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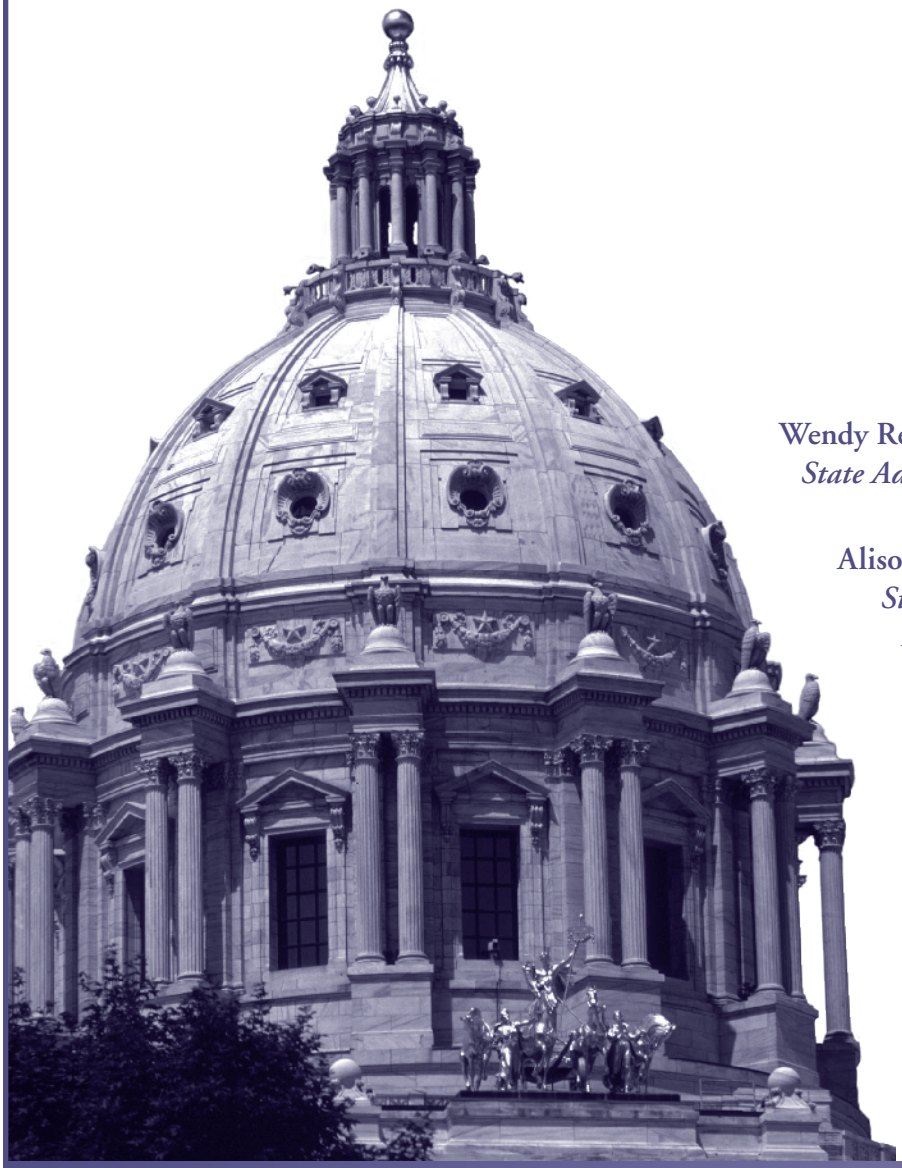
STATE ADVISORY COUNCIL ON MENTAL HEALTH
and Subcommittee on Children's Mental Health

2010 Report *to the* Governor and Legislature



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Letter from the Chairs and Vice Chair

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health thank the Governor and the Legislature for your continued commitment to improving Minnesota's mental health system.

Mental illnesses can affect persons of any age, race, religion, or income. It is estimated that mental illnesses affect one in five families. Without treatment, the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives. The economic cost of untreated mental illness is more than 100 billion dollars each year in the United States. By ensuring access to services and supports that have been proven to be effective, recovery is possible.[1]

The upcoming biennium will be challenging for the Governor and Legislature. This report is a product of the work of consumers, family members, providers, elected officials and other stakeholders over the past two years. Through our review of research, data and our own personal and professional experiences, our recommendations promote policies that are responsive to the needs of adults and children with mental health issues that are efficient and cost-effective. The recommendations highlight the following:

- Early identification, screening, referrals and treatment.
- Services for children in the juvenile justice system.
- Services for children in schools.
- Improvement of mental health awareness, cultural sensitivity and competency among diverse communities in Minnesota.
- Integration of mental health and primary care.
- Personal care assistant services.
- Housing support services.
- Local mental health advisory councils.

Many of our recommendations support the continuation of the mental health infrastructure grants enacted in 2007. These infrastructure grants helped to better utilize community supports, avoid costly hospitalizations, and reduce involvement in the criminal justice system.

Through our own personal experiences we have been involved with the mental health system at both the local and state level for many years. Our experiences have given us insight into both the strengths and weaknesses of Minnesota's mental health system. We are pleased to present our *2010 Report to the Governor and Legislature*.

Sincerely,

Wendy Rea
Chair, State Advisory Council on Mental Health

Alison Wolbeck
Vice Chair, State Advisory Council on Mental Health

Linda Hansen
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Co-Chair, Subcommittee on Children's Mental Health

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1 NAMI-Minnesota. www.namihelps.org/assets/PDFs/fact-sheets/General/What-is-Mental-Illness.pdf

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COST TO PREPARE REPORT

Minnesota Statutes, section 3.197 requires disclosure of the cost to prepare reports. The cost of this report was approximately $3,000.

Executive Summary

The State Advisory Council on Mental Health was established in 1987.[1] The Council is a 30 member bipartisan governor-appointed body consisting of a broad array of stakeholders, including recipients of mental health services, their family members, providers of services, advocates, elected officials, state department representatives and others as required by the law. The Children's Subcommittee was established in 1989 in order to make recommendations to the Council on policies, laws, regulations, and services relating to children's mental health.[2] The Children's Subcommittee also has approximately 30 members as established in statute. The Council and Subcommittee are to report to the governor not later than October 15 of each even numbered year, and to the chairs of the appropriate policy committees of the house and senate not later than November 15 of each even numbered year.[3] (see appendices for statute and membership lists).

The State Advisory Council and Children's Subcommittee have seven working committees. Each committee has contributed a chapter to this report. This is a summary of their recommendations.

Children's Subcommittee Early Childhood Development and Mental Health

Substantial brain development occurs from before birth to age five that can influence mental health and well-being outcomes for the rest of one's life. The interplay between external and internal factors can positively or negatively impact mental, emotional and physical health. The committee recommends:

- Expanding educational opportunities for all parents and care providers of young children to include early social and emotional development.
- Increasing accessibility for caregivers of young children to affordable, quality mental health consultation.
- Increasing the percentage of children age four and under who are formally screened, with parental consent, for social and emotional development problems, providing assessment at regular intervals.
- Building collaboration between the children's and adult mental health systems to better address the needs of the child and caregiver as well as the child-caregiver relationship.

Children's Subcommittee Mental Health in the Schools

School Wide Positive Behavioral Interventions and Supports (SW-PBIS) is a systems approach to improving social competence for children and adolescents within the educational environment focusing on prevention. SW-PBIS shows great promise in reducing asocial behavior, and promoting social competence as well as academic achievement. The committee recommends:

- Coordinating efforts between SW-PBIS and School Linked Mental Health grants, including the collection and reporting of data on culturally diverse student populations.
- Collecting information to recognize schools that have coordinated School Linked Mental Health grants and individual SW-PBIS efforts and have evidence of positive implementation of SW-PBIS.

