteran status	29.41%	5	35.29%	6	35.29%	6	17
5	Religion & Spirituality	11.76%	2	58.82%	10	29.41%	5	17
6	Neurodivergence	17.65%	3	23.53%	4	58.82%	10	17
7	Disability	5.88%	1	29.41%	5	64.71%	11	17
8	Other	100.00%	2	0.00%	0	0.00%	0	2

Q13 - Patients benefit from care that is relevant to their culture, identity and experience. Please tell us if the care your organization or place of work provides is relevant to the following culture, experiences and identities:

#	Question	The care provided is not relevant		The care provided is somewhat relevant		The care provided is relevant		Total
1	Culture & Ethnicity	5.88%	1	47.06%	8	47.06%	8	17
2	Gender Identity	11.76%	2	23.53%	4	64.71%	11	17
3	Sexual Orientation	5.88%	1	29.41%	5	64.71%	11	17
4	Veteran status	17.65%	3	35.29%	6	47.06%	8	17
5	Religion & Spirituality	6.25%	1	56.25%	9	37.50%	6	16
6	Neurodivergence	11.76%	2	41.18%	7	47.06%	8	17
7	Disability	6.25%	1	25.00%	4	68.75%	11	16
8	Other	66.67%	2	33.33%	1	0.00%	0	3

Q14 - Can you think of some additional challenges that you face in your work that were not covered in this survey and might be of help to improve services (if any)?

My primary conflict at work is regulating my clients' emotions and trying to keep them safe and avoid self-harm and violent behaviors. It would be nice to have more defined crisis hotline or crisis response.
Challenges in regard to accessibility to technology used for communication or keeping track of appointments, answering calls, meeting via telehealth
Working with other professionals in the community who are not informed about mental health and do not support patients/clients in healthy ways. Lack of training by professionals in the community and lack of staffing.
More access to in-school providers or the ability to provide transportation for our young clients.
The patient's ability to pay for medications they need to prevent complications like eliquis, etc. Another huge challenge are the barriers insurance companies create in terms of getting coverage for medicines and treatments (those requiring a lengthy prior authorization). You have to sit on hold for 40+ min to get to any person at an insurance company and also typically get transferred to someone new. It's infuriating how the insurance companies do not allow the providers to provide the care the patient's need to keep them healthy and from being readmitted to the hospital (where costs go up).
Retention rates are low due to low compensation in community mental health.
length of wait list for services, especially QRTP and PRTF can be half a year up to two year wait. I want to emphasize the lack of crisis stabilization services for children outside of the Duluth immediate area.
Short staffed pay scales

Q15 - Can you tell us if there are other activities - such as additional training, expansion or reduction of services, sharing of data and information or other - that would be helpful for you to be able to do your work better?

Mental health training
Trainings and expansion of services of would be ideal for our community.
More training dollars. Our current budget is $500 per therapist per year. It's great that we have this as a training budget, but it often isn't enough to cover bigger, more impactful trainings which turns providers away from seeking further education.
I would LOVE some central website/database with updated information and resources for patients and family members. There are so many good resources but there isn't a central spot for them.
Usually it comes down to burnout and pay.

Q16 - Below you will find a list of areas of care. We would like to know which areas you make referrals... - I make referrals to this resource

#	Question	Yes		No		Total
1	Emotional literacy & well-being (Well-being & health promotion)	53.85%	7	46.15%	6	13
2	Parent support, education, screening (Prevention)	43.75%	7	56.25%	9	16
3	Home visiting, early childhood, mental health first aid, etc. (Early intervention)	66.67%	10	33.33%	5	15
4	Primary care, psychiatry, etc. (Basic clinical services)	86.67%	13	13.33%	2	15
5	Therapist, school-based mental health (Community services & supports)	80.00%	12	20.00%	3	15
6	Peer support, ARMHS, club houses (Community services & supports)	82.35%	14	17.65%	3	17
7	Case management, assertive community treatment (Community services & supports)	94.12%	16	5.88%	1	17
8	Mobile crisis team, crisis calls (Crisis prevention & response)	88.24%	15	11.76%	2	17
9	Law enforcement, first responder (Crisis response)	66.67%	10	33.33%	5	15
10	ER, inpatient, partial hospitalization, residential treatment, DETOX (Hospitalization & residential treatment)	100.00%	16	0.00%	0	16
11	Crisis stabilization (Crisis prevention & response)	81.25%	13	18.75%	3	16
12	Peer recovery facilitation, healing interventions (Recovery & healing)	66.67%	10	33.33%	5	15
13	Other	0.00%	0	100.00%	1	1

Q17 - Below you will find a list of areas of care. We would like to know which areas you make referrals... - This resource is usually available for my patients

