

# **Recommendations on Strengthening Mental Health Care in Rural Minnesota**

**WORKGROUP OF THE RURAL HEALTH ADVISORY COMMITTEE**

2021

## **Recommendations on Strengthening Mental Health Care in Rural Minnesota**

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6/3/2021

Jan Malcolm, Commissioner  
Minnesota Department of Health  
625 North Robert Street  
St. Paul, MN 55155

Dear Commissioner Malcolm,

We are pleased to present this report from the Rural Health Advisory Committee:  
*Recommendations on Strengthening Mental Health Care in Rural Minnesota.*

In May of 2019 the Rural Health Advisory Committee (RHAC) formed a workgroup to assess mental health care in rural Minnesota. The workgroup began by focusing on crisis mental health care, and expanded the project's scope to include other services, policies, and best practices that support the mental health needs of rural residents. Workgroup members included mental health practitioners, crisis response services, health care systems, community clinics, government, and advocacy organizations. The report offers a series of recommendations across four categories:

- Increasing awareness of mental health needs and resources
- Increasing access to services and supports
- Strengthening the rural mental healthcare system
- Supporting collaboration between stakeholders

We appreciate the opportunity to share this report and contribute to the discussion of mental health in rural Minnesota. Thank you for your continued support of rural health.

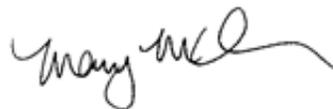
Sincerely



Tom Vanderwal  
Rural Health Advisory Committee Chair  
Mental Health Workgroup Co-chair



Margaret Kalina  
Mental Health Workgroup Co-chair



Mary McClernon  
Mental Health Workgroup Co-Chair



Tom Vanderwal, Chair  
Rural Health Advisory Committee  
2300 24th St NW, Suite 103  
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Dear Mr. Vanderwal,

Thank you for the Rural Health Advisory Committee's report *Recommendations on Strengthening Mental Health Care in Rural Minnesota*. We thank you, the Rural Mental Health Work Group, and the entire committee for your efforts.

Ensuring that Minnesotans have access to mental health care is an important concern. The recommendations made in this report highlight the need for continued efforts to support and strengthen the mental health care system across the entire spectrum of care. This report helps us understand the need for increased access to mental health care in the context of rural Minnesota, and will help target resources and services to the areas where they are needed most.

Thank you for your excellent work. The Minnesota Department of Health is committed to finding solutions that continue to strengthen mental health care in Minnesota. This report and its insightful recommendations are an important step. I look forward to working together to protect, maintain, and improve the health of all Minnesotans.

Sincerely,

Jan Malcolm  
Commissioner of Health  
PO Box 64975  
St. Paul, MN 55154

## Contents

Recommendations on Strengthening Mental Health Care in Rural Minnesota .....	1
Introduction .....	1
Issue.....	1
Methods.....	2
Recommendation 1. Increase awareness of mental health needs and resources .....	3
Recommendation 2: Increase access to mental health services in rural communities.....	5
Recommendation 3: Strengthen the rural mental healthcare system .....	7
Recommendation 4: Support Collaboration between Stakeholders.....	13
Appendix A: Rural Health Advisory Committee Membership.....	14
Appendix B: Work Group Members.....	2

# Introduction

In 2019 the Rural Health Advisory Committee (RHAC) convened a work group to look at mental health services in rural Minnesota and identify policy and practice recommendations that could strengthen the system in rural parts of the state. The Rural Health Advisory Committee is a diverse, statewide forum for addressing rural health interests. The Committee's duties as defined in statute are to:

- Advise the commissioner of the Minnesota Department of Health and other state agencies on rural health issues
- Provide a systematic and cohesive approach toward rural health issues and planning, at both a local and statewide level
- Develop and evaluate mechanisms to encourage greater cooperation among rural communities and among providers
- Recommend and evaluate approaches to rural health issues that are sensitive to the needs of local communities
- Develop methods for identifying individuals underserved by the rural health care system.