1 M.S. 245.697.

2 M.S. 245.697 Subd. 2a.

3 M.S. 245.697 Subd. 3.

Children's Subcommittee Mental Health and Juvenile Justice

Unrecognized and/or untreated mental health problems significantly contribute to a youth's engagement in the juvenile justice system. The lack of early identification and follow-through, limited availability of treatment resources, and comprehensive data to identify and address these needs can result in increased and more costly juvenile justice involvement in the lives of these children and youth. The committee recommends:

- Collection of data that is consistent throughout the juvenile justice system.
- Consistent and comprehensive mental health screening and follow-up of youth involved or at risk of involvement in juvenile justice.
- Development of targeted mental health services and supports for disparate underserved populations, particularly youth from communities of color and violent and aggressive youth in the juvenile justice system.

Children's Subcommittee Outreach to Diverse Communities

The number of immigrants and refugees in Minnesota is growing at a rapid pace and is expected to continue to grow. Consequently, it is essential that we give attention to mental health issues of all residents, regardless of race, origin and ethnicity. The committee recommends:

- Increasing the number of cultural and ethnic minority infrastructure grants to additional areas of the state.
- If placement in a home or program does not reflect a child's culture, placement agencies should provide an ambassador, coach or consultant from the child's cultural community or ethnic group for the foster parents and staff.
- Support for additional mental health professionals from culturally diverse communities in the workforce and collaborative education and training in diverse communities on mental health issues.
- Including a representative from mental health on the health care disparities advisory group which should collect data to address ways to better identify and reduce mental health disparities.
- Developing a mechanism for qualified interpreter services that supports meaningful access to mental health care regardless of income level or insurance status.

Primary Care and Mental Health Reforms

The recent legislative changes to General Assistance Medical Care (GAMC) and restrictions on Personal Care Attendant (PCA) services have had a negative impact on adults and children with mental health needs. Only a small portion of the GAMC population has or will be served by the end of the program that was put in place. Changes to PCA requirements will limit access to this needed service for people with mental health disorders. The committee recommends:

- The Governor exercise the early expansion of the federal Medicaid option.
- Expedited review for Medicaid eligibility through State Medical Review Teams (SMRT) for as many people as possible.
- Education of the public to raise awareness of individuals' rights under recent federal mental health and substance abuse parity legislation.
- Reinstatement of PCA legislation so people who need assistance because of mental health or other brain disorders can be served in order to best remain at home and in their communities.
- Expansion of the availability of Integrated Dual Disorder Treatment in both inpatient and outpatient settings in Minnesota.
- Allocation of significant resources for individuals with complex conditions who are intensive users of State Operated Services who should be served in the community and develop intensive long-term living arrangements for this population.

Housing

The state lacks a full array of housing options. Supportive housing provides residents the opportunity to live in housing of their choice. The committee recommends:

- Supportive housing services in all levels of housing.
- Continued and increased funding for the Housing with Supports for Adults with Serious Mental Illness (HSASMI) and Bridges programs so options for supportive housing are available in more communities statewide.
- That State Operated Services partner with communities and contribute fiscal and human resources for the coordination of housing supports during their current process of redesign for the Chemical and Mental Health Administration.

Local Mental Health Advisory Councils

It is legislatively mandated that each county have a local advisory council (LAC) for adult and children's mental health, with membership to include consumers, family members and others. The committee recommends:

- In partnership with the State Advisory Council, the Department of Human Services develop a process of accountability to assure that each county has an adult and children's LAC.
- Continue training of adult LACs in leadership and effectiveness, and expand the training to children's LACs.
- Develop a mechanism to provide financial support for consumers and family members to participate on their LACs.

Early Childhood Development and Mental Health

Background

Mental and behavioral health problems commonly occur among today's children and youth. In any given year, it is estimated that one in five children from before birth to age 18 has a diagnosable mental illness.[4] One in ten youth has a serious mental health problem that significantly impairs how they function at home, in school, or in the community.[5] These problems in early childhood set the stage for mental health problems throughout life.

It is increasingly evident that mental illnesses are best characterized as disorders of nerve cell connections and the chemicals that communicate information between these cells. From conception to age five, the human brain undergoes unsurpassed growth and differentiation. Nerve cells branch, grow, connect, and are pruned in response to complex interactions between biological, environmental, and relationship factors. Thus, nerve cells, their connections, and the concentration of chemicals that convey messages between these cells can be built or altered positively (i.e., in a normal, adaptive fashion) or negatively depending on the type and quality of these factors.

Adverse experiences and overwhelming stress have been shown to disrupt normal, healthy early brain development, especially during critical developmental periods. Such disruption leads to an increased likelihood of developing a wide range of mental and behavioral health disorders throughout life. Established adverse childhood experiences include: psychological, physical and sexual abuse; violence against the mother; and living with household members who have abused drugs, have a mental illness, are suicidal, or who have been imprisoned.[6]

Yet research also indicates that early identification of and interventions for emerging mental health problems and risk factors significantly improve short and long-term development and mental health outcomes and can even erase the effects of adverse early experiences. For example, interventions that help support or create warm, mutually responsive, and supportive caregiver-child relationships buffer against adverse experiences by enhancing a child's ability to adapt and overcome a broader range of stress severity and adversity. This enhanced "resilience" or "adaptive capacity" leads to healthy, strong early social and emotional development, which in turn leads to improved lifelong mental health and well-being outcomes.[7]

Unfortunately, our mental health system remains fragmented. This can impede problem and risk identification and subsequent referral to and utilization of comprehensive, quality interventions. In addition, adults and children with mental health problems are too often addressed in relative isolation. Given our current understanding of the importance of early brain development and the effects of excess early adversity, it is imperative to find ways to improve collaboration and communication between the various providers, services, and programs in the children's and adult mental health systems. Otherwise, we waste golden opportunities to potentially prevent or reduce risk for the onset or worsening of mental health problems.

4 *Report of the Surgeon General on Mental Health, Chapter 3 1999.*

5 *New Freedom Commission on Mental Health, 2003.*

6 Anda R, et al. 2006. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3): 174-186

7 Mercy JA, Saul J. 2009. *JAMA* 301(21): 2262-2264

It is from this knowledge, research, and identified gaps that the Early Intervention and Prevention Task Force of the Subcommittee for Children's Mental Health proposes the following recommendations for the State of Minnesota:

Recommendations

(a) Expand formal social and emotional development educational opportunities for parents and care providers of young children in order to enhance early childhood mental health competencies.

(b) Increase accessibility and reimbursement for families and caregivers of young children to quality, evidence-based mental health consultation practices, particularly for those children and families at an elevated risk for mental health problems because of environmental or biological factors.

(c) Increase the percentage of children age four and under who are formally screened, with parental consent, at regular intervals using validated screening tools selected by the Minnesota Interagency Developmental Screening Task Force for social and emotional development problems. This can occur in any of the systems or programs currently serving young children and their families including: health care, child care, Help Me Grow Infant and Toddler Intervention/Preschool Special Education, Head Start/Early Head Start, public health and home visiting.

(d) Ensure that families of young children experiencing atypical emotional and behavioral development have access to needed services and supports including formal comprehensive development and mental health assessments.

(e) Provide the infrastructure and incentives to improve collaborative relationship building between the children's and adult mental health systems so that services, resources and programs can be best coordinated to optimally address the needs of the child and the caregiver and facilitate a healthy caregiver-child relationship.

Mental Health in the Schools

Background

Schools are searching for ways to increase graduation rates and academic progress while decreasing the rise in student problem behaviors.

Current research reveals that punishing problem behaviors without a proactive student support system is associated with increases in aggression, vandalism, truancy and dropping out.[8]

There is a need for a statewide comprehensive system to help create a safe and respectful learning environment for all staff, students and families. The implementation of School Wide Positive Behavioral Interventions and Supports (SW-PBIS) shows great promise in creating such an environment and reducing asocial behavior, and promoting social competence as well as academic achievement.