#	Question	Yes		No		Total
1	Emotional literacy & well-being (Well-being & health promotion)	85.71%	12	14.29%	2	14
2	Parent support, education, screening (Prevention)	80.00%	8	20.00%	2	10
3	Home visiting, early childhood, mental health first aid, etc. (Early intervention)	100.00%	12	0.00%	0	12
4	Primary care, psychiatry, etc. (Basic clinical services)	78.57%	11	21.43%	3	14
5	Therapist, school-based mental health (Community services & supports)	91.67%	11	8.33%	1	12
6	Peer support, ARMHS, club houses (Community services & supports)	78.57%	11	21.43%	3	14
7	Case management, assertive community treatment (Community services & supports)	71.43%	10	28.57%	4	14

#	Question	Yes		No		Total
8	Mobile crisis team, crisis calls (Crisis prevention & response)	71.43%	10	28.57%	4	14
9	Law enforcement, first responder (Crisis response)	91.67%	11	8.33%	1	12
10	ER, inpatient, partial hospitalization, residential treatment, DETOX (Hospitalization & residential treatment)	71.43%	10	28.57%	4	14
11	Crisis stabilization (Crisis prevention & response)	76.92%	10	23.08%	3	13
12	Peer recovery facilitation, healing interventions (Recovery & healing)	69.23%	9	30.77%	4	13
13	Other	0.00%	0	100.00%	1	1

Q18 - Below you will find a list of areas of care. We would like to know which areas you make referrals... - This resource is usually helpful for my patients

#	Question	Yes		No		Total
1	Emotional literacy & well-being (Well-being & health promotion)	81.82%	9	18.18%	2	11
2	Parent support, education, screening (Prevention)	100.00%	11	0.00%	0	11
3	Home visiting, early childhood, mental health first aid, etc. (Early intervention)	100.00%	13	0.00%	0	13
4	Primary care, psychiatry, etc. (Basic clinical services)	100.00%	14	0.00%	0	14
5	Therapist, school-based mental health (Community services & supports)	100.00%	12	0.00%	0	12
6	Peer support, ARMHS, club houses (Community services & supports)	100.00%	15	0.00%	0	15
7	Case management, assertive community treatment (Community services & supports)	100.00%	15	0.00%	0	15
8	Mobile crisis team, crisis calls (Crisis prevention & response)	86.67%	13	13.33%	2	15
9	Law enforcement, first responder (Crisis response)	71.43%	10	28.57%	4	14
10	ER, inpatient, partial hospitalization, residential treatment, DETOX (Hospitalization & residential treatment)	73.33%	11	26.67%	4	15
11	Crisis stabilization (Crisis prevention & response)	91.67%	11	8.33%	1	12
12	Peer recovery facilitation, healing interventions (Recovery & healing)	92.86%	13	7.14%	1	14
13	Other	50.00%	1	50.00%	1	2

Region 3 - Consumers and Persons with Lived Experience Survey

August 2024

Q1 - What is your race or ethnicity? Select all that apply.

#	Answer	%	Count
1	American Indian or Alaskan Native	13.04%	3
2	Asian or Asian American	0.00%	0
3	Black, African or African American	0.00%	0
4	Hispanic or Latino/a	0.00%	0
5	Middle Eastern /North African	0.00%	0
6	Native Hawaiian or Other Pacific Islander	0.00%	0
7	White	82.61%	19
10	Other	4.35%	1
	Total	100%	23

Q2 - What is your gender?

#	Answer	%	Count
1	Male	18.18%	4
2	Female	63.64%	14
3	Non-binary / third gender	4.55%	1
4	Prefer not to say	9.09%	2
5	Other	4.55%	1
	Total	100%	22

Q3 - What is your age?

#	Answer	%	Count
1	Under 18	0.00%	0
2	18-29	9.09%	2
3	30-44	31.82%	7
4	45-54	45.45%	10
5	Older than 54	13.64%	3
	Total	100%	22

Q4 - What is your tribal affiliation (if applicable)?

#	Answer	%	Count
1	Bois Forte	0.00%	0
2	Fond du Lac	0.00%	0
3	Grand Portage	50.00%	2
4	Other	50.00%	2
	Total	100%	4

Q5 - What is your current living situation?

#	Answer	%	Count
1	I am a homeowner	63.64%	14
2	I am a renter	27.27%	6
4	I am unhoused or in unstable housing	0.00%	0
5	I prefer not to answer	4.55%	1
6	Other	4.55%	1
	Total	100%	22

Other - Text
rehab center

Q6 - What County do you live in?

#	Answer	%	Count
1	Atkin	0.00%	0
2	Carlton	0.00%	0
3	Cook	18.18%	4
4	Itasca	9.09%	2
5	Koochiching	0.00%	0
6	Lake	9.09%	2
7	St. Louis North	31.82%	7
8	Other	4.55%	1
9	St. Louis South	27.27%	6
	Total	100%	22

Other - Text
Crow wing

Q7 - In your personal life, do you provide care to other family members, such as elderly or sick relatives, or young children?