## Issue

RHAC identified mental health access and innovation in rural Minnesota as a priority issue in 2018. A 2017 report from the Center for Rural Policy & Development looked at adult mental health service regions in Minnesota, and found that almost all were lacking in at least one critical service and none met demand for every service.<sup>1</sup> The ratio of population to mental health providers also showed that there was an insufficient mental health workforce in rural parts of the state, with a ratio of 1,960 people to each mental health provider in rural or isolated areas as compared to 340 people per provider in metropolitan areas.<sup>2</sup> Rural residents frequently have to travel longer distances to see providers, with weather and road issues creating further challenges. 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.

Mental health mobile crisis services are part of the continuum of mental health services in Minnesota. Mobile crisis services are delivered by mental health professionals and practitioners who provide intensive face-to-face, short-term mental health services initiated during a crisis to help the individual return to their baseline level of functioning. There is no out-of-pocket cost for these services, though insurance will be billed if available, but funding is provided to cover

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<sup>1</sup> Center for Rural Policy and Development, "Mental health services in greater Minnesota; Limited resources are putting growing pressure on rural communities." 5/25/2017 [Mental health services in Greater Minnesota | Center for Rural Policy and Development \(ruralmn.org\)](#)

<sup>2</sup> Data source: Minnesota Boards of Psychology, Nursing, Behavioral Health and Therapy, Social Work, and Marriage and Family Therapy. Includes the following licensed professions: licensed independent clinical social workers; licensed professional counselors; licensed professional clinical counselors; licensed alcohol and drug counselors; licensed psychologists; licensed marriage and family therapists; psychiatric certified nurse specialists; and psychiatric nurse practitioners.

uninsured and underinsured individuals in need of these services. As of 2018 mobile crisis services were made available in all counties 24 hours a day, seven days a week. Mobile crisis services that are available in all counties are still a relatively new addition to mental health services within the state of Minnesota. RHAC chose to focus on them as the starting point to their study on addressing barriers to mental health care in rural parts of the state, with the understanding that the work group would then expand the project's scope to include other services, policies, and best practices that support mental health needs of rural residents.

## Methods

The rural mental health work group consisted of stakeholders from many different sectors, including mental health practitioners, crisis response services, health care systems, community clinics, government, and advocacy organizations. A full list of work group members can be found in Appendix B.

The work group began by looking at crisis mental health services. They expanded their view to include the broader spectrum of mental health needs, and looked more broadly at how to create communities that are supportive of people experiencing mental health issues. The work group convened six times from 2019 to 2020, and hosted three regional listening sessions to learn from rural communities in different parts of the state. As a result of this research, the work group identified a series of recommendations across four categories:

- Increasing awareness of mental health needs and resources
- Increasing access to services and supports
- Strengthening the rural mental healthcare system
- Supporting collaboration between stakeholders

The work group identified a series of recommendations by March of 2020. Because of the COVID-19 pandemic, MDH staff and work group members had to set aside work on the report to focus on pandemic response work for the rest of the year. In 2021 the work group reviewed the recommendations, and agreed that many were still relevant. In some cases the issues addressed by the recommendation had become even more pressing. RHAC urges consideration of these recommendations in the interest of strengthening mental health care in rural Minnesota.

## Recommendation 1. Increase awareness of mental health needs and resources

- Increase Mental Health First Aid training in rural populations
- Launch targeted and culturally specific public awareness campaigns
- Include mental health related phone numbers, including the National Suicide Prevention Line, the Minnesota Crisis Text Line, and local mental health crisis phone numbers, on public facing materials, including city and county websites, health care provider websites, and insurance cards

A key part of supporting the mental health of rural residents is increasing awareness of both mental health needs and the resources available to support them. In addition to advocating for greater awareness generally, the work group had three specific recommendations that could impact awareness in rural Minnesota.