SW-PBIS is a systems approach to improving social competence for children and adolescents within the educational environment. It focuses on prevention and provides a structure in which to put in place research based practices at the classroom, school, district, regional, state and national levels.

SW-PBIS is a data-driven, framework that reduces suspensions and expulsions and increases student achievement by creating a safe and positive learning environment for all students and provides individualized interventions for students with the most serious needs.[9]

Schools that implement SW-PBIS with integrity and durability have teaching and learning environments that:

- Are more engaging, responsive, preventive, and productive;
- Are less reactive, aversive, dangerous, and exclusionary;
- Address classroom management and disciplinary issues (e.g., attendance, tardiness, antisocial behavior);
- Improve supports for students whose behaviors require more specialized assistance (e.g., emotional and behavioral disorders, mental health); and
- Most importantly, maximize academic engagement and achievement for all students.

SW-PBIS provides an operational framework for achieving these outcomes. SW-PBIS is **NOT** a curriculum, intervention, or practice, but is a decision making framework that guides selection, integration, and implementation of the best evidence-based academic and behavioral practices for improving important academic and behavior outcomes for all students.

PBIS in Minnesota

In 2004, the Minnesota Department of Education (MDE) began collaboration with Dr. George Sugai, co-director of the national center for Positive Behavior Interventions and Supports. MDE created a leadership team to develop a state action plan and blue print for supporting schools that were ready to implement SW-PBIS in Minnesota.

8 Mayer 1995, Skiba and Peterson 1999 and March & Homer 2002.

9 For more, see http://pbismn.org/PBISschools.html.

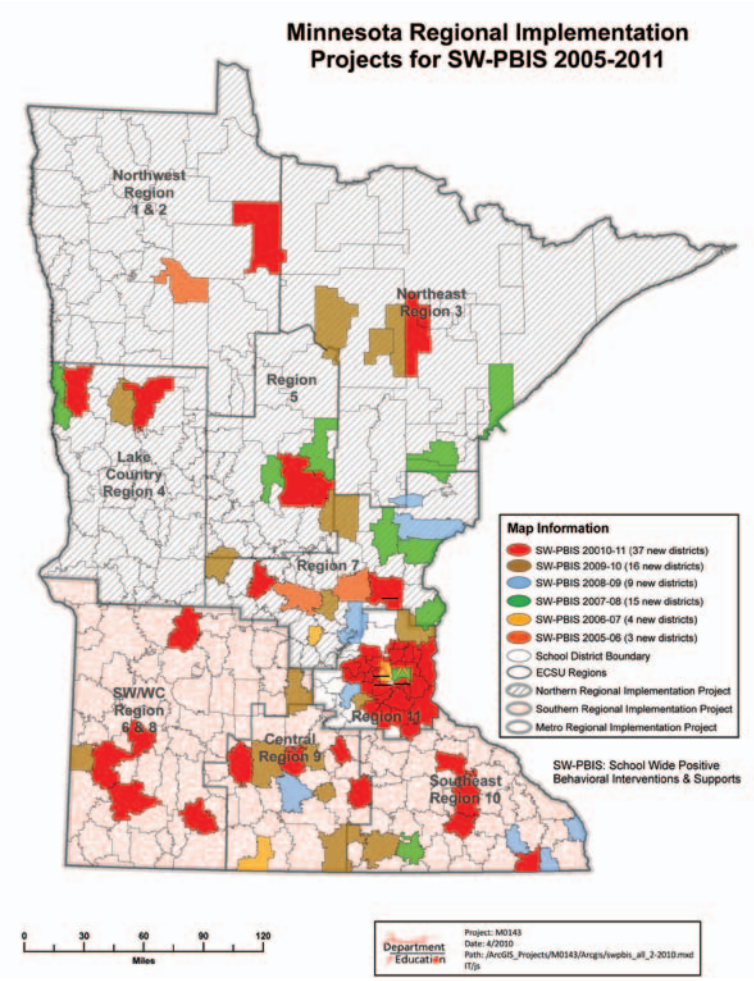
The first SW-PBIS training in Minnesota was offered in the summer of 2005. This initial two-year training included a cohort of nine schools from three independent school districts. The first cohort included elementary, middle, and high schools.

Since the first cohort of SW-PBIS schools were trained in 2005, the state has added between 13 and 50 schools per year from a diverse group of districts. Several cohorts have graduated from Minnesota's two-year training sequence and have moved into a phase of sustained implementation. Minnesota has an estimated 225 active schools with SW-PBIS.[10]

A number of Minnesota schools that have implemented SW-PBIS also have **School Linked Mental Health programs**. The school linked mental health grants, provided by the Department of Human Services, shore up school-based mental health services infrastructure for uninsured and under-insured children.

Currently, schools that have implemented SW-PBIS that also have school linked mental health grant programs have not coordinated their efforts. These complementary initiatives would benefit from coordinating activities, outreach and data collection.

The very important and effective work of MDE that supports and trains SW-PBIS initiatives in schools across the state needs to continue and expand. Positive outcomes of Minnesota schools and schools nationwide that implement SW-PBIS demonstrate the need to support and promote its existence in our schools.



Recommendations

(a) Coordinate the efforts of SW-PBIS initiatives and School Linked Mental Health grants, including the collection and reporting of data on culturally diverse student populations.

(b) Develop a statewide recognition system that:

  i. Recognizes schools that have coordinated School Linked Mental Health grants and individual SW-PBIS efforts.

  ii. Recognizes schools that have evidence of positive implementation of SW-PBIS.

(c) Continue, support and promote SW-PBIS statewide infrastructure for training, coaching, and evaluation.

10 See http://pbismn.org/documents/pbisMNmapcohort1_6.pdf for a full page color copy of the map.

Mental Health and Juvenile Justice

Background

The goal of the Children's Subcommittee Juvenile Justice Task Force is to raise awareness of, and advocate for needed improvements in Minnesota's mental health system pertaining to children and youth involved in, or at risk of involvement in the juvenile justice system.

The 1999 US Surgeon General's report on mental health found that approximately 21% of all children and youth experience a mental health disorder and that half are severe enough to cause impairment at home, school, or in the community.[11] A 2006 study by the National Center for Mental Health and Juvenile Justice found that 70% of youth in juvenile justice suffer from a mental health disorder. Over one-third experience a disorder so severe that it impairs their ability to function.[12]

Unrecognized and/or untreated mental health problems significantly contribute to a youth's engagement in the juvenile justice system. The lack of treatment resources to address these needs often results in increased and more costly juvenile justice involvement in the lives of these children and youth. While some progress has been made over the last decade, much more work remains to be done.

The mental health needs of these youth have been a priority of the Children's Subcommittee for at least the past decade. Several common needs have been consistently identified in past reports to the governor and legislature:

- Data collection improvements, including public dissemination of information pertaining to mental health needs.
- Earlier identification of mental health needs, and earlier access to needed treatment.
- A comprehensive array of effective services and strategies.
- Financing strategies to develop and sustain targeted mental health services and interventions.
- The disproportionate representation of certain ethnic minority populations and lack of strategies to address this problem.

Recent Developments

2003 Legislation Requiring Youth in Juvenile Justice and Child Welfare to Receive Children's Mental Health Screening.[13] Since 2005, approximately 24,000 youth have been screened within the juvenile justice population through this initiative. The Department of Human Services distributes grant funds to counties to help subsidize the screening activities and assist with needed treatment services for uninsured youth. The funds are allocated based on the number of screenings reported by each county.

