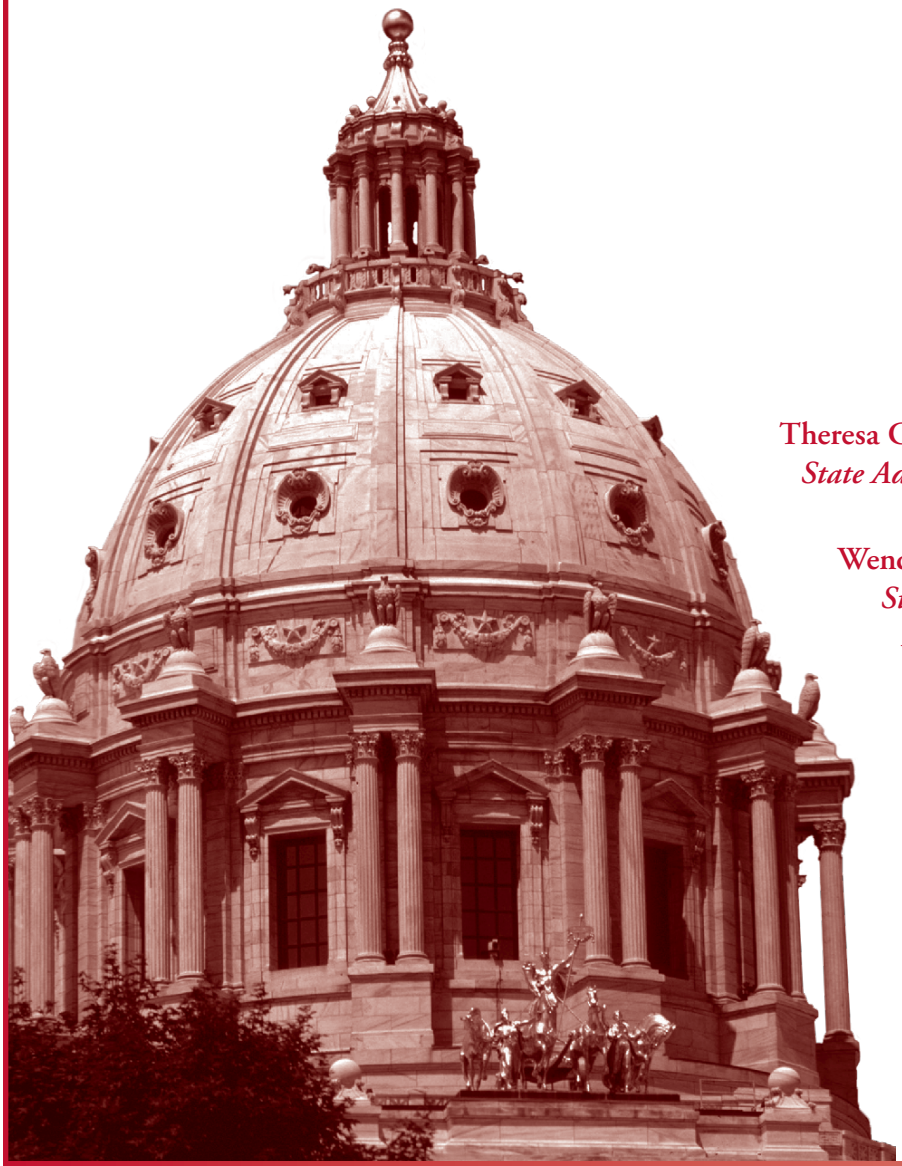
DHS-4278-ENG 10-08

STATE ADVISORY COUNCIL ON MENTAL HEALTH
and Subcommittee on Children's Mental Health

2008 Report *to the* Governor and Legislature



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Letter from the Chairs

The Minnesota State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health are pleased to present our *2008 Report to the Governor and Legislature*.

We would like to thank the governor and the legislature for their commitment to improving mental health care for adults and children.

The Mental Health Initiative enacted in 2007 was unprecedented legislation in Minnesota. Minnesota continues to be a national leader in supporting people whose lives are affected by a mental illness.

This report highlights legislative initiatives and offers further suggestions that we believe are important to improve the state's mental health system.

Stigma continues to be a barrier at all levels of society. The Council supports initiatives aimed at effecting change and educating the public. This will help eliminate the misperceptions and biases that keep people with mental illness from living, working, and participating in the community. Local advisory councils continue to be an important vehicle in anti-stigma activities. Trends in Minnesota and nationally indicate that there is still much work to be done.