#	Answer	%	Count
1	Yes	59.09%	13
2	No	40.91%	9
	Total	100%	22

Q8 - In the past two years, which services did you try to access, and which ones were you able to access? Select all that apply.

#	Question	Tried to access but was unable to		Tried, and was able, to access	
1	Emotional-literacy, well-being (well-being & health promotion)	5.97%	4	12.82%	10
2	Parent support, education, screening, etc. (prevention)	8.96%	6	3.85%	3

3	Home visiting, early childhood, mental health first aid, etc. (early intervention)	8.96%	6	5.13%	4
4	Primary care, psychiatry, etc. (basic clinical services)	7.46%	5	19.23%	15
5	Therapist, school-based mental health (community services & supports)	7.46%	5	10.26%	8
6	Peer support, ARMHS, club houses (community services & supports)	11.94%	8	7.69%	6
7	Case management, assertive community treatment (community services & supports)	8.96%	6	8.97%	7
8	Mobile crisis team, crisis calls (crisis prevention & response)	5.97%	4	7.69%	6
9	Law enforcement, first responder (crisis prevention & response)	5.97%	4	8.97%	7
10	ER, inpatient, partial hospitalization, residential treatment, DETOX (hospitalization & Residential treatment)	13.43%	9	5.13%	4
11	Crisis stabilization (crisis response)	7.46%	5	7.69%	6
12	Peer recovery facilitation, healing interventions (recovery & healing)	7.46%	5	2.56%	2
13	Other	0.00%	0	0.00%	0
	Total	Total	67	Total	78

Q9 - If there was a service you tried but were unable to access, can you tell us what were the barriers or problems you were faced with when trying to access this service? Select all that apply.

#	Question	No Barrier	Somewhat of a barrier	Significant barrier	Total
7	The service was too far, or I had no transportation	4	4	11	19
6	There was a long wait time to access this service	3	5	11	19
3	The service I needed was not available	3	5	11	19
9	I had a bad experience in the past	5	4	10	19
5	The service didn't have openings, or did not have openings at times and days that I could access	2	8	9	19
1	I didn't know what service I needed or how to get in touch with them	6	4	9	19
8	I have caregiving responsibilities (for kids, family members, pets etc.) that prevented me from accessing services	9	4	6	19

4	I didn't have insurance or coverage, or the co-pay was too high	13	1	5	19
2	I was not sick enough or was not sure I needed this service	7	7	5	19
10	The service requires to use telehealth and I am unable to do so	11	6	2	19
11	Other	3	1	0	4

#	Field	Mean	Count
1	I didn't know what service I needed or how to get in touch with them	2.16	19
2	I was not sick enough or was not sure I needed this service	1.89	19
3	The service I needed was not available	2.42	19
4	I didn't have insurance or coverage, or the co-pay was too high	1.58	19
5	The service didn't have openings, or did not have openings at times and days that I could access	2.37	19
6	There was a long wait time to access this service	2.42	19
7	The service was too far or I had no transportation	2.37	19
8	I have caregiving responsibilities (for kids, family members, pets etc.) that prevented me from accessing services	1.84	19
9	I had a bad experience in the past	2.26	19
10	The service requires to use telehealth and I am unable to do so	1.53	19
11	Other	1.25	4

Q10 To what extent do the following common barriers impact your access to care?

#	Field	Mean	Count
7	Long wait time for needed services	2.27	22
6	Lack of availability of type of care needed	2.23	22
8	Unfamiliar with care options	1.95	22
3	Caregiving responsibilities (children, parents, pets)	1.86	21

#	Field	Mean	Count
5	Lack of access to transportation	1.73	22
4	Instability of basic needs (including housing)	1.59	22
9	Limited access to telehealth because of broadband or limited technology	1.55	22
1	Inadequate or no insurance	1.52	21
2	Cultural or identity considerations	1.48	21

#	Question	This is not a barrier for me		This is somewhat of a barrier for me		This is a significant barrier for me		Total
7	Long wait time for needed services	22.73%	5	27.27%	6	50.00%	11	22
6	Lack of availability of type of care needed	22.73%	5	31.82%	7	45.45%	10	22
5	Lack of access to transportation	59.09%	13	9.09%	2	31.82%	7	22
8	Unfamiliar with care options	36.36%	8	31.82%	7	31.82%	7	22
3	Caregiving responsibilities (children, parents, pets)	33.33%	7	47.62%	10	19.05%	4	21
2	Cultural or identity considerations	66.67%	14	19.05%	4	14.29%	3	21
4	Instability of basic needs (including housing)	54.55%	12	31.82%	7	13.64%	3	22
9	Limited access to telehealth because of broadband or limited technology	59.09%	13	27.27%	6	13.64%	3	22
1	Inadequate or no insurance	57.14%	12	33.33%	7	9.52%	2	21

Q11 - Are the services you are able to access relevant to your culture, experience and identity?