The following youth between the ages of 10 to 18 years are to be screened through a court order within the juvenile justice population:

- Youth with a judicial finding of delinquency, according to Minnesota statute 260B.007, subd. 6.
- Youth who have allegedly committed a delinquent act and who have had an initial detention hearing, with the court ordering the child continued in detention
- Youth found to have committed a juvenile petty offense for the third or subsequent time.

11 U.S. Public Health Service (1999) Mental health: A report of the surgeon general. Chapter 3, Children and Mental Health, Table 3-1. www.surgeongeneral.gov/library/mentalhealth/chapter3/sec1.html

12 A Blueprint for Change, National Center for Mental Health and Juvenile Justice (June 2006). www.ncmhjj.com/Blueprint/pdfs/ProgramBrief_06_06.pdf

13 The following sections 245.4874, subdivision 14; section 260B.157, subdivision 1; section 260B.176, subdivision 2; section 260B.178, subdivision 1; section 260B.193, subdivision 2; and section 260B.235, subdivision 6

2007 Department of Corrections (DOC) Juvenile Justice and Mental Health Initiative. In partnership with state and local agencies and organizations, DOC established an initiative to improve outcomes through systems change for youth in the justice system with mental health or co-occurring disorders. Four areas of need repeatedly emerged from focus groups and research:

- The need to collect data that better informs the process and to share data without jeopardizing the legal interests of youth as defendants.
- The need for post-screening coordination.
- The need to better engage families and caregivers as partners.
- The need for evidence-based, community-based mental health interventions that is effective with justice-involved youth.

2009 Juvenile Justice System Decision Points Study Bill. A DOC Criminal and Juvenile Justice Information Policy Group studied Minnesota's ability to report on data on youth involved in the state's juvenile justice system. Its February 2010 report to the legislature presented recommendations on collection of data at "decision points" that affect a youth's status within the juvenile justice system. Data would be sorted by age, gender, race, ethnicity, offense, county of offense, and county of residence by the entities responsible for data collection and analysis.[14] Other considerations were frequency of reporting and cost of implementing a data collection plan. To date, no legislative action has been taken on the report.

The Juvenile Detention Alternative Initiative (JDAI). JDAI is a national systems change initiative of the Annie E. Casey Foundation which was implemented in Minnesota's three largest metro counties in 2006; Ramsey[15], Dakota[16], and Hennepin[17]. It has since developed into a statewide effort to create equity, efficiency and effectiveness in juvenile justice practice due to the significant over representation of youth of color in detention, particularly American Indian and African American youth. St. Louis County became Minnesota's first expansion site for this model in January 2009.[18]

Recommendations

Based on a review of our recommendations over the last decade, the Minnesota Juvenile Justice Mental Health Initiative, reports from state department representatives, and discussions with key stakeholders, the Juvenile Justice Mental Health Task Force has the following recommendations for action by the State of Minnesota:

1. Continuing improvements are needed for Minnesota's mental health screening programs.

Screening of youth in the juvenile justice and child protection populations is a positive contribution to identifying youth with mental health needs. The Department of Human Services is collecting data that helps illustrate the mental health needs of youth in juvenile justice, and the state has staff assigned to work on the screening program.

However, the data shows that only half of the youth deemed eligible for screening are actually screened (though the number of youth screened has been increasing).

14 *Juvenile Justice Decision Points Study: Strategies to Improve Minnesota's Juvenile Justice Data.* www.ojp.state.mn.us/cj/publications/Reports/2010JuvenileJusticePolicyReportSections/1_Vision_Table%20of%20Contents.pdf

15 www.ramseyjdai.org

16 www.co.dakota.mn.us/LawJustice/CPCP/JDAI/

17 http://hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=eaf4d5d48c263210VgnVCM20000048114689RCRD

18 www.co.st-louis.mn.us/slcportal/LinkClick.aspx?fileticket=1cmCr6YNbRY%3D&tabid=74

Year	Total eligible youth for screening	Number of youth screened	Number of youth referred for assessment
2008	7388	4340	1104
2009	7682	4698	1367

There is inconsistent and incomplete data reporting from county to county, though counties (except Hennepin) will be moving to reporting through Court Services Tracking System which should help in generating reports on demographics and whether the youth meet exemption categories.

In addition, the number of "eligible youth" documented are only youth on active probation; those in diversion programs for petty offenses are not being counted. There also is not information regarding follow-up assessments and access to services resulting from the screenings being conducted.

Recommendations:

(a) Move to a statewide data system for collection of screening data; identify and address any state barriers that may interfere with data collection and service follow up.

(b) Add ethnicity data to the screening system to help identify disparities.

(c) Take steps to increase the number of children and youth who are screened within eligible populations by providing additional technical assistance and highlighting screening results statewide.

(d) Implement protocols and data tracking regarding follow-up post screening, and referral to and engagement in services.

(e) Develop enforcement strategies, consequences and incentives to ensure that required screening for third petty offenders takes place in order to promote earlier identification of mental health issues for youth who are at risk of committing more serious juvenile offenses.

2. Financing strategies to promote service development and long-term sustainment of needed mental health services.

The JDAI initiatives and some Minnesota counties have worked to promote the development of evidence based community services as alternatives to detention, placement, and incarceration. Many of these services use local property tax dollars and/or grant funds, and are in jeopardy of continuing from year to year.

In addition, federal and state Medicaid rules prohibit the use of Medical Assistance funding for services provided to incarcerated youth. Access to critical mental health medication, services and supports during an incarceration is inconsistent from county to county and can be dependent on local resources. This inconsistent funding stream limits the availability of needed treatments for youth prior to incarceration, during incarceration, and often creates barriers to establishing treatments post-incarceration.

Recommendations:

(a) Develop financing strategies to maximize state and federal public dollars in support of evidence-based or promising community-based mental health treatments for youth involved in the juvenile justice system.

(b) Develop funding strategies to provide continuous and transitional mental health services for incarcerated youth.

(c) Promote increased program and fiscal responsibility between the State Departments of Corrections and Human Services for mental health services for detained and incarcerated youth within the juvenile corrections system.

3. Data and reporting systems should be enhanced.

Data systems do not provide adequate information to support timely and appropriate mental health services in the juvenile justice system. A number of data systems in state and local communities collect data. However, additional and consistent data is needed, including data from mental health, student surveys, and the Minnesota's children's mental health data reporting system (CMHRS).

Recommendations:

(a) Fully consider and implement the Decision Points Policy Group's February 2010 recommendations concerning data collection and reporting.

(b) Collect data to identify the number of youth in juvenile justice who currently do or do not receive mental health services.

(c) Include questions about youth who are engaged in mental health services and youth involved in the juvenile justice system in the Minnesota student survey.

(d) Promote collaborative data analysis between the Departments of Education, Human Services and Corrections.

(e) See the discussion and recommendations regarding screening on pages 4-5.

4. Disparities in the juvenile justice system need to be addressed.

The JDAI initiatives, where implemented, have illustrated that there are severe disparities in communities of color, and have demonstrated that targeted interventions can help reduce these problems. These kinds of efforts need to be supported statewide by making improvements to standardized data collections systems and developing specialized services and strategies to meet the mental health needs of over identified populations. Additional information is also needed related to other disparities such as regional disparities and the growing number of girls in juvenile justice.

Recommendations:

(a) Track ethnicity information in state and local data systems.

(b) Develop and provide services and interventions that are targeted to over-represented ethnic and minority populations with mental health issues and juvenile justice involvement, such as Native American, African American, and new immigrant populations.

5. Targeted populations should be prioritized for service development.

There are specific populations of youth at risk or involved in the juvenile justice system in need of services and interventions. Without such interventions, they are highly likely to enter into, remain, and/or return to the system due to lack of available and appropriate services.

Recommendations:

(a) Develop services and strategies for violent and aggressive youth with mental health issues who are involved in the juvenile justice system. Services should be developed in all of the following venues: community-based services, out of home placement services, short-term hospitalization, State Operated Services, and incarceration.