The Council and Subcommittee recommend taking these actions to address those trends:

- Early identification, screening, referrals and treatment.
- Improvement of mental health awareness, cultural sensitivity and competency among diverse communities in Minnesota.
- Integration of mental health and primary care.
- Services for children in the juvenile justice system.
- Transition services for youth into the adult system.
- Services for the increasing senior population.

We thank you for the opportunity of serving on behalf of those who are some of society's most vulnerable and under served people. Both the Council and the Subcommittee are committed to working to improve Minnesota's mental health system.

Sincerely,

Theresa Carufel
Chair, State Advisory Council on Mental Health

Wendy Rea
Vice Chair, State Advisory Council on Mental Health

Kate Casserly
Co-Chair, Subcommittee on Children's Mental Health

Carol Cirocco
Co-Chair, Subcommittee on Children's Mental Health

Table of Contents

Introduction

The State Advisory Council and Children's Subcommittee acknowledge the work of the governor and legislature in the passage of the Mental Health Initiative of 2007. Over $34 million in net new state funding was approved for community mental health services for the ensuing biennium – by far the largest amount of new state money ever appropriated in Minnesota.

Part of the foundation for the Initiative came from the work of the Minnesota Mental Health Action Group, a public-private partnership which included State Advisory Council representation.

New funding and programs will go a long way toward improving the mental health system in our state. Furthermore, despite a budget deficit in 2008, the mental health gains of 2007 were largely untouched.

The Mental Health Initiative of 2007 included infrastructure investments to shore up the children's and adult's mental health systems. Also included was the adoption of a comprehensive mental health benefit set across all publicly funded health care programs. Services available under the Medical Assistance fee-for-service program were added to General Assistance Medical Care (GAMC), MinnesotaCare, and the Prepaid Medical Assistance Program (PMAP).

An important product of the 2007 session implemented reforms in the delivery and financing of public mental health services through development of selected preferred integrated service networks to serve adults and children with disabling mental health problems. Networks are to be developed by county and health plan partnerships, with voluntary enrollment.

A rate increase for mental health providers was passed to address workforce shortages. This remains a major issue in Minnesota.

The recommendations in this report are a reflection of the work of the State Advisory Council and Children's Subcommittee for the past two years. The report covers the entire life span.

Themes that cut across the report include:

- **Screening:** Screening and early intervention should be provided throughout all phases of life for assessment and referral, particularly to assure access to an adequate and integrated system of early childhood mental health services and resources. Screening in youth detention centers for mental health issues is also necessary.
- **Continuing Education:** Standards of continuing education on mental health topics to primary care providers and in medical school curricula should be promoted in the state.

- **Parity:** Parity for mental health care with physical health care has not yet been fully achieved at state and federal levels.
- **Transition services:** The mental health system needs to adapt to improve transition from the children's mental health care to adult mental health systems. Particular issues arise upon transition out of school and discharge from the juvenile justice system.
- **Corrections:** Children and youth with serious mental health needs in juvenile corrections should be provided with effective treatment with the goal of remaining free of further engagement in the state's correctional system. Too many individuals end up receiving their mental health care in the corrections system.
- **Workforce Issues:** Incentives should be provided to increase the amount of culturally diverse and rural providers. Included should be cultural competence as a requirement of licensure and licensure renewal for all mental health providers.
- **Older Adults:** Health care professionals and service professionals need training to recognize mental health issues of older adults and how to respond accordingly. This is particularly important for all nursing home personnel. Caregivers for older adults need education on mental health issues for that age group.
- **Local Advisory Councils:** Strengthening and supporting local advisory councils will better equip counties and the state to receive input on effective services and unmet needs from consumers and family members.
- **Stigma:** Stigma remains an issue, though gains in public awareness are being made.

Early Intervention and Prevention

Research reveals that healthy infant and early childhood social and emotional development produces positive short- and long-term mental health and overall health outcomes.[1]

Recent strides in all of Minnesota's early childhood care systems have led to increases in the use of early childhood mental health screening tools that help identify children who are at-risk for experiencing problems in their social and emotional development. However, challenges persist regarding:

- Fidelity to the implementation of the tool (e.g., who administers the screening tool and how it is administered);

1 Shonkoff, J., Phillips, D. (Eds). National Research Council and Institute of Medicine. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Washington, DC: National Academy Press (2000).

- Effectiveness with diverse populations;
- Appropriate follow-up to screening (e.g., data collection, referral, and access to parent information, services, and/or treatment);
- Training, consultation, and supervision of screeners;
- Providing universal access to screening; and
- New opportunities and challenges provided by expanded Part C eligibility (federal funding program for the Early Intervention Program for Infants and Toddlers with Disabilities).

