Minnesota State Advisory Council on Mental Health

Subcommittee on Children's Mental Health

2014 Report to the Governor and Legislature

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Letter from the Chairs

The State Advisory Council on Mental Health and Subcommittee on Children's Mental Health commend the governor and legislature for the advances in mental health services that you have accomplished since our 2012 Report.

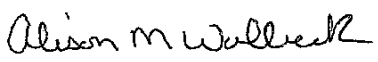
We heartily endorse the restoration and hoped for growth of funding for mental health resources.We applaud the research efforts to quantify adverse childhood experiences and to understand their relationship to community health.

The support of early childhood programs in all areas of health and education will help families be stronger and healthier. We thank you for your continued investment in school linked mental health services.

The new focus on community health by the governor and department commissioners will complement the national movement toward integration of primary care with mental health and chemical dependency care.

We now look to the years ahead. Minnesota will have the challenge, and opportunity, to reshape and restructure its service system to meet the requirements of the Olmstead Plan.This may call for revamping mental health policies, as well as introducing and expanding existing services.

Our recommendations are based on a belief in recovery and resiliency. We look forward to continued work with the governor, legislature, and state departments in the hope that you will take additional steps to implement as many of our recommendations as possible.



Alison M. Wolbeck
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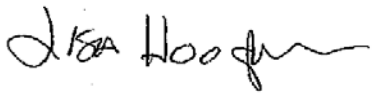

Lisa Hoogheem
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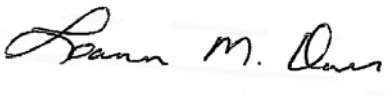

Leann M. Dorr
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Executive Summary

The State Advisory Council on Mental Health was established in 1987[1]. The Council was charged to make recommendations to the Governor and state departments on policy, programs, and services affecting individuals with mental illness. By including representatives from virtually all groups with an interest in the mental health system, the vision was to have a body that would make recommendations by a consensus of all viewpoints.

The Subcommittee on Children's Mental Health was established in 1989[2] with a similar array of stakeholders of the children's mental health system in order to make recommendations to the State Advisory Council.

The recommendations in this report are organized by chapters representing the work groups on the State Advisory Council and Children's Subcommittee.

The work groups are:

- Schools and Mental Health
- Outreach to Diverse Communities
- Mental Health and Juvenile Justice
- Families and Communities
- Housing and Homelessness
- Primary Care and Mental Health Reforms

A summary of their recommendations is as follows:

Schools and Mental Health

Education on Suicide

Suicide is the second leading cause of death for youth in Minnesota.