(b) Promote identification and early intervention efforts for siblings and children of incarcerated juveniles and adults, especially regarding the impact of trauma.

Outreach to Diverse Communities

Background

Over the past ten years, there has been a growing awareness and understanding of the unique mental health needs of culturally and linguistically diverse communities that has led to several supportive initiatives and laws at the federal, state and local level.

In 2008, Minnesota ranked 19th in immigration in the country.[19] Minnesota's immigrant population has increased by 35 percent just this decade. The numbers of Latino, black, and Asian Minnesotans are projected to more than double over the next 30 years.[20] Immigrants and refugees leave their native countries due to political unrest, war, trauma, economic instability and other stressors that make their mental health needs very complex. Consequently, it is essential that we give attention to mental health issues of all residents, regardless of race, origin and ethnicity.

The Children's Subcommittee Task Force on Diverse Communities has identified the following issues:

1. Cultural And Ethnic Minority Infrastructure Grants

With funds appropriated as part of the 2007 Mental Health Initiative, the Children's Mental Health Division of the Department of Human Services has led a strategic initiative to support the infrastructure for children's mental health services to cultural and ethnic minority groups.

This included one to two years of start-up and ongoing funding to increase the capacity of mental health practitioners and professionals from diverse cultural and ethnic groups. Grants were awarded to seven agencies in four counties.[21]

Funds were utilized to:

(1) Build provider capacity groups to deliver culturally competent mental health services to their own cultural and ethnic communities, and

(2) Train and supervise individuals from diverse cultural and ethnic groups as they become mental health practitioners and mental health professionals.

On August 3, 2010, the Department of Human Services issued a second Request for Proposals to increase the number of practitioners from cultural and ethnic minority communities. Work is proposed to start November 1, 2010. The Children's Subcommittee Task Force on Diverse Communities recognizes this progress in the area of improving mental health services for culturally and linguistically diverse communities.

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19 Estimates of the Legal Permanent Resident Population in 2008, United States Department of Homeland Security, October 2009. www.dhs.gov/xlibrary/assets/statistics/publications/ois_lpr_pe_2008.pdf
See also *A New Age of Immigrants: Making Immigration Work for Minnesota.* The Minneapolis Foundation for Wilder Research. August 2010. www.mncompass.org/immigration/

20 McMurry, *Minnesota Population Projections by Race and Hispanic Origin, 2005 to 2035*. Minnesota Department of Administration State Demographic Center. www.demography.state.mn.us/documents/MinnesotaPopulationProjectionsbyRaceandHispanicOrigin2005to2035.pdf. The numbers of Latino, black, and Asian Minnesotans are projected to more than double over the next 30 years. McMurry, Minnesota Population Projections by Race and Hispanic Origin, 2005 to 2035. Minnesota Department of Administration State Demographic Center. www.demography.state.mn.us/documents/MinnesotaPopulationProjectionsbyRaceandHispanicOrigin2005to2035.pdf

21 Hennepin County (Washburn Center for Children, Volunteers of America Minnesota), Ramsey (Guadalupe Alternative Programs, Wilder Child Development Center), Mahnomen County (White Earth Indian Reservation), and *Comunicades Latinas Unidas En Servicio* (CLUES), Hennepin and Ramsey Counties.

Recommendation:

There be ongoing funding and support to strengthen and sustain the existing projects and establish additional projects.

2. Culturally Competent Mental Health Placements for Children

When a child's mental health issues require placement in a foster home or treatment center, every effort should be made for placement in a home or program that reflects the child's culture.

Recommendations:

(a) When this is not in the best interest of the child, placement agencies should provide an ambassador, coach or consultant from the child's cultural community or ethnic group for the foster parents and staff.

(b) Department of Human Services licensing rules should have explicit expectations for programs to provide for the cultural needs of children in out of home placement and for cultural competency training of foster parents and program staff.

3. Capacity Building

Additional mental health professionals from culturally and linguistically diverse communities are needed in the workforce.

Recommendations:

(a) Public education systems, from middle school through community college, should be required to offer preparatory curriculum to encourage, recruit and retain culturally and linguistically diverse students in a mental health field.

(b) Loan reimbursement programs, including federal student loan forgiveness and loan repayment programs, should be offered to individuals who provide mental health services to designated minority populations.

(c) Stipend programs and educational awards for tuition, books, living expenses, and other expenses should be offered to students of culturally diverse populations.

4. Mental Health Education for Culturally and Linguistically Diverse Communities

Mental health education for culturally and linguistically diverse communities is needed to foster understanding and recognition of mental health issues, mutual cooperation, access to mental health services and personal growth. Professional training and education for minorities and diverse cultural communities in the concepts and efficacy of mental health services is needed, particularly for hard to reach families and communities.

Recommendation:

Minnesota should establish an ongoing cross-cultural mental health collaborative in which state agencies work together to provide leadership, training and education about mental health needs for culturally and linguistically diverse communities.

5. The Health Care Disparities Act

2010 Legislation requires the commissioners of health and human services to conduct an inventory of their respective health-related data relating to ethnicity, country of origin, primary language, tribal

enrollment status and socioeconomic status. A report is to be submitted by January 15, 2011. Once the information is collected, the commissioners must consult with an advisory group of representatives of culturally based community groups and other stakeholders, to make recommendations on the sufficiency of current data, necessity for additional data, and ways to improve data collection efforts.[22]

Recommendations:

(a) The Health Care Disparities Advisory Group should include a representative number of members from a culturally and linguistically diverse mental health community.

(b) The data collected to identify and describe health disparities should include data related to mental health and the recommendations should address ways to better identify and reduce mental health disparities.

6. Quality of Health Care and Interpreter Services

Interpreter services for people with limited English proficiency improve the quality of health care for the increasingly culturally and linguistically diverse population in Minnesota. Accurate and effective communication with health care providers is critical to access quality mental health care. Language barriers can lead to misunderstandings, patient dissatisfaction, the omission of vital information, inappropriate treatment, misdiagnoses, serious medication errors and failure to comply with treatment protocols. This can occur when family members or others unskilled in translating medical concepts provide the interpretation.

Recommendation:

A mechanism for qualified interpreter services must be developed that supports meaningful access to mental health care regardless of income level or insurance status.

22 1st Special Session, Chapter 1, H.F. 1, Laws 2010, Article 19 Miscellaneous, Sec. 23 Data Collection on Health Disparities

Primary Care and Mental Health Reforms

1. Stable and adequate health care coverage for those in Minnesota who would have been covered under General Assistance Medical Care (GAMC).

General Assistance Medical Care (GAMC) provided state health care coverage to adults without children who make less than 75 percent of federal poverty guidelines ($8,123 per year). In the 2010 legislative session, the Governor and Legislature agreed to a final budget compromise which significantly reduced funding for the GAMC eligible population.

The compromise designated that health care services for GAMC recipients would be delivered by "Coordinated Care Delivery Systems" (CCDSs). This health care coverage solution for impoverished Minnesotans has proven to be wholly inadequate, since only four hospitals, all in the metro area, are participating as CCDSs. Only a fraction of the estimated 70,000 people who were eligible for GAMC will be able to access this care due to geographic location and enrollment caps, some of which have already been met. Service requirements to be met by CCDSs are not well-defined.

While the legislation included an appropriation of a $20 million uncompensated care pool (that expires in March 2011) uncompensated care is expected to increase in light of these issues far beyond state appropriations for this purpose. Emergency departments and other providers will bear much of the costs which are ultimately paid for by the general public.

The MinnesotaCare program, as it is currently structured, is also not a workable option for the GAMC population due to both access and fiscal sustainability problems. The premium payments, hospitalization, office visit and medication co-pays are difficult for this population to comply with, thereby reducing access to care.