Mental Health First Aid is a skills-based course that trains people to identify, understand, and respond to signs of mental illness. In the United States Mental Health First Aid is operated by the National Council for Mental Wellbeing in partnership with the Missouri Department of Mental Health. They maintain a website, [www.mentalhealthfirstaid.org](http://www.mentalhealthfirstaid.org), where people can search for courses by location, and also learn how to become certified as an instructor, enabling them to bring these courses to their community.<sup>3</sup> Increasing the number of Mental Health First Aid courses available in rural Minnesota communities would build awareness of mental health, particularly among community members with a high number of interactions with the public, such as bartenders, hairdressers and teachers, and also would reduce negative public attitudes.

Multiple listening session participants shared that while public awareness campaigns in general had the potential to be effective, they had found that targeting the campaigns to specific segments of the community was a more effective approach. For example, a mental health coalition in northwest Minnesota targets a different sector of the community each year, traveling in person to share resources on site and including leave-behind materials.

The work group also discussed how to better promote phone and text lines that people can access quickly, including:

- National Suicide Prevention Line

The National Suicide Prevention Line is available 24/7. People who call it receive free and confidential support and resources.<sup>4</sup> As of May, 2021 the telephone number was 1-800-

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<sup>3</sup> Mental Health FIRST AID from National Council for Mental Wellbeing. <https://www.mentalhealthfirstaid.org/>

<sup>4</sup> National Suicide Prevention Line webpage: <https://suicidepreventionlifeline.org/>

## RURAL MENTAL HEALTH RECOMMENDATIONS

273-8255, although it is anticipated to transition to the three-digit number,988, by July 2022.

- Minnesota Crisis Text Line: Text MN to 741741  
Minnesota’s suicide prevention and mental health crisis texting services have been available since 2018. People can text MN to 741741 and be connected to the Crisis Text Line, which will then connect them to resources within their communities.<sup>5</sup>
- Local mental health crisis phone numbers  
DHS maintains a directory of mental health crisis phone numbers for all mobile crisis service providers in Minnesota by county.<sup>6</sup>

The work group recommends including these helplines in more public-facing materials, including city and county websites, health care provider websites, and insurance cards.

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<sup>5</sup> Minnesota DHS Crisis Text Line page: <https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/crisis-text-line/>

<sup>6</sup> <https://mn.gov/dhs/partners-and-providers/policies-procedures/adult-mental-health/crisis-services/>

## Recommendation 2: Increase access to mental health services in rural communities

- Strengthen telehealth in rural communities by supporting policies that expand broadband and support compatible platforms
- Support regional and local solutions to increasing transportation for people experiencing a mental health crisis

Telehealth is a key tool for expanding access to healthcare services in rural areas. It can be especially useful for patients experiencing a mental health crisis who need stabilization in the moment and are not in the same vicinity as a care team. While telehealth has been seen as a promising mode of healthcare delivery for years, the COVID-19 pandemic accelerated telehealth use dramatically. A survey conducted by the Office of Rural Health and Primary Care showed that mental and behavioral health providers were the group most likely to transition to telemedicine, with over 60 percent moving to this mode of practice within the first six months of the pandemic.<sup>7</sup> While telehealth use is increasing, patients can only benefit if they can access the platform to receive care. Residents of some rural areas are unable to access services offered via telehealth due to lack of broadband. Providers responding to the workforce survey reported that unreliable internet access limited how helpful telehealth could be in treating patients in rural areas. The work group recommends supporting policies that increase funding for broadband development, especially ones that recognize the need for increased and affordable broadband coverage in rural areas. The work group also recommends increasing access by supporting uniform or compatible telehealth platforms.

While telehealth can be a valuable mode of delivering care, it should not be considered a comprehensive solution to access issues in rural areas. In-person care remains necessary and/or optimal for many interventions, and rural residents may face challenges in accessing care due to distance and infrastructure issues. Work group members, listening session participants, and background research all emphasized the need for transportation solutions. Proposed solutions varied by region and community, and the work group recommends supporting regional and local solutions that help residents get the care they need when they need it. Examples include:

- Counties contracting with or providing protected transport to transfer patients

Protected transportation is nonemergency medical transportation that can be used when a recipient received a transportation level-of-service assessment that indicated this level was appropriate. Protected transport providers must be certified by the Minnesota Department of Transportation, and have a protected vehicle that meets the criteria for the service and is not an ambulance or police car. Some counties shared they were considering contracting with protected transport services that could transport patients to facilities outside their

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<sup>7</sup> ORHPC Spotlight on Telehealth, Minnesota Department of Health, December 2020. <https://content.govdelivery.com/accounts/MNMDH/bulletins/2b00d77>

## RURAL MENTAL HEALTH RECOMMENDATIONS

region. While some areas considered this a potential solution, other regions chose not to pursue this option as they did not have the volume necessary for a transport company to create a hub. Participants recommended the counties explore other uses for protected transport that would increase volume and allow this solution to be viable.