#	Question	The care I received was not relevant	The care I received was relevant	Total
5	Religion & Spirituality	10	2	12
6	Neurodivergence	9	1	10
2	Gender Identity	9	4	13
1	Culture and Ethnicity	9	6	15
7	Disability	7	3	10

#	Question	The care I received was not relevant	The care I received was relevant	Total
3	Sexual Orientation	7	5	12
4	Veteran status	4	1	5
8	Other	0	0	0

Q12 - Stigma regarding mental and behavioral health care is one of the main barriers for accessing care. Based on your experience, in what setting, and by whom, does stigma impact your ability to seek and receive care?

#	Field	Minimum	Maximum	Mean	Count
2	Social stigma	1.00	3.00	2.09	22
3	Stigma among family/community	1.00	3.00	2.05	22
1	Individual/self stigma	1.00	3.00	1.95	22
5	Stigma at work	1.00	3.00	1.86	21
8	Stigma among other behavioral health providers	1.00	3.00	1.77	22
7	Stigma among primary care or other healthcare providers	1.00	3.00	1.77	22
6	Stigma among law enforcement and/or first respondents	1.00	3.00	1.77	22
4	Stigma at school	1.00	3.00	1.50	22
9	Other	1.00	3.00	1.40	5

#	Question	Does not affect me	Affects me somewhat	Affects me significantly	Total
3	Stigma among family/community	7	7	8	22
2	Social stigma	6	8	8	22
6	Stigma among law enforcement and/or first respondents	11	5	6	22
7	Stigma among primary care or other healthcare providers	10	7	5	22
5	Stigma at work	8	8	5	21
1	Individual/self stigma	6	11	5	22

#	Question	Does not affect me	Affects me somewhat	Affects me significantly	Total
8	Stigma among other behavioral health providers	9	9	4	22
4	Stigma at school	15	3	4	22
9	Other	4	0	1	5

Q13 - What is your experience with telehealth services, an appointment via video call, for behavioral health care or any other healthcare need?

#	Answer	%	Count
1	I never used telehealth services	13.64%	3
2	I used telehealth services for other healthcare needs, but not behavioral health care	22.73%	5
3	I used telehealth services for behavioral health care	63.64%	14
	Total	100%	22

Q14 - Which of the following statements do you find to be accurate regarding telehealth services for you?

#	Field	Minimum	Maximum	Mean	Count
6	I am not sure that telehealth services are effective	1.00	3.00	1.76	21
5	The services I need do not offer telehealth option	1.00	3.00	1.62	21
8	Other:	1.00	3.00	1.60	5
7	I prefer to use telehealth, rather than have a face-to-face meeting	1.00	3.00	1.60	20
3	I do have the equipment and/or reliable internet service, but I find the technology challenging to use	1.00	3.00	1.57	21
4	I don't have a private place that allows me to use telehealth comfortably	1.00	3.00	1.52	21
2	I can't use telehealth because I don't have a reliable or fast internet connection	1.00	3.00	1.45	22
1	I can't use telehealth because I don't have the required equipment (IPad, Phone, computer etc.)	1.00	3.00	1.32	22

#	Question	This statement is not accurate for me	This statement is somewhat accurate for me	This statement is accurate for me	Total
6	I am not sure that telehealth services are effective	10	6	5	21
2	I can't use telehealth because I don't have a reliable or fast internet connection	14	6	2	22
1	I can't use telehealth because I don't have the required equipment (IPad, Phone, computer etc.)	17	3	2	22
3	I do have the equipment and/or reliable internet service, but I find the technology challenging to use	12	6	3	21
4	I don't have a private place that allows me to use telehealth comfortably	13	5	3	21
7	I prefer to use telehealth, rather than have a face-to-face meeting	12	4	4	20
8	Other:	3	1	1	5
5	The services I need do not offer telehealth option	14	1	6	21

Q15 - Based on your experience, what are your top (3-5) ideas for improving the behavioral health care that is provided to you?