There is a better alternative. The 2010 federal health care reform law permits Minnesota and 10 other states the immediate option to expand Medicaid coverage to individuals with incomes up to 133% of federal poverty guidelines. The federal government will assume 100% of the costs of Medicaid coverage in 2014. States that exercise the early option will maintain a share of the costs until then, but this share ramps down from 2010 to 2013. The net additional cost for Minnesota to participate in the early option (for those under 75% of federal poverty guidelines) was estimated to be $188 million, but the increase in matched federal dollars over the next three years would be $1.4 billion.

The eligible population would include those who were covered under GAMC as well as some MinnesotaCare enrollees. The 2010 Minnesota legislature passed legislation which permits the Governor by executive order to take part in this early Medicaid expansion option. This authority expires on January 15, 2011.

A limited number of enrollees under GAMC may be eligible under Medicaid if they are determined to have a qualifying disability. Disability determinations are made by the State Medical Review Team (SMRT) at the Department of Human Services. Assembling the necessary documentation for the review is often a difficult process. Assistance should be available, and the determinations should be as expeditious as possible.

Recommendations:

(a) The Governor should exercise the authority to issue an executive order for Minnesota to participate in the early expansion option into Medicaid. If, for any reason, the Governor cannot

act by January 15, the Legislature should extend this authority or otherwise ensure Minnesota's participation.

(b) Improve access to the SMRT process and streamline information gathering and determinations for those who may be Medical Assistance-eligible on the basis of disability.

2. Educate consumers about their rights under the federal Mental Health Parity and Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) was enacted on October 3, 2008, marking historic support by Congress for equitable coverage of treatment for mental illness and substance use disorders.[23] The legislation requires health insurance companies to offer fair and equal coverage of treatment for mental health and substance use disorders. After two years, the State Advisory Council is concerned that people in Minnesota may not be aware of their rights under the law.

Recommendations:

(a) The Department of Human Services should collaborate with the Department of Commerce to develop a marketing campaign to educate their respective populations about their rights under the Federal Mental Health Parity and Addiction Equity Act.

(b) The Minnesota Department of Commerce should develop information on their website summarizing the federal/state parity requirements.

3. Personal Care Assistance (PCA) Services

Beginning January 1, 2011, a person needing PCA assistance only for behavioral needs, including cognitive vulnerability, will no longer have access to PCA time for those needs. At that time, PCA services to persons with disabilities will focus on the need for hands on physical assistance and supervision with activities of daily living such as positioning and eating.[24] This approach to daily assistance with one's basic needs is contrary to state and federal mental health parity policies as it discriminates against disabled persons who need assistance because of developmental, mental health, or other brain disorders.

PCA services are a cost-effective way for the State of Minnesota to assist persons with mental illnesses to remain in their homes and communities and reduce avoidable institutionalization. PCAs should be available to all persons with a disability so they can maintain their independence in the community.

Recommendations:

(a) The governor and legislature need to repeal or amend the new PCA criteria so that people with mental illnesses and other brain disorders that need assistance with daily living who would not qualify can again access this important service.

(b) The state needs to evaluate the 1915(k) option ("in-home supports")[25] in new federal healthcare reform law as an alternative to PCA services, and if it is a viable option, needs to seek a state plan amendment to include this option as soon as possible.

(c) DHS must track community living outcomes for people with mental illness who lose PCA services in order to determine the effects of the loss of PCA services, the alternative services put into place for persons losing PCA services, and the effectiveness of the alternative services.

23 H.R.1424. 110th Congress (2007 - 2008).

24 2009 Laws of MN, Chapter 76, Art. 8.

25 Sec. 1915. [42 U.S.C. 1396n. (k)

4. Mental Illness/Chemical Dependency (MI/CD)

Roughly 50% of people with a psychiatric diagnosis also deal with a substance abuse component.[26] This population is currently served inadequately in our state. As a result, they are frequently involved with the criminal justice system rather than in appropriate treatment. Integrated Dual Disorder Treatment (IDDT) is an "evidenced-based practice", shown to be effective based on research. Currently, IDDT is available on a very minimal basis to people in our state.

Recommendation:

The governor and legislature should invest significant resources to expand the availability of Integrated Dual Disorder Treatment in both inpatient and outpatient settings in Minnesota.

5. State Operated Services (SOS) Redesign

A small percent of children and adults with complex needs are not well-serviced in our current mental health system.[27] These people need the appropriate level of care in the right setting at the right time. As directed by the Laws of Minnesota 2010, First Special Session, Chapter 1, Article 19, Section 4, a Chemical and Mental Health Services (CMHS) Transformation Advisory Task Force was established to make recommendations to the commissioner of human services and the legislature on the continuum of services needed to provide individuals with complex conditions including mental illness, chemical dependency, traumatic brain injury, and developmental disabilities access to quality care and the appropriate level of care across the state to promote wellness, reduce cost, and improve efficiency.

The task force was also to make recommendations regarding an array of community-based services in the metro area to transform the services provided at the Anoka Metro Regional Treatment Center. The task force's recommendations had not been submitted as this report went to print."

Recommendations:

(a) Allocate significant resources for individuals with complex conditions who are intensive users of State Operated Services who can and should be served in the community.

(b) Develop intensive long-term living arrangements for this small but complicated population of persons with mental illness.

26 Darrel A. Regier; Mary E. Farmer; Donald S. Rae; Ben Z. Locke; Samuel J. Keith; Lewis L. Judd; Frederick K. Goodwin, Comorbidity of Mental Disorders With Alcohol and Other Drug Abuse: Results From the Epidemiologic Catchment Area (ECA) Study. Journal of the American Medical Association, Nov 1990; 264: 2511-2518. Twenty-six percent of all sheltered persons who are homeless have a severe mental illness and 37% of all sheltered adults who are homeless have chronic substance use issues. These statistics refer to a given night in January 2008. U.S. Department of Housing and Urban Development (HUD). (2009). The 2008 Annual Homeless Assessment Report to Congress. Washington, DC.

27 *Chemical and Mental Health Services Transformation: State Operated Services Redesign in Support of the Resilience &Recovery of the People We Serve. State Operated Services Report to the 2010 Legislauture*, March 2010; and *Minnesota Department of Human Services State Operated Services Consumer Focus Group Results*, May 2010.

Housing

Background

When safe, stable, affordable housing with adequate support services is not available for those affected by mental illnesses, the challenges and expenses to consumers, families, providers and government entities increase exponentially. Efforts are being made to search for cost effective means to better meet the critical housing needs.

In early 2010, the Chemical and Mental Health Services State Operated Services Administration of the Department of Human Services conducted consumer focus groups around the state. Common themes that arose included the need for better coordination of services, the need for an array of housing options and the availability of housing with supports.

The current array of housing options in some communities may consist of rental assistance vouchers or residential programs. The current voucher system, primarily Section 8[28] and Bridges[29] continues to see increased waiting lists of 2-5 years, with fewer people moving off vouchers during the current economic distress. What is missing in most communities is a continuum of housing options that provides a broad array of choice. The continuum needs to include shared housing options, home ownership and other models of permanent housing, along with adequate support services.

> Decent, safe, and affordable community-based housing that provides residents with the rights of tenancy under state and local landlord/ tenant laws and is linked to voluntary and flexible support services designed to meet residents' needs for preferences. *Carol Bianco: 2010 National Mental Health Block Grant and Data Conference presentation.*

Studies have shown that supportive housing for people with mental illness leads to more housing stability, improvement in mental health symptoms, reduced hospitalizations and increases satisfaction and quality of life.[30] Supportive housing gives participants immediate, permanent housing in their own apartments, homes or other setting of their choice and offers residents access to a comprehensive array of services and supports when they need them.