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

## Recommendation 3: Strengthen the rural mental healthcare system

The mental health work group recommended several actions to strengthen the rural mental healthcare system across the continuum of care, with recommendations on strengthening mobile crisis services, increasing the mental health workforce, enhancing services for youth, and increasing options for housing and residential placements.

### 3A. Strengthen mobile crisis services:

- Improve response time in rural areas by allotting funding to help increase staffing, including peer specialists
- Support sustainability by expanding reimbursement to include:
  - Phone screens that result in crisis team interventions
  - Use of a complexity billing code in appropriate situations
  - Identified spaces, such as community buildings, that can be used when crisis team members feel unsafe meeting a patient in a remote area
  - Train crisis teams in both mental health and substance use disorders

Mobile crisis teams are mental health professionals and practitioners that offer services in the home or at sites convenient to the person in crisis, with the goal of resolving the crisis and supporting the patient in connecting with ongoing needed services. Crisis teams are located across the state, and services are available to children and adults in all 87 counties. Rural teams often face unique challenges related to the distances they cover and the populations they serve. To address the challenges posed by the long distances response teams may have to travel, the work group recommends increasing funding for staffing with the goal of more team members being available throughout the area they cover, increasing their ability to reach the person experiencing a mental health crisis in a shorter amount of time.

Mobile crisis teams are funded by a combination of state and county funds, and through reimbursement for services. Currently Minnesota Health Care Plans, which includes Medical Assistance, the state's Medicaid program, and MinnesotaCare, a premium-based program for people who earn too much to qualify for Medical Assistance but too little to pay for private insurance, reimburse for assessment, intervention, stabilization, and community interventions. Rural team members shared two areas of activity that could benefit from review and consideration for reimbursement. Before completing a face-to-face assessment, crisis teams spend time receiving and screening calls for assessments and interventions, and propose that

Minnesota Health Care Plans consider reimbursing for time spent on those calls that do lead to an assessment being completed. The work group also recommends that Minnesota Health Care Plans consider allowing a complexity code to be used for interventions that meet standards for high complexity and merit higher reimbursement. Increasing reimbursement for crisis team services will support rural teams in building the staffing and resources needed to serve their area.

Rural crisis teams also shared that there are occasions where the remote nature of some settings means that meeting the patient in that remote location does not feel safe. While the mobile mental health crisis program aims to meet the patient where they are at, rural teams may benefit from identifying a community space that can be used in very select situations. Examples included space at local hospitals that could be used without the community member receiving the intervention having to be admitted to the facility, and space at local community centers.

Another issue rural crisis teams reported was the overlap between mental health and substance use disorders, and the difficulty in performing an assessment when these two situations overlap. The mobile health crisis program is designed to support individuals experiencing a mental health crisis, and the work group does not recommend expanding the program to include responding to substance use disorder crises. However, by providing crisis teams with a level of training in chemical dependency, similar to the level of training housing navigators receive, they may be able to more easily identify when substance use is the primary issue being experienced, and then better direct them to the appropriate services. The work group recommended exploring whether grants for opioid-use prevention could be used to support this kind of training.