The benefits of screening are realized if we ensure that all children who are deemed to be at significant risk for poor mental health outcomes undergo further assessment and receive effective interventions when appropriate.

There is a need for comprehensive community-based systems to support infant and early childhood social and emotional development screening, assessment, referral, and access to services and/or treatment. We are interested in discovering and promoting a model that communities can adapt to their needs and resources in order to ensure that children identified with mental health concerns through screening and their families receive appropriate follow-up assessment and evidence-based services interventions.

The Council and Subcommittee recommend:

- Promotion of the use of the ASQ:SE (Ages & Stages Questionnaire: Social-Emotional)[2] or other validated tools as recommended by the DSTF (Developmental Screening Task Force) for initial early childhood social and emotional development screening.
- Systematic adoption of the screening tool, including expanded translation and validation studies with diverse populations.
- Access to an integrated system of early childhood mental health services/ resources, possibly through enhancing the coordinating and referral roles of Interagency Early Intervention Committees (IEIC).
- Providing educational materials and social marketing activities to statewide programs and organizations with an interest in early childhood outcomes in order to better educate families and policy makers about the benefits of early childhood social and emotional development and screening.

2 The ASQ:SE is a standardized developmental screening tool for children ages 6–60 months which focuses on early childhood social and emotional behavior and development. Developed by Jane Squires, Ph.D., Diane Bricker, Ph.D., and Elizabeth Twombly, M.S.

"Eric is a 21 year old college student struggling with the everyday demands of school. He is also working to adjust to society's rules while living with Asperger's Disorder. Youth with Asperger's Disorder often have difficulty reading social cues, have rigid views of the world, odd behaviors, and obsessive thoughts and ideas. Eric's transition from high school to college was supported through a federally funded grant program, named PRIDE 4 (based on the TIP model), through the PACT 4 Families children's mental health collaborative. PRIDE 4 provided extensive transition services including job coaching, peer support, college readiness, and age-appropriate services. These individualized supportive services helped Eric successfully transfer from high school to college. When the grant funding ended and the services were no longer available, Eric lost a very important support system. This had a negative impact on his success."

Transition Age: 14–25 Year Olds

In eras of constrained budget resources, the governor, legislature and state agencies must prioritize resources and spending. The research on the developmental crisis period of young adulthood clearly stands out as a high priority for primary, secondary, and tertiary prevention.

In Minnesota there is not a coordinated system of support or services for youth ages 14 to 25 who need organized transition services due to a mental illness. Often when a youth turns 18, mental health care is disrupted due to eligibility rules.

Many mental health conditions that are diagnosed during childhood or adolescence persist into adulthood. Youth with mental illnesses seem to fall through the gaps in the systems because services are often incomplete and uncoordinated.

Youth and families encounter many barriers when seeking and using transition services. Often there are not age-appropriate services for youth that need ongoing support.

Young adults who have mental health impairments need help with job coaching, transportation, support for living situations and medical insurance so they can continue to access medical and mental health support from professionals. The complexity of the interagency connections is especially challenging for these youth.

Examples abound of youth and young adults:

- Transitioning from high school with diagnoses from childhood or adolescence continuing on to adulthood
- Transitioning out of the child protection and juvenile justice systems
- Emancipating from problematic family situations
- Facing the emergence or a recurrence of a major mental illness in college or university; and
- Living precariously housed or chronically homeless.

What is working:

The Transition to Independence Process (TIP)[3] model provides coaching for young people with mental illnesses to successfully move to adulthood. The

3 For more information regarding the TIP System and related programmatic resources and evaluation methods, please contact Hewitt B. "Rusty" Clark, Ph.D., Nicole Deschenes, M.Ed., or Jordan Knab, Ed.S., Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa FL 33612. E-mail: clark@fmhi.usf.edu, deschenes@fmhi.usf.edu, jknab@fmhi.usf.edu. TIP Web site: http://tip.fmhi.usf.edu. National Technical Assistance Center on Youth Transition Web site: http://ntacyt.fmhi.usf.edu

coaches provide case management services to help the young adult access support for education, employment, housing, and community involvement. The coach also provides instruction in self-awareness and self-advocacy skills.

Youth involved with the TIP model report the support they received from the coaches greatly improved their situations and helped them to achieve adult independence across each domain.

What does Minnesota need?

Minnesota needs a coordinated system of care that is sustainable at the local level. By supporting a coordinated person-centered, strength-based approach to transition we can improve outcomes for youth.

Minnesota needs to build the capacity of the education system, employment services, social services, and the post-secondary education system to serve youth with mental illnesses by providing effective professional development and ongoing coaching.