Supportive housing can be available in various models, but there are common themes. The services and supports are individualized, flexible, and facilitate full integration into the community by encouraging employment, volunteering, and social activities. Services can include medication management, case management, Assertive Community Treatment (ACT), Adult Rehabilitative Mental Health Services (ARMHS), tenant service coordination, training in social skills or homemaking aids.

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28 The U.S. Department of Housing and Urban Development (HUD) Section 8 Rental Voucher Program enables affordable housing choices for very low-income households by permitting families to choose privately owned rental housing. Section 8 (Housing Choice) tenants qualify for federal housing assistance for a number of different reasons. There are no racial, ethnical or other criteria over who may or may not qualify. www.hud.gov

29 Bridges is a collaborative program between the state Department of Human Services and Housing Finance Agency that offers rental assistance that provides interim rental assistance for persons with serious mental illness, who may or may not also be long-term homeless, until they receive Section 8 Rental Assistance. Participants must be eligible to receive a Section 8 Housing Choice Voucher subsidy or currently on Section 8 waiting lists. The Bridges program is administered to participants by the local housing agency in communities where eligible applicants live. Referral to the program must be made by a mental health professional. www.mnhousing.gov/initiatives/housing-assistance/rental/MHFA_000479.aspx

30 See the SAMHSA Housing Toolkit at http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/housing/

The most significant road block to providing supportive housing is the cost not typically covered by either the service source or the capital resource. There may be a revenue shortfall to cover the difference between the cost of operating the housing development and rents paid by low income tenants and the unique costs to cover the operation of supportive housing (e.g., front desk expenses, tenant services coordination, etc.). Currently the Department of Human Services Adult Mental Health Division and Minnesota Housing Finance Agency (MHFA) collaboratively administer Housing with Supports for Adults with Serious Mental Illness (HSASMI), which offers an operating subsidy for developments to cover these costs of supported housing.

Recommendations:

(a) The Department of Human Services extend their current task force on housing to provide a statewide cost effective plan to implement a more comprehensive continuum of housing for people with a mental illness. This choice should include shared housing options, home ownership and other models that provide the coordination of the necessary services people need to remain living as independently as possible.

(b) Continued and increased funding of the for the Housing with Supports for Adults with Serious Mental Illness (HSASMI) and Bridges programs so the options for supportive housing are available in more communities statewide.

(c) That State Operated Services partner with communities and contribute fiscal and human resources for the coordination of housing supports during their current process of redesign for the Chemical and Mental Health Division. See also Item 5 on page 18.

Array of Housing Options:

1. Supervised Group Housing: 24-hour on-site staff.
   Example: Multi-person supportive living facility.
2. Partially Supervised Group Housing: Staff on-site as needed.
   Example: Multi-person group homes and residential homes.
3. Independent Congregate Living: No staff on-site, but may include limited services.
   Example: Non-supervised group homes, boarding homes.
4. Shared Housing: Scattered site in community. Housing is separate from services.
   Example: 2 or more individuals sharing an apartment or home.
5. Subsidized Housing Voucher: Private market, public and non-profit housing projects. Housing is separate from services.
6. Home Ownership: Permanent homes and condos. Housing is separate from services.

Local Advisory Mental Health Advisory Councils

Background

Minnesota Statutes require county boards to establish "a local mental health advisory council (LAC) or mental health subcommittee of an existing advisory council" with specific membership and duties for adult and children's mental health (or combined).[31] The State Advisory Council on Mental Health is required to help with coordination of local advisory councils.[32]

1. Establishment of LACs

Some counties do not have an LAC, while others may only have an adult or children's LAC. Some LACs do not fulfill all of their statutory duties or membership requirements.

Recommendation:

In order to assure that county boards and local advisory councils are meeting their statutory requirements some process for accountability needs to exist. The Department of Human Services should work with the State Advisory Council to develop a process of accountability, through uniform reporting, that will help identify the needs of individual counties so the state can better help counties to meet their statutory requirements.

2. LAC Training

In October 2008 a statewide LAC conference was held and was a huge success. Participants at the conference showed great interest in continued networking and leadership training. An interactive tool for LACs that was recommended in our *2008 Report to the Governor and Legislature* was initiated in June 2010. This website will enable LACs to better communicate with each other, and increase the awareness of the State Advisory Council and Children's Subcommittee about local issues.

In addition, the Mental Health Association of Minnesota (MHAM) received a contract from the Department of Human Services to engage in personal visits with adult LACs across the state where it shared information vital to their effectiveness and assisted them with goal setting and follow up.

Recommendations:

(a) The Department of Human Services should continue the work begun in training local advisory councils in leadership, consumer involvement, and advocacy, and expand the work to training children's LACs.

(b) The Department of Human Services should develop a system to hold regional consumer/family membership meetings to be held regularly to educate and support leadership in LACs.

31 M.S. 245.466 Subd. 5 and M.S. 245.4875 Subd. 5

32 M.S. 245.697 Subd. 2 (8) and M.S. 245.466, Subd. 5 (4)

3. Support for consumers and family members on LACs

Counties were established primarily for consumers and family members to provide input to their county board on unmet needs and other issues within the mental health system.[33] Some counties are already providing financial support to their consumer and family members to help them attend the meetings. When professionals are getting paid for their time to attend LACs, it makes sense that consumers and family members do as well. A stipend for time and expenses requires minimal funding, and helps to recruit and retain consumers and family members on LACs.

Recommendation:

The state should develop a mechanism with counties where adequate funds for LAC operations should be provided, including expense reimbursement and stipends (per diem), for consumers and family members who cannot obtain expense reimbursement or compensation from other sources. This will encourage and validate the participation of consumers and family members. Expense reimbursement and per diem should be consistent with amounts paid for other county councils, committees and work groups.

33 M.S. 245.466 Subd. 5 (3) and M.S. 245.4875 Subd. 5 (b) and (c)

Appendix A

Minnesota Statutes 245.697

245.697 STATE ADVISORY COUNCIL ON MENTAL HEALTH.

Subdivision 1. **Creation.** A State Advisory Council on Mental Health is created. The council must have 30 members appointed by the governor in accordance with federal requirements. In making the appointments, the governor shall consider appropriate representation of communities of color. The council must be composed of:

(1) the assistant commissioner of mental health for the department of human services;

(2) a representative of the Department of Human Services responsible for the medical assistance program;

(3) one member of each of the four core mental health professional disciplines (psychiatry, psychology, social work, nursing);

(4) one representative from each of the following advocacy groups: Mental Health Association of Minnesota, NAMI-MN, Mental Health Consumer/Survivor Network of Minnesota, and Minnesota Disability Law Center;

(5) providers of mental health services;

(6) consumers of mental health services;

(7) family members of persons with mental illnesses;

(8) legislators;

(9) social service agency directors;

(10) county commissioners; and

(11) other members reflecting a broad range of community interests, including family physicians, or members as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the governor. The council shall select a chair. Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. Notwithstanding provisions of section 15.059, the council and its subcommittee on children's mental health do not expire. The commissioner of human services shall provide staff support and supplies to the council.

Subd. 2. **Duties.** The State Advisory Council on Mental Health shall:

(1) advise the governor and heads of state departments and agencies about policy, programs, and services affecting people with mental illness;

(2) advise the commissioner of human services on all phases of the development of mental health aspects of the biennial budget;

(3) advise the governor about the development of innovative mechanisms for providing and financing services to people with mental illness;

(4) encourage state departments and other agencies to conduct needed research in the field of mental health;

(5) review recommendations of the subcommittee on children's mental health;

(6) educate the public about mental illness and the needs and potential of people with mental illness;

(7) review and comment on all grants dealing with mental health and on the development and implementation of state and local mental health plans; and

(8) coordinate the work of local children's and adult mental health advisory councils and subcommittees.