### 3B. Increase the rural mental health workforce:

- Develop regional recruitment efforts that introduce youth to a wide variety of healthcare careers
- Decrease barriers to training by implementing flexible training and graduate school schedules, increasing access to and affordability of supervisory hours, and increasing loan forgiveness for mental health professionals
- Extend the careers of retiring workers by supporting them in working part-time and/or via telehealth
- Expand the reach of mental health care by supporting collaboration between primary care providers and mental health professionals

## RURAL MENTAL HEALTH RECOMMENDATIONS

To better support rural Minnesotans across the spectrum of mental health needs, including but not limited to mental health crises, communities need a sufficient mental health workforce. While the mental health workforce needs to be increased in most areas, the shortage in rural areas is especially alarming. The work group identified a series of recommendations to support the mental health workforce in rural Minnesota. Many of these align with recommendations from the 2015 “Gearing Up for Action: Mental Health Workforce Plan for Minnesota,” report to the Legislature,<sup>8</sup> developed by a special committee charged with holding a mental health summit and writing a state workforce plan.

In order to build the mental health workforce pipeline, the rural mental health work group recommends introducing youth in rural communities to health care careers at an early age; this could be accomplished through recruitment efforts such as job fairs and summer internships that allow young people to get a sense of the breadth and variety of careers within the health care sector, including those in mental health. These events would also be opportunities to share information on the workforce pipeline, for example how peers can become practitioners, and then with more education, become a clinical trainee. By holding recruitment events in the community, youth are able to learn what kinds of careers are available, and get support in understanding how to get there.

Work group members and listening session participants shared that the cost of education and training was a barrier for community members interested in entering the workforce, and the work group recommends a series of actions to decrease barriers to training. Traveling to in-person trainings often takes longer for rural residents, and implementing flexible training and graduate school schedules would help ease this burden. “Gearing Up for Action” also recommends ensuring access to and affordability of supervisory hours, with specific suggestions that could achieve this aim, including allowing internship hours to count towards licensure and practicum hours to count towards supervisory experience. Increasing loan forgiveness opportunities for mental health professionals would also increase support for individuals entering the field.

The work group also recommends extending the career of mental health providers nearing retirement by supporting them in continuing to practice part time or via telehealth. In Minnesota, social workers can apply for an Emeritus Active License<sup>9</sup> that allows social workers who have retired to engage in limited practice activities, such as providing certain kinds of pro bono or unpaid social work practice, and providing paid social work not to exceed 500 hours per year spent performing a limited set of activities, such as providing licensing supervision and presenting continuing education activities. The work group suggested working with licensure boards and professional associations to explore whether an emeritus active license is a possibility within other professions, as this could be a way for retired mental health

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<sup>8</sup> “Gearing Up for Action: Mental Health Workforce Plan for Minnesota” Report to the Minnesota Legislature, 2015. Completed by HealthForce Minnesota and Minnesota State Colleges and Universities.

<http://www.healthforceminnesota.org/assets/files/GearingUpForAction.pdf>

<sup>9</sup> 2020 Minnesota Statute 148E.0753 Emeritus Active License Status

<https://www.revisor.mn.gov/statutes/cite/148E.0753>

professionals and practitioners in rural parts of the state to continue supporting the workforce within their communities.

In addition to increasing the mental health workforce in rural Minnesota, this report recommends supporting collaboration between primary care providers and mental health professionals to further expand the reach of mental health care. Examples include providing ongoing and immediate access to a mental health provider to primary care residents throughout their training, and facilitating primary care provider consultations with psychiatrists to support complex case management.

### 3C. Increase Youth Services

- Increase support for programs in the community that provide services to both youth and their parents or caregivers
- Increase grant funding for school-linked mental health services

While the work group identified many populations in need of mental health services, listening session participants consistently highlighted the lack of sufficient services for youth in rural areas.

The work group recommends increasing support for programs in the community that support not only youth but also their caregivers. For example, the Parent Support Outreach Program (PSOP) was highlighted by work group participants. PSOP is an early intervention program in Minnesota that provides short-term voluntary support for children and their families<sup>10</sup>. The Minnesota Department of Human Services allocates funding to counties and tribal agencies to implement the program within their communities. While programs like PSOP are not directed specifically at adults or children experiencing mental health issues, increasing support for families in need of assistance may lead to a healthier environment for the child, supporting mental health and overall wellness.