The Council and Subcommittee recommend:

- With the goal of statewide, coordinated, individualized transition services for youth; ages 14 -25 with mental illnesses:
  - Provide state funding with a local match to implement a statewide system of support for youth ages 14-25 with mental illness such as the Transition to Independence Process (TIP) model from the University of South Florida, which is based on age-appropriate services in the domains of education, employment, housing, and community life integration.
  - Allow youth with mental illnesses to maintain state funded health insurance coverage to age 25.
- Funding must be integrated to pay for the continuity of mental health services to span across the transitions of children into young adulthood. Access to funding or eligibility criteria for publicly funded mental health care must be expanded in all cases to include young adults.
- Health care insurance must be mandated to provide continuity of coverage for young adults regardless of the change in their life circumstances or living situation. Therefore, policies such as automatic eligibility and enrollment maintaining coverage for young adults should be enacted. For example, state colleges and universities should be allowed to participate in Minnesota health care programs at the student's income level.

Primary Care

The State Advisory Council and Children's Subcommittee have been focusing their work the past two years on the interface between primary care health providers and mental health providers.

Primary Care providers serve as the point people and gateways to integrated and coordinated mental health care. More than 80 percent of the drugs used to treat mental illness in Minnesota are prescribed by primary care physicians in family practice, internal medicine, and ob/gyn; 20 percent are prescribed by psychiatrists.[4]

Non-integrated mental health care frequently results in inadvertent evaluation and treatment of consumers, contradictory diagnoses, incompatible therapeutic approaches, and service redundancies.

The Council and Subcommittee recommend:

- State agencies and the legislature sponsor pilot studies, with the intention of full scale replication of single-site integrated service and funding models in the treatment of serious mental illness (e.g., the DIAMOND project[5])
- Care coordination services that are a part of managed care contracts between the Department of Human Services (DHS) and health plans for publicly funded health care must be designed with the principles of systems of care, care coordination as well as establishing a "health care home" for people with mental health issues.
- Care coordination should apply not only to the coordination between physical and mental health, and treatment for dual disorders (e.g., mental health and substance abuse), within the same health care network, but also between the insurer and the entire continuum of mental health services within other mental health and social service delivery systems (e.g. schools, counties).
- DHS and the Department of Health should promote standards of continuing education on mental health topics to primary care providers and in medical school curricula. DHS should utilize its role in policy making, rule making, contracting, and technical assistance work with health plans, licensing boards and professional associations to accomplish this recommendation.
- DHS should disseminate information on when to utilize electronic medical records as a facilitative tool so as not to become a barrier to the human factor of therapeutic efficacy.

4 *A Report from Minnesota's Council of Health Plans: Minnesota's Mental Health*, Minnesota Council of Health Plans, February 2008, p. 7.

5 "Depression Improvement Across Minnesota Offering a New Direction". A collaborative public-private project to create an evidence-based best practice model for structured collaborate follow-up care and management of adults with depression in primary care settings. Mental Health Association *Fall/Early Winter 2007 Forum*, p. 6.

Mental Health and Juvenile Justice

Our goal is to provide recommendations for improvements in mental health systems of care for justice involved youth with mental health disorders to reduce the social, financial and human costs associated with that involvement.

The Governor and his administration are to be commended for supporting our 2006 recommendation to establish the Interagency Advisory Task Force (IATF) to review Minnesota's systems of mental health care for this population and provide recommendations to improve the effectiveness of those systems. The Juvenile Justice committee of the Children's Subcommittee worked closely with the IATF over the past year to support its goals. The IATF was effective in accomplishing its mission and is providing the Commissioners of Corrections and Human Services with a number of pragmatic recommendations that the Children's Subcommittee fully supports.[6]

The work of the IATF highlighted the national consensus that the majority of children involved in juvenile justice systems have treatable mental health and chemical dependency disorders. Unfortunately, these disorders play an important role by increasing the vulnerability of youth to becoming involved in the juvenile justice system and, tragically, our corrections systems too often become the location of treatment of last resort. When these youth remain untreated or do not receive effective interventions, they remain at heightened risk for continuing long-term corrections systems involvement.

Our work to better understand the scope and nature of these problems with Minnesota's youth was consistently hampered by the lack of relevant statewide data. At present, there is no systematic, coordinated, comprehensive, statewide, data collection in place that provides policy makers or state, county, or private agencies with the information needed to accurately understand these problems in Minnesota. Similarly, there is no systematic data collection that identifies which youth receive or don't receive needed services or to evaluate the quality and effectiveness of resources that are provided.