Transportation resources, assistance with getting rides to appointments

#1: INCREASE ASL-FLUENT (& DEAF) PROFESSIONALS Saint Louis County (particularly South) has approximately 6,000 - 7,000 Deaf/HH individuals, and as of this writing, there are only THREE known behavioral health therapists serving the Duluth/Superior area who are ASL-fluent and knowledgeable about Deaf Culture! #2: Provide case management and behavioral health services remotely/telehealth - especially in ASL (i.e., Zoom). As far as I know, there's only ONE agency that does provide case management services to Deaf individuals in Saint Louis County, but the quality of services are not satisfactory. Again, there is a need for ASL access. Also, the Deaf & HH Services Division under the State of Minnesota are not returning calls or e-mails regarding resources for case management or behavioral health services. DHHSD does provide free behavioral health services, yes, but it doesn't seem they process it in a reasonable amount of time. As such, D/HH folks need another source of information on how to access culturally-specific or linguistically-specific resources. #3: The Arrowhead Regional Crisis Line needs to have at least an ASL option, for D/HH folks who are unable to use English. Additionally, the website (firstcall211.net) doesn't seem to offer any chat services as advertised? #4: When accessing behavioral health services that involves taking prescribed medications, D/HH folks struggle to understand proper dosage, possible contraindications, side effects, and how to best adhere. There needs to be ASL-fluent personnel who can be their patient care navigator, which goes beyond just medical professionals with ASL interpreters. D/HH folks also struggle to understand how to use their benefits to access behavioral health services, which further justifies the need for ASL-fluent patient care navigators.

More providers in the area. Easier access to transportation.

Faster assessments to get into substance use treatment. The window of time for someone to accept help is small. I almost lost my loved one to suicide because of the wait. Need knowledgeable crisis response operators who know how to resource quickly. Commercial insurance doesn't pay for DHS programs that benefit behavioral health.

Get clear on and stop using interchangeably the words Mental health vs. Mental Illness. They are not the same. Put people in housing. Get rid of specialization. I can't tell you how many times a person calls the intake line, then gets scooted around to five people only to end up where they started. Duluth crisis stabilization is near worthless... Someone will be there a week and can't get meds. This whole thing of inpatient care and outpatient care is ridiculous. A person inpatient can't get their meds before discharge, then has to follow up outpatient, which is too much to follow through with when they are homeless or addicted. We need to start helping people rather than referring them somewhere that never ends up happening.

Current professionals within the county need to have better mental health training and how to address it. The emergency department needs to be better informed on how to address services for mental health needs. Home based services need to be addressed by the county and how those services can be added to the community.

Crisis management for drug and mental health..By the time you can get help, the crisis has passed, you are using again and really sick and it's so easy to bs counselors into releasing you from hospital even though you are still high and suicidal....it's pretty much a sham and nobody wants to treat a severe mental health crisis..just send them back on the street until the next crisis, overdose or suicide...

reducing stigma in the community, Affordable and accessible treatments, Having more than one option for treatments

location and accessibility. The crisis center in Duluth use to be right on the hillside where a lot of people with mental health issues live. Now it is tucked up behind the mall so many people don't know where it is and cannot access it. The second is so many programs have far too much paperwork and steps to take to get access to their program. That is far too overwhelming for somebody with severe mental health issues.

Make longer term treatment option for kids more available so we aren’t waiting 6 months for a residential treatment to open up

Getting the services I need to me

1. Access to more providers. 2. Access to private community spaces and technology assistance for accessing telehealth providers. 3. More advertisement, community awareness, and community education about local crisis services and what it looks like to access them. 4. MOST IMPORTANT: Transportation to crisis stabilization facilities. 5. More funding for our local mental health agencies, law enforcement, and hospitals. Services that are not available are taken on by these agencies who are not equipped with the proper resources.

Increased telehealth options for services like anger management Increased "after-hours" care Increased training for law enforcement and ER services regarding mental illness

Persons with Lived Experience (19 people; Chisholm, Ely and Virginia)

1. Most helpful
   - Northern Lights Clubhouse
     - We have a community of people to talk to. We are a close community.
     - Here, I am accepted and not judged
     - This is my primary social group.
     - Not judgmental
     - Helps that we get a text every Monday to see if we are coming.
   - Range Mental Health
     - ARMHS & medication management nurse
   - Ely-based supports
     - Psychiatry in Ely is helpful. They helped me reduce the medication I take.
     - Recovery groups in Ely (AA, Sober Squad, Hope meeting, Recovery Alliance Duluth)
     - housing authority even though there is a wait list
     - Ely library is very nice but feels like an untapped resource.
     - Ely's Family Resource Center has been great and reaches out to offer support. The mentoring program has been helpful and has had a positive influence on our lives.
   - Chisholm-based supports
     - Chisholm in general is making some progressive decisions in the city. The leadership is strong and it is feeling like a "community".
     - VEMA is being integrated into the community and consulted on things as well as supported.
     - Chisholm schools have mental health services if someone is already a client but we need supports for all kids.
   - Virginia-based supports
     - Wellstone Center groups and the beauty of the space. Staff are great and it is nice here. Wished I had more time.

2. Less helpful
   - Some hospital stays haven't been helpful. It seemed like it wasn't anyone's job to see how I was doing and what I needed.
   - Can't get help for our kids at the hospital. My child threatened to kill themselves, so we went to the Ely hospital, then Duluth. They couldn't help us. Eventually, we ended up in Miller-Dwan, but it took a long time to get help.
   - For people who aren't in need to recovery support, we need more activities.
   - Having kids in classrooms with untreated trauma, anxiety or depression doesn't work for students or teachers.
   - Peer Support Specialists training and support in Minnesota is all under one person which makes it challenging to expand.
   - The lack of care options in Ely, especially for substance use, is hard on everyone, especially the families. People have to lose everything before they can get help.
   - Ely is beautiful but very isolated.
   - Appreciate help at Wellstone Center but need more people just to listen.