A theme throughout the listening sessions was the need to increase access to mental health services for children. Participants reported success with programs that supported students attending therapy appointments without leaving the school, either in-person or through telehealth. The work group recommends increasing grant funding for school-linked mental health services to further support these programs.

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<sup>10</sup> Minnesota Department of Human Services Parent Support Outreach Program (PSOP) webpage. [https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-327050](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=DHS-327050)

### 3D. Increase support for residential placements in rural areas

- Increase support for inpatient psychiatric beds
- Conduct a study on residential options for youth experiencing mental health crises to identify potential solutions that could be implemented in a rural setting

Minnesota residents who need residential mental health care already face a lack of placements, and when a placement does become available, rural patients and their families often have to travel great distances to access it. Listening session participants across multiple regions shared that sometimes residents have had to travel to an inpatient bed that was available, as opposed to one that allowed the patient to remain close to family and supports. This increases the burden on the patient, family, and also the organizations doing the transport, such as law enforcement. The work group identified Psychiatric Residential Treatment Facilities (PRTFs) as a residential option that has the potential to benefit rural youth. PRTFs provide inpatient level of care to children and youth in a residential facility, rather than a hospital. Minnesota enacted legislative support for PRTFs in 2015, in part in response to studies by the Minnesota Association of County Social Service Administrators and Wilder Research showing a lack of services for youth with complex mental health conditions in need of residential treatment services.<sup>11</sup> Legislation has increased the number of PRTFs in Minnesota, and the work group recommends continued expansion of these treatment facilities to increase access to needed residential services. While PRTFs are a promising solution, they can be difficult to staff in rural areas, and they do not serve adults. The work group also suggests studying and supporting ways to increase the number of beds available to residents of all ages across the state, as this increases the possibility that Minnesotans living in rural areas could receive care closer to home when they need it.

The work group also emphasized the need for increased options for youth who need residential treatment that does not reach an inpatient level of care. While some youth may need inpatient treatment, others may benefit from residential treatment which offers clinically supervised services provided in a community setting, or from short-term crisis residential stabilization services. The work group recommends conducting a study on the full spectrum of residential options for youth experiencing mental health crises, as a way to identify potential solutions.

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<sup>11</sup> Psychiatric Residential Treatment Facility: An Overview. Minnesota DHS, [https://mn.gov/dhs/assets/prtf-general-overview\\_tcm1053-328795.pdf](https://mn.gov/dhs/assets/prtf-general-overview_tcm1053-328795.pdf)

### 3E. Increase supportive housing and shelter services for adults and youth

The work group highlighted the need for housing and shelter services for adults and youth living within the community. People with mental illnesses are more likely to face housing instability or homelessness. And homelessness as an issue has been getting worse in Minnesota for years, even before the start of the COVID-19 pandemic. The 2018 Minnesota Homeless Study conducted by Wilder Research showed a 10% increase in homelessness in Minnesota, overall, between 2015 and 2018, with a 13% increase outside of the 7-county Twin Cities metro area.<sup>12</sup> Housing issues have been further exacerbated by the COVID-19 pandemic, and the need for housing that is safe and affordable continues to be a key issue in rural parts of the state.

One way to support mental health is to link mental health services to shelters and supportive housing. While many systems have been working to integrate these services, they have faced new challenges during the COVID-19 pandemic, when providing in-person services became even more difficult. Rural communities have benefitted in the past from grants that support mental health practitioners working on-site, such as the Projects for Assistance in Transition from Homelessness (PATH) grants provided by the Substance Abuse and Mental Health Services Administrations (SAMHSA) and the Housing with Supports for Adults with Serious Mental Illness grants provided by the Minnesota Department of Human Services.