A key recommendation from the IATF calls for a standardized data collection and reporting process. This recommendation builds on the 2003 Minnesota legislation that required mental health screening for all child welfare and juvenile justice populations in order to identify unmet needs and ensure access to needed treatment that would help reduce recidivism. As a result of the legislation, mental health screening is conducted throughout the state in detention centers for youth found to be delinquent. However, data is not available to inform the post screen process, either locally or statewide. Unanswered questions remain. Do all screens that meet the threshold result in diagnostic assessments? Do diagnostic assessments result in appropriate

6 *Minnesota's Juvenile Justice and Mental Health Initiative, Final Report.* www.doc.state.mn.us/publications/documents/07-08JuvenileInitiative-Final_001.pdf, Minnesota, Department of Corrections (2008).

A commonly repeated statement made by parents is, "For years I have been trying to get my son the help he needs. I knew jail wasn't going to help him. He had a mental health screening that showed he has problems and needs help but we couldn't find the help we needed and now he's back in detention. Don't agencies talk to one another? Jail isn't what he needs!"

interventions (if desired by the youth and family)? Do the interventions provided reduce recidivism? The lack of data is a significant barrier to accomplishing the intent of Minnesota's legislation, and inhibits development a model screening and post screening process that assures access to needed care and effective treatment.

Our work with the IATF also heightened our understanding of the complexity of the service provider systems for youth involved in the corrections systems in Minnesota and their families. Unfortunately, there are numerous barriers to information sharing among these provider groups that undermine their ability to coordinate care. Failure to coordinate services among providers undermines the effective and efficient utilization of spare resources and increases the risk of families "falling through the cracks." We support the IATF's recommendation that "system navigators" be identified within each county to help families navigate the complexities of the juvenile justice and the mental health systems so they can successfully access the services that will have the most impact on their sons and daughters.

The Council and Subcommittee recommend:

- The Governor support the recommendations of the IATF for the development of a post-screening protocol to ensure that the intent of Minnesota's screening legislation is fulfilled.
- The Governor direct the Departments of Corrections and Human Services, along with other appropriate state agencies, to develop a comprehensive and coordinated system of data collection and sharing for youth involved in corrections systems. This will allow increased coordination of care and provide agencies and policy makers accurate and meaningful data to determine appropriate resource allocation

Both of these recommendations serve to help ensure that children and youth with serious mental health needs who are involved in our juvenile corrections systems are provided with the appropriate resources needed to help them succeed and remain free of further engagement in the state's correctional systems.

Outreach to Diverse Communities/ Workforce Professionals

According to the Minnesota Demographic Center, the minority population in Minnesota is projected to more than double, while the white population (excluding Hispanics) will grow only about four percent by the year 2025.[7]

7 *Faces of the Future: Minnesota Population Projections 1995-2025*, prepared by Martha McMurry of Minnesota State Demographic Center (1998). This is referred to as the "minority/majority." It is now predicted that Minnesota will be a minority/majority state by 2015, David Sirota, *The Nation*, (December 26, 2005).

"Perhaps nowhere is the importance of culturally competent care greater than in the delivery of mental health services, where cultural issues and communication between consumer and provider are a critical part of the services themselves".[8] New approaches are needed in mental health service delivery to address cultural differences among consumers.

The Mental Health Legislative Network[9] has noted that there are statewide workforce shortages in psychiatry, psychology, social work, and other core mental health professions. It is also difficult to recruit and retain mental health professionals in rural areas. The shortage is even more compounded when culturally and linguistically competent mental health providers are considered.

It is commendable that the 2007 legislative session, inspired by the governor's mental health initiative, invested in the mental health system to improve the delivery of mental health services to children and adults in the state. This new funding has created some opportunities for grants to "support increased availability of mental health services for persons from cultural and ethnic minorities within the state."[10] It also allowed grants to assist members of an ethnic minority to pursue third party reimbursable qualifications to be mental health professionals or practitioners.

This was very encouraging and a step in the right direction. However, the complex challenges in the mental health service delivery to immigrant and ethnic minorities require ongoing government support in creative ways in order to maintain the overall health and productivity of Minnesotans.

The Council and Subcommittee recommend:

- Ensure that when children need to be removed from their home that they are placed in programs or foster homes with culturally competent providers and programs that are sensitive to their ethnic needs so that cultural bereavement is minimized whenever possible.[11]
- Provide affordable and easily accessible interpreter services for all children and families who are not proficient in the English language and need mental health services.

8 *Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/ Underrepresented Racial/Ethnic Groups* prepared by SAMHSA, US Department of Human Services

9 The Mental Health Legislative Network advocates for statewide mental health system that is of high quality, accessible and has stable funding. Over 19 organizations work together in this network to inform legislators and other elected officials of existing mental health issues.