- Concerned about therapists seeing our kids alone without telling the parents about things we should know or could help with. We need therapists to give our kids the skills they need but bring us in as parents.
- As a person of color, I don't feel comfortable calling the Crisis Response Team. I don't trust them. I would rather call another man with lived experience.
- Schools are too quick to identify kids as having behavior issues rather than talking to parents about how best to communicate with their child. We should be consulted. Have experienced a child of color being called the 'N word' and reacting aggressively in response but the child who used the word is not punished like our child who is reacting to the racism.
- Too much unstructured time. Boredom is a killer.

3. Stigma observations and experiences
   - Stigma is a big problem. For example, my son needs connection but said they would have to 'wear a bag over their head' if they came to the Clubhouse.
   - Need to normalize the need for support and skills, like DBT. Everyone could benefit.
   - People say, 'lets help mental health' but there is still a lot of stigma. Too much judgement, especially when someone has a diagnosis.
   - We need stories that are positive and examples of what is helpful for people. What if we approached this as, 'hey, how can I help you'? Let's educate the community. Mental health isn't talked about enough. It should be as important as the presidential election!
   - When we focus our efforts on temporary fixes rather than underlying problems.
   - If I am in the community with crisis stabilization staff, it feels like they are 'holding my hand' and makes me feel uncomfortable.

4. culture, identity or spirituality important for care
   - Need more supports like Sober Squad, that is designed by Mille Lacs Human Services

5. Investments needed in continuum of care
   - We need to help the homeless, especially in Duluth. People are going to die without help.
   - Gap between being OK and needing the emergency room. Need some lower-level supports.
   - Need a peer respite home, not the psychiatric ward. Many people just don't feel safe at home and need to be with others but don't need hospital care. Or, a room at the hospital (which is open 24/7) where someone in a low level of crisis can just sit (Empath type space).
   - Need recovery sponsors in Ely and supports in the evening.
   - Need more supports in the evening.
   - Need crisis response team in Ely.
   - Expand adult peer support and youth peer support in schools and community.
   - Want other options besides therapy for my kids and myself.
   - More IRTTS beds.

6. Most significant barriers to care
   - Funding for the clubhouse to open more. They get a lot of support but not enough to be open more. It seems a long time between Friday and Tuesday.

- Transportation (x3)
- Accessing care in Virginia, if you are able to, takes so much time and costs a lot to access.
- Law enforcement needs better training about mental health and ER needs to collaborate more. Know of a person who was suicidal, taken to the hospital by law enforcement, but discharged by ER doctor. They soon died by suicide.
- Housing for everyone, including new workers.
- Help for addiction is too far away. It is easier to go to the local liquor store and get another bottle than to get help. It is easier to stay addicted.
- Services need to be available in most Iron Range communities.
- Seems like white people in distress are experiencing a mental health crisis but people of color in distress are "not compliant"
- MH and CD are separated but they aren't separate experiences. Addiction is a symptom of mental health, not a disease on its own.
- Homeless shelters need counselors to help with the broader issue.
- Some of the therapeutic interventions, like for anxiety, cost money and are unaffordable.

> *We have spent a lot of time trying to get help for our family; hospital, therapy, inpatient care, out-of-state. Being suicidal isn't enough to get care. If our kids is in a critical state and clearly suicidal, why isn't that enough? Why don't we have options for these kids?*
> St. Louis County – North Person with lived experience

- Waiting list. Range Mental Health is in Ely, but they are full.
- We have spent a lot of time trying to get help for our family; hospital, therapy, inpatient care, out-of-state. Being suicidal isn't enough to get care. We spent 5-6 hours in the emergency room after they said they were killing themselves. We were sent home. They said they are going to use knives so we removed all the knives from the house. I have other kids and trying to keep them safe. When I ask for help, the county says there is nothing they can do.
- Need access to assessments locally, especially for kids. It took over a year to get an ADHD assessment, which was a year of struggling in school with learning challenges. Then, we ended up driving over 5 hours to get tested. Locally, I had to call 2-3 times a week to see if there were any openings. The answer was always no.
- Challenging when care providers aren't connected to the same agency. The communication is complicated. Helps when agencies like Range Mental Health can do internal referrals.

7. Telehealth experiences
   - Able to access therapy via telehealth although it doesn't work for everyone.

8. Top ideas
   - Need more diversity in behavioral health workforce. Care professionals are not listening to people of color. Examples were shared of someone not getting pain medication for a procedure where that would have been expected and was painful and being judged and observed rather than being listened to.