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<sup>12</sup> Homelessness in Minnesota; Detailed Findings from the 2018 Minnesota Homeless Study. Wilder Research. [Homelessness in Minnesota \(mnhomeless.org\)](https://mnhomeless.org)

## Recommendation 4: Support Collaboration between Stakeholders

- Support collaboration between first responders and crisis teams. Specific examples include law enforcement using iPads to access mobile crisis teams, and contracting with crisis teams to embed social workers into first responder teams
- Implement protocols that prompt emergency department and inpatient units to coordinate with mobile crisis teams when a patient is discharged back into the community so that the crisis teams can offer support through a stabilization plan
- Encourage and ensure that there is representation from local government bodies, tribal nations, and members of the mental and behavioral health care workforce at local government meetings and/or coalitions
- Support health systems overburdened by patients presenting in the emergency department with mental health crises through creative staffing models, such as an emergency department sitter program and/or increased use of peer specialists

One theme that emerged from studying the rural mental healthcare system in Minnesota was the importance and value of local and regional collaboration. Participants in all three listening sessions highlighted collaboration as their region's main strength, and offered many examples of different ways community members and mental health providers collaborate to support their community's mental health needs. After reviewing specific examples, the work group offered the suggestions above as examples of collaboration that have been successful in rural communities.

Listening session participants also shared their experiences building successful partnerships. One key suggestion was to build coalitions that included a wide variety of stakeholders. Multiple communities recommended this technique, sharing that it was effective in shifting the perspective from one in which they had the potential to be competing for resources, to one in which they were partnering to best gain access to supports and services. Participants also urged creating structure with these collaborative efforts, sharing that regularly scheduled meetings fostered more long-term partnerships.

## Appendix A: Rural Health Advisory Committee Membership

**Ann Bussey**

Consumer Member

**Andrew Johnson**

Mid-level Practitioner Member

**Jeff Carpenter**

Consumer Member

**Margaret Kalina**

Registered Nurse Member

**Ray Christensen**

Higher Education Member

**Mary Kiffmeyer**

Senate Majority Member

**Trevor Coons**

Consumer Member

**Joe Schomacker**

House Minority Member

**Thomas Crowley**

Hospital Representative Member

**Laura Schwartzwald**

Licensed Health Care Professional Member

**Nick Frentz**

Senate Minority Member

**Keith Stelter**

Physician Member

**Kyle Hedlund**

Long-Term Health Care Member

**Tom Vanderwal (Chair)**

EMS Member

## Appendix B: Work Group Members

**Margaret Kalina**

*Workgroup Co-Chair*

Rural Health Advisory Committee Member

**Mary McClernon**

*Workgroup Co-Chair*

Behavioral Health Leadership Solutions  
Principal Consultant

Regional Clinical Manager, Minnesota  
Department of Human Services

**Tom Vanderwal**

*Workgroup Co-Chair*

Rural Health Advisory Committee Member

**Sue Abderholden**

Executive Director, NAMI Minnesota

**Sarah Ackerman**

Executive Director, Western Mental Health  
Center

**Glenn Anderson**

Former Executive Director, Northern Pines  
Mental Health Center

**Laura Birnbaum**

St. Louis County Public Health & Human  
Services

**Leon Flack**

Community & Provider Liaison, Mental  
Health and Substance Use Disorder Service,  
UCare

**Jan Carr-Herseth**

Director of Behavioral Health, LifeCare  
Medical Center

**Kimberly Holm**

Director, Southwest Minnesota Adult  
Mental Health Consortium

**Ashley Kjos**

CEO, Woodland Centers

**Amber Larson**

Stellher Crisis Coordinator, Stellher Human  
Services

**Becky Lauer**

Family & Child Services Division Manager,  
Itasca County Health & Human Services

**Dave Lee**

Director, Public Health & Human Services,  
Carleton County

**Tina Olson**

Treatment Director for Crisis Services,  
Horizon Homes

RURAL MENTAL HEALTH RECOMMENDATIONS

**Lorraine Pierce**

Crisis Response Services, Minnesota  
Department of Human Services

**Alyssa Schultz**

Crisis Services Supervisor, Lakeland Mental  
Health Center

**Shauna Reitmeier**

Executive Director, Northwestern Mental  
Health Center

**Michelle Thordal**

Social Services Supervisor, Clay County  
Social Services

**Sarah Richter**

Crisis Program Manager, Region 4 South  
AMHC

**Corinne Torkelson**

Social Services Supervisor, Kandiyohi  
County