10 HF1812 Conference Committee Report Article 18 Health and Human Services Appropriations, Children's Mental Health (2007)

11 Cultural Bereavement is a term used to describe the experience of an individual who is removed from his cultural environment and grieves the loss of familiar foods, sounds, smells, sights and other aspect of his culture and as result feels disoriented.

- Include cultural training and competence as a requirement of licensure and licensure renewal for all mental health providers.[12]
- Provide mini-grants to allow mental health professionals, practitioners, or cultural ambassadors to reach out to various ethnic communities and educate them about mental health awareness.
- Provide mini-grants and other incentives to recruit mental health professionals in rural areas.[13]

Mental Health and Aging

The goal of the State Advisory Council on Mental Health has been to better understand the unique and unaddressed mental health issues of older adults within Minnesota.

According to the Minnesota State Demographic Center (2007) the fastest growth in population in Minnesota will occur in the over sixty-five age group. It is projected that the numbers will more than double for this age group by 2035.[14]

The primary care of older adults is by spouses, older adult children, other family members, and friends. According to the U.S. Department of Health and Human Services, caregivers are at an increased risk for developing serious physical health issues like heart disease, cancer, diabetes, or arthritis. Nearly one-half of all caregivers show signs of clinical depression as a result of this long-term stress.[15] Developing adequate support of caregivers provides a protective factor for both the caregiver and the older adult receiving care. Research shows that adequate supports delays nursing home placement by over three hundred days.[16]

12 Boards of Social Work, Psychology and Marriage and Family Therapy (2004 Reports)

13 A report released on July 23, 2008 by three agencies of the U.S. Department of Health and Human Services recommends increased payment for professional services by non-physician practitioners under Medicare and Medicaid, particularly in underserved rural and urban areas. The full report is available on the Web at http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf.

14 Minnesota State Demographic Center. (2007). *Minnesota population projections, 2005–2035*. Prepared by Martha McMurray. Page 1. Retrieved on June 15, 2008 at www.demography.state.mn.us

15 American Association for Geriatric Psychiatry (2004) Geriatrics and mental health – The facts. Retrieved on June 23, 2008 from www.aagpgpa.org/prof/facts_mh.asp. Web page 3.

16 U.S. Public Health Service (1999) *Mental health: A report of the surgeon general*. Chapter 5. Older Adults and Mental Health. Washington, DC: U.S. Department of Health and Human Services. Retrieved online from section 2, Web page 6 – Overview of Mental Disorders in Older Adults – Prevention of Premature Institutionalization on June 15, 2008 at www.surgeongeneral.gov/library/mentalhealth/chapter5/sec2.html

Only 50 percent of older adults who admit to having a mental health problem will receive treatment from any health care provider. Of those receiving assistance only three percent will get help from a mental health specialist.[17]

Only 11 percent of older adults treated for depression in a primary care setting will be given adequate treatment.[18] Thirty-four percent will receive inadequate treatment, and 55 percent will receive no treatment . There are many reasons that mental health issues go undetected or under treated by health care professionals, including the mistaken belief of patient and/or doctor that depression is a normal part of aging.

With age, an increase in physical illnesses is often seen. For those experiencing mental health issues, successfully managing a physical illness becomes more difficult and costly. Depression and anxiety are associated with higher utilization rates of medical care and diminished levels of daily functioning.[19] Early identification and appropriate treatment is crucial to the physical and emotional recovery needed to remain independent.

A major cost of untreated depression is the suicide rate seen among older adults. A National Institute of Mental Health (NIMH) report found that the two highest rates of suicide exist in the seventy-five to eighty-five and the over eighty-five age groups.[20] These two age ranges account for only 12 percent of the population but nearly 16 percent of all suicides.[21] White men, over the age of eighty-five are at highest risk for suicide. It is estimated that up to 75 percent of older adults committing suicide have had contact with a physician in the month preceding their death.[22]

17 Administration on Aging (2001) *Older adults and mental health: Issues and opportunities*. Washington D.C.: Department of Health and Human Services. 2001. Page 11

18 U.S. Public Health Service (1999) *Mental health: A report of the surgeon general*. Chapter 5. Older Adults and Mental Health. Washington, DC: Retrieved from section 3 Web page 5 – Depression in Older Adults – Barriers to Diagnosis and Treatment on June 15, 2008 at www.surgeongeneral.gov/library/mentalhealth/chapter5/sec3.html