- Need to have trained professionals responding to crises rather than law enforcement. Their training is good but MH crisis can't be their primary responsibility.
- Need accountability for health care equity, especially with mental health and substance use care. In housing, St. Louis County has adopted a racial equity framework to apply to housing services. There is an advising group of people with lived experience who get paid to help assess services and assist them to adopt more equitable practices. This feels helpful and very valuable. We should use this same framework for mental health. The REAP Team is having a big impact on housing.
- Support schools in their communication with parents so it feels more of a partnership
- I personally want to put a flag in my yard to express that my home is an 'open house' for anyone who needs community. If the flag is up, people are welcome to come in.
- Inpatient care needs to include fresh air.
- Crisis stabilization needs to include healthy eating and the 10 days shouldn't count weekends. It is too hard to make arrangements for after-care when we can't contact any agencies on the weekend. Need the option to get an extension.
- Supervised vision at crisis stabilization for someone who has an OFP. Having visit with child is helpful to mental health.
- Group activities for the clubhouse. Maybe the theater.
- DBT should be universally taught.
    - It saved my life (x2)
    - Have it at the library, at college, in K-12 schools.
    - Once you have these skills they are applicable in your whole life.
- More mental health and substance use training in Vermillion law enforcement training program. Embed CIT right into their curriculum.
- More support and education to teachers and parents. This will only help them to reduce the stress of their stressful roles.
    - Train parent and teachers about trauma-informed care
    - Add mental health information into teacher inservice days
    - Mental health care for teachers themselves
    - Need parent support groups, like one that is being started in Cherry School. ECFE isn't relatable to some parents and school-based education or support can feel judgmental for some parents rather than welcoming.

<u>Providers (8 people)</u>

1. Rewards and impacts
    - Resolving past trauma and reducing the impact of trauma on their daily lives. There is a ripple effect from that.
    - Coping skills.
    - Treatment and interventions.
    - Seeing people get in touch with their self and applying new skills.
    - I have my own story of recovery and expect others to recover versus having that be the exception. That is the bias that I apply to my work. I meet people where they are at.

- I empower people as a therapist.
- The ripple effect of the work is significant. We are able to benefit the entire family system.
- Therapy is a hopeful profession.
- When I have the opportunity to facilitate groups, like a women's wellness group, it is extremely fulfilling and feels helpful for them and for me.
- Funding from Region 3 BHI for uncompensated care is huge, especially for persons on Medicare. We had 3 stabilization stays that never would have happened if not for that gap funding.
- Watching the Range Mental Health Mobile Crisis Team do their work was amazing. A story was shared of a recent response for a veteran staying at a rural camp who was experiencing a mental health crisis. The response was successful, and the person was able to access regional care that was needed.
- Our crisis stabilization program is avoiding psychiatric in-patient stays. 95% of the persons leaving stay they were helped.
- We wear many hats.
- People we work with develop better coping skills, self-esteem and connection.
- We often work miracles to get housing for folks because we know the landlords.
- Recovery Alliance Duluth now has office in Virginia and doing a lot of community-based activities that are free and pro-social. They are also family friendly.
- Love my crisis stabilization job (x2)!

2. Greatest challenges
   - The wait list, which now is about 6-9 months. (x2)
   - Primary care providers aren't the best educated about what we do, and they are required for a referral to our outpatient care.
   - Transportation (x2). Even the MA funded transportation isn't consistent, and people have to wait on the phone for a long time.
   - Recruiting staff in behavior health care is extremely challenging. We have 2 openings for BSW case managers and one for an LICSW. We need dedicated HR for behavioral health.
   - ER assessments are challenging. We recently changed our process from contracting with DECK (telehealth provided assessment) to an internal intake process with support from an intake nurse. This has dramatically improved our intake process and support to the local community. With DECK, our inpatient unit housed mostly (approximately 80%) people from out of the region and now it is approximately 20%.
   - Insurance barriers. For example, a client changed their job and had to stop coming to therapy because they had a gap in coverage. They weren't in crisis but needed support. Insurance. Some insurance plans don't pay for crisis stabilization unless someone is actively suicidal. Instead, they have to go to the hospital.
   - A lot of lonely people in N St. Louis County.