Subd. 2a. **Subcommittee on Children's Mental Health.** The State Advisory Council on Mental Health (the "advisory council") must have a Subcommittee on Children's Mental Health. The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health. Members of the subcommittee must include:

(1) the commissioners or designees of the commissioners of the Departments of Human Services, Health, Education, State Planning, and Corrections;

(2) the commissioner of commerce or a designee of the commissioner who is knowledgeable about medical insurance issues;

(3) at least one representative of an advocacy group for children with emotional disturbances;

(4) providers of children's mental health services, including at least one provider of services to preadolescent children, one provider of services to adolescents, and one hospital-based provider;

(5) parents of children who have emotional disturbances;

(6) a present or former consumer of adolescent mental health services;

(7) educators currently working with emotionally disturbed children;

(8) people knowledgeable about the needs of emotionally disturbed children of minority races and cultures;

(9) people experienced in working with emotionally disturbed children who have committed status offenses;

(10) members of the advisory council;

(11) one person from the local corrections department and one representative of the Minnesota District Judges Association Juvenile Committee; and

(12) county commissioners and social services agency representatives. The chair of the advisory council shall appoint subcommittee members described in clauses

(3) to (11) through the process established in section 15.0597. The chair shall appoint members to ensure a geographical balance on the subcommittee. Terms, compensation, removal, and filling of vacancies are governed by subdivision 1, except that terms of subcommittee members who are also members of the advisory council are coterminous with their terms on the advisory council. The subcommittee shall meet at the call of the subcommittee chair who is elected by the subcommittee from among its members. The subcommittee expires with the expiration of the advisory council.

Subd. 3. **Reports.** The State Advisory Council on Mental Health shall report from time to time on its activities to the governor, the chairs of the appropriate policy committees of the house and senate, and the commissioners of health, employment and economic development, and human services. It shall file a formal report with the governor not later than October 15 of each even-numbered year so that the information contained in the report, including recommendations, can be included in the governor's budget message to the legislature. It shall also report to the chairs of the appropriate policy committees of the house and senate not later than November 15 of each even-numbered year.

History: 1987 c 342 s 2; 1988 c 629 s 45; 1988 c 689 art 2 s 95,96; 1989 c 282 art 4 s 56-58; 1990 c 568 art 5 s 29; 1991 c 292 art 6 s 27; 1994 c 483 s 1; 1Sp1995 c 3 art 16 s 13; 1997 c 7 art 2 s 33,34; 1997 c 192 s 32; 1999 c 39 s 1; 2003 c 112 art 1 s 17; 2003 c 130 s 12; 2004 c 206 s 52

Appendix B

Minnesota State Advisory Council on Mental Health

Member	Affiliation
Phyllis Brashler Minnesota Department of Health	Rep. of Minnesota Department of Health
Jan Buntz Minneapolis	Rep. of family members of persons with mental illnesses.
Theresa Carufel Minneapolis	Rep. of family members of persons with mental illnesses.
Kate Casserly Maple Grove	Rep. of parents of children with emotional disturbances.
Claire Courtney Department of Employment and Economic Development	Rep. state vocational services agency
Paula DeSanto Minneapolis	Rep. of providers of mental health services.
Michelle Frauenshuh Woodbury	Rep. of parents of children with an emotional disturbance.
Amanda Gramlich Minneapolis	Rep. of the discipline of social work.
Troy Hanson New Prague	Rep. of family physicians.
Susan Haugen Minnesota Housing Finance Agency	Rep. of Minnesota Housing Finance Agency.
Harriett Copher Haynes St. Paul	Rep. of discipline of psychology.
Teri Herder-Blahnik Walnut Grove	Rep. of consumers of mental health services.
Patty Holycross Cohasset	Rep. of family members of persons with mental illnesses.
Renée Jenson St. Paul	Rep. of consumers of mental health services.
Tom Johnson Roseville	Rep. of the Mental Health Association of MN.

Member	Affiliation
James Jordan St. Paul	Rep. of discipline of psychiatry.
Nicole Lynch Apple Valley	Rep. of discipline of nursing.
Ken Moorman Baudette	Rep. of county commissioners (Lake of the Woods County).
Heidi Nordin Eagan	Rep. of the National Alliance on Mental Illness (NAMI).
Representative Bud Nornes Fergus Falls	Rep. of state legislators (House of Representatives).
Annie Pierre Le Sueur	Rep. of consumers of mental health services.
WENDY REA St. Cloud	CHAIR OF ADVISORY COUNCIL. Rep. of consumers of mental health services.
Senator Kathy Sheran Mankato	Rep. of the Minnesota State Senate.
Read Sulik Minnesota Department of Human Services	Rep. of state mental health and social services agency.
Timothy B. Walsh Shakopee	Rep. of county social services directors (Scott County).
ALISON WOLBECK Moorhead	VICE CHAIR OF ADVISORY COUNCIL. Rep. of consumers of mental health services.

Appendix C

Subcommittee on Children's Mental Health

Member	Affiliation
Sue Abderholden Minneapolis	Rep. of an advocacy group for children with emotional disturbances (NAMI – MN).
Steve Allen Minnesota Department of Corrections	Rep. of state juvenile corrections agency.
ZEHRA ANSARI White Bear Lake	CO-CHAIR OF SUBCOMMITTEE Rep. of persons knowledgeable about the needs of children with emotional disturbances of minority races and cultures.
Paul Bailey Isle	Rep. of county commissioners (Aitkin County).
Phyllis Brashler Minnesota Department of Health	Rep. of state health agency.
Tovarich Bourne Hastings	Rep. of parents who have children with emotional disturbances.
Kate Casserly Maple Grove	Rep. of parents who have children with emotional disturbances.
Glenace Edwall Director, Children's Mental Health Division Department of Human Services	Rep. of state mental health agency.
BraVada Garrett-Akinsanya Golden Valley	Rep. of people experienced in working with children with emotional disturbances who have committed status offenses.
Judy Gilow Winona	Rep. of parents who have children with emotional disturbances.
Jamie Halpern Area Manager, Children's Mental Health Hennepin County Human Services and Public Health Department	Rep. of county social services agencies (Hennepin County).
LINDA HANSEN Dakota County Juvenile Services Center	CO-CHAIR OF SUBCOMMITTEE. Rep. of local corrections department.

Member	Affiliation
Troy Hanson New Prague	Rep. of State Advisory Council on Mental Health.
Christine Harnack Vadnais Heights	Rep. of providers of mental health services to adolescent children.
Lisa Hoogheem St. Paul	Rep. of educators currently working with children with emotional disturbances.
Jeffrey Lind Bemidji	Rep. of county social services agencies (Beltrami County).
Sherri Mortensen Brown Minnesota Department of Commerce	Rep. of state agency regulating private insurance (Commerce department).
Renelle Nelson Minneapolis	Rep. of an advocacy group for children with emotional disturbances (PACER Center).
Charlie Olson Parkers Prairie	Rep. of present or former consumers of adolescent mental health services.
Richard Oni St. Paul	Rep. of persons knowledgeable about the needs of children with emotional disturbances of minority races and cultures.
Kate Onyeneho Burnsville	Rep. of persons knowledgeable about the needs of children with emotional disturbances of minority races and cultures.
George Realmuto Minneapolis	Rep. of hospital-based providers of children's mental health services.
Becky Romosz Willmar	Rep. of parents of children with emotional disturbances.
Deborah Saxhaug St. Paul	Rep. of an advocacy group for children with emotional disturbances (Minnesota Association for Children's Mental Health).
Nancy Schouweiler Inver Grove Heights	Rep. of county commissioners (Dakota County).
David Stern Alexandria	Rep. of providers of children's mental health services to pre-adolescent children.
Benjamin Woodcock Brooklyn Center	Rep. of present or former consumers of adolescent mental health services.
Robyn Widley Minnesota Department of Education	Rep. of state education agency.