19 Bird M., Parslow R. (2002) *Preventing depression: Potential for community programs to prevent depression in older people*. Medical Journal of Australia 177(supp7): S107-S110. Retrieved on February 22, 2008 at www.mja.com.au/public/issues/177_07_071002/bir10369_fm.pdf
DiMatteo M., Lepper H., Croghan T. (2000) *Depression is a risk factor for noncompliance with medical treatment: Mental-analysis of the effects of anxiety and depression on patient adherence*. Archive Internal Medicine. 2000. Vol. 160, July 24, 2000. Pages 2101–2107. Retrieved on February 22, 2008 at www.archintermed.com
New Hampshire National Alliance for the Mentally Ill. (2006). *Mental health, mental illness, healthy aging: A New Hampshire guidebook for older adults and caregivers*. Page 27. Retrieved on January 1, 2008 at www.naminh.org/documents/GuideBk_OA.pdf

20 National Mental Health Association (ND) *Fast facts – Mind your health*. A mental health month facts sheet. Page 2. Retrieved on June 15, 2008 at www1.nmha.org/may/fast_facts.pdf

21 National Institute of Mental Health. (2008) *Older Adults: Depression and Suicide Facts*. National Institutes of Mental Health. Page 1. Retrieved on June 23, 2008 at www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts.shtml

22 National Institute of Mental Health. (2008) *Older Adults: Depression and Suicide Facts*. Page 1. Retrieved on June 23, 2008 at www.nimh.nih.gov/health/publications/older-adults-depression-and-suicide-facts.shtml

Currently, parity for mental health care does not exist for individuals on a fixed income.[23] Medicare has limited access to providers and limited resources to pay for services or psychiatric medications. For those with more serious mental illnesses, the lifetime caps on mental health hospital days may affect their ability to receive appropriate care in later life.

There is an untrained workforce working with elders in nursing homes, assisted living and the community. When mental health issues arise and behaviors create problems, staff untrained to deal with the underlying issues may see the person as inappropriate for the current level of care and the individual may be moved to a more restrictive setting.

While nursing homes and assisted living facilities may provide for psychiatric assessment and medication management ongoing therapy or supportive services are limited. For individuals living in their own homes there are few in-home psychiatric resources available to those with limited physical mobility or limited access to transportation.

The Council and Subcommittee recommend:

- Health care professionals and service professionals should be trained to recognize mental health issues of older adults and how to respond accordingly. This is particularly important for all nursing home personnel and other long term care providers. Ongoing education should focus on:
  1. Interest and commitment within the helping professions to increase their knowledge and skill in working with older adult mental health.
  2. Awareness of "normal" aging and mental health issues facing older adults in our communities by primary care providers.
  3. Recognition of mental health issues by health care professionals emphasizing symptoms, prevention, early intervention, available resources, evidenced-based treatment, and the costs associated with untreated or under treated mental health issues.
  4. Training for agencies contracted to provide aging services and/or mental health services within Minnesota on evidenced-based practices and the unique issues facing older adults.
- Collaboration between stakeholders toward an increased knowledge of available resources, the improvement of age related services, and easy access to services.
- Legislative action requiring all health plans practicing in Minnesota to provide mental health parity in age specific services, reimbursement rates, and individual co-payments in Medicaid and Medicare Supplemental plans.

23 A Medicare bill passed by Congress on July 16, 2008 by veto override will phase out the current 50 percent co-insurance rate for mental health services to the 20 percent rate beneficiaries now pay for other medical outpatient services. The disparity, which has existed since the inception of Medicare in 1965, is a major barrier to needed services. *Mental Health America News Release*, July 16, 2008, www.mentalhealthamerica.net

- Creating a permanent member position on the Minnesota Board on Aging specifically representing older adult mental health and ensuring the inclusion of mental health services in the implementation of the vision, themes, and strategies of the Minnesota Transform 2010 report.[24]
- Expand and further develop successful peer counseling services throughout Minnesota to increase access for older adults experiencing mental health issues. Peer counselors are able to successfully address adjustment to life transitions, caregiver stress, depression, anxiety, grief and bereavement, and other mental health issues affecting the older adult.

Local Mental Health Advisory Councils

The Comprehensive Mental Health Act of 1987 and Children's Mental Health Act of 1989 require each county to have a local advisory council for adult and children's mental health.[25] Membership must include consumers (recipients) of mental health services, family members of adults with mental illnesses, parents of children with emotional disturbances, and providers of mental health services.

Consumers and family members are "the voice of the customer." They inform their county commissioners of unmet needs as well as effective services in their county. This helps counties as they prioritize spending and in their decision making.