> *If there aren't supports in the community, we are only able to be so helpful for people. We have gotten calls 4 days after a discharge from crisis stabilization, that someone is back in crisis. We are losing people this way.*
> St. Louis County Provider - North

- I am concerned that people receiving Social Security Disability may be barely meeting their basic needs but are cut off from parts of their life that bring purpose and meaning; their work. As someone who assesses people for their ability to work, the three options are: Can't work at all, Limited work, Unlimited work. People get denied financial assistance if I select 'limited work'. That seems to be a disincentive to participate in the workforce part-time, which would help with purpose and meaning (and purpose some of our workforce shortage issues). Work can be part-time.
- If there aren't supports in the community, we are only able to be so helpful for people. We have gotten calls 4 days after a discharge from crisis stabilization, that someone is back in crisis. We are losing people this way.
- As quick as therapists set up their businesses, they are full.
- Virginia hospital in N St. Louis County will only respond to a law enforcement 72-hour hold request not from mobile crisis team. The response with Duluth hospitals is more collaborative.
- GRH isn't enough for people to get out of the poverty cycle. So, often people are in crisis because of the stress from being homeless. They can rest, get some sleep and de-stress while in crisis stabilization.
- Temporary shelter for pets is needed in N St. Louis County.
- Competition between providers in N St. Louis County isn't helpful.
- More support from City of Virginia would be helpful. Virginia City Council seems to be making decisions that are reducing supports rather than increasing them.
- More collaboration with SLC Sheriff's department would be helpful. Local city law enforcement partnerships seem to be getting better. Eveleth is great and Hibbing PD has been getting better.
- EMS response seems slow. Not sure why.

3. Greatest needs to become mentally healthy
    - Basic needs, sleep, childcare, food (x2)
    - Housing (x2) health, community and purpose.
    - Avoiding substances.
    - Connection and opportunities for recreation that is cost free and alcohol/drug free.
    - Many people are in a cycle of poverty and can't get out.

9. Investments needed in continuum of care
    - Prevention and early intervention.
        - We need more 'upstream' prevention work, maybe in schools. We could have community forums on topics like sleep hygiene, mindfulness, DBT, medications, etc.
        - We need an emotional literacy class in schools, especially elementary school.
            - Fairview used to do more wellness activities in the community, like yoga, etc. These were helpful for the medical system as well as the community. People seem very lonely.
    - Outpatient psychiatry.

- There is no drop-in center in Virginia, Hibbing and Virginia. They were closed during COVID and never re-opened. There are so many people without things to do during their day and only interaction related to mental health is with their clinical care providers.
- Need Intense Outpatient Treatment Programs, that are longer than partial hospitalization.
- Follow-up care for people integrating into community from incarceration, treatment, or in-patient care.
- More in-patient access.
- Need more recovery support in the community.
- Need more affordable temporary housing like board and lodging and shelter beds. (x3)

4. Impacts on well-being from working in behavioral health care

- In this work, I learn about a lot of resources and share them with others. This is helpful.
- Feels like I am actually making an impact.
- The work is tiring (x2)
- Burnout is real but our organization does well with PTO and pay is much better than it was.
- My capacity to be engaged in the community in fun and meaningful ways is limiting.

> *What is most depleting is to not be able to give people what they need, like housing. It is like their house is on fire and I give them a glass of water.*
> St. Louis County Provider - North

- "What is most depleting is to not be able to give people what they need, like housing". It is like their house is on fire and I give them a glass of water.
- It would be helpful if we had more of a team at our workplace.
- Need a lower caseload, lower than 32 people a week.
- Acknowledge the non-paid work that we do.
- I receive support for continuing education but not enough, often having to pay part of cost.
- Need to support rewarding work, including projects or work that brings a level of flexibility.

5. Telehealth observations and needs
   - Approximately 25-30 % of case load.
   - I don't allow people to do telehealth while driving or trauma processing via telehealth.
   - It helps with removing barriers from transportation and childcare and still helpful in rural areas.
   - For some people, coming in for therapy is one of our goals – like someone with agoraphobia.
   - I have never been trained in telehealth so that might be helpful.

6. Integration between mental health and substance use care
   - The CCBHC model does this well. We offer substance use and mental health treatment no matter the entry. It is the aftercare that is missing.
   - Need more cross-training with CD and MI.

7. Top ideas
   - Prevention and emotional literacy

    - Need more community-based opportunities for learning about mental health and universal skills, like emotional regulation, DBT-type skills, grounding, etc.
    - Having a designated mental health class in elementary school – emotional literacy.
- Innovations and flexibility
    - Itasca County is doing some amazing things and some should be duplicated, like First Call for Help Kiesler Wellness Center, which is completely focused on recovery.
    - Need flexible funds for things like McDonalds meals, bus tickets, medications or medication co-pays. Co-pays for medications should not be a barrier.
- Recruitment and retention
    - Implement stepping stone training programs, like CNAs to crisis stabilization.
    - Recovery-based employment for people on SSDI. Structured, meaningful part-time employment or activity.
    - More support for recruitment of therapists, reaching into high schools.
    - License support across states. If interstate compact was passed, how do we apply?
- Intervention ideas
    - Better partnerships with local emergency room and crisis response teams. They say they can't keep using their beds for mental health but they mandate their own assessment.
    - Establish more follow-up care.
    - Need more practical and simple solutions for people. One person didn't need a bed, they needed some place to wash their clothes.