In addition, the State Advisory Council on Mental Health is required to coordinate the work of local adult and children's advisory councils.[26]

One way the State Advisory Council plans to do this is through a statewide conference for local advisory council members in October 2008. The conference will provide an opportunity for local advisory council members to observe a variety of working models and hear suggestions on building advisory councils consisting of consumers, family members, service providers and community leaders to work with county commissioners to ensure community collaboration.

The State Advisory Council would also like to coordinate with local advisory councils in other ways. Previously, there was a state position that served as a liaison between the State Advisory Council on Mental Health, the Department of Human Services, and local advisory councils. The individual in this position

24 *A Blueprint for 2010, Preparing Minnesota for the Age Wave.* For additional information on this report, contact Transform.2010@state.mn.us or visit the DHS Web site at www.dhs.state.mn.us/2010.

25 Adult Local Advisory Council (M.S. 245.466 Subd. 5.); Children's Local Advisory Council (M.S. 245.4875 Subd. 5.)

26 M.S. 245.697 Subd. 2 (8)

conducted valuable trainings and workshops that empowered local advisory councils to perform their role of providing vital information to their counties. In addition, the individual brought back information from local advisory councils to the State Advisory Council. In return, local advisory councils were educated about statewide developments and legislative issues.

The position has been vacant since 2003. While many local advisory councils are continuing to carry out their duties effectively, many others are languishing. They have begun to lose membership and lose their sense of direction. Communication with the State Advisory Council has suffered.

This affects the quality of Minnesota's mental health system. Without the connection between consumers and family members and their counties, there is a void as to the quality and outcomes of mental health services. Just as the state benefits from the recommendations of the State Advisory Council on Mental Health, counties need to hear recommendations through their statutorily required local advisory councils. Without strong input from local advisory councils, the State Advisory Council lacks important information to make recommendations to the governor and legislature.

State Advisory Council members would also benefit from participation at local advisory council meetings. The State Advisory Council would like to provide materials that local advisory councils can use in educating their communities on mental health and mental illnesses. Opportunities exist at county events to raise awareness about the existence of the state and local advisory councils.

Some counties provide financial support to their local advisory council consumer and family members. When professionals are getting paid for their time to attend local advisory councils, it makes sense that consumers and family members do as well. As noted above, counties were required by state law to establish local advisory councils mainly for consumers and family members to provide input to their county board on unmet needs and other issues within the mental health system. A stipend for time and expenses requires minimal funding, and helps to recruit and retain consumers and family members on local advisory councils.

The Council and Subcommittee recommend:

- The Department of Human Services reinstate the position of liaison to local advisory councils with the primary duties of coordination and communication between local advisory councils, the State Advisory Council on Mental Health, and the Department of Human Services by 2009. The Council would like to provide input in the hiring of this position.

- Funding to counties to support the activities of local advisory councils, specifically to encourage the participation of consumers and family members. Examples of such support would be mileage reimbursement and a per diem for attending meetings.
- Funding for an annual statewide conference for local advisory councils, and additional activities to allow the State Advisory Council to fulfill its mandate to coordinate the work of local advisory councils and funding for the State Advisory Council on Mental Health to provide support materials to local advisory councils.

Conclusion

Serious mental illnesses, which affect about six percent of all Americans, cost society about $193.2 billion in lost individual earnings each year, a study published in the *American Journal of Psychiatry* indicates.[27] The data used by the study is from 2002; the incidence of mental illnesses is actually probably higher today. It also doesn't take into account incarceration, Social Security, and other costs to society. The $193 billion figure also only considers severe mental illnesses.

In addition, suicide is the second leading cause of death for 15- to 34-year-olds; the third leading cause of death for 10- to 14-year-olds; and the fourth leading cause of death for 35- to 54-year-olds in Minnesota. Approximately three times the number of Minnesotans dies from suicide than from homicide (approximately 500 deaths per year).

Fifteen percent of those who are clinically depressed die by suicide; however 80 percent of people that seek treatment for depression are treated successfully.[28] A 2003 study of suicide prevention in the United States Air Force demonstrated that a community-wide suicide prevention program was associated with a 33 percent risk reduction for completed suicide.[29]

Investments in mental health are cost-effective. Mental health services make fiscal sense. More importantly, recovery is possible and the quality of life of all Minnesotans can be improved. Minnesota has made great strides in recognizing the crucial role of mental health services. The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health look forward to continuing to work with the governor and legislature to improve the lives of all Minnesotans.

27 *Time Magazine*, May 5, 2008.

28 See Suicide Facts, Suicide Awareness Voices of Education, www.save.org

29 *Suicide Prevention Plan Progress Report, February 2005*, Minnesota Department of Health, www.health.state.mn.us/mentalhealth/suiciderpt05.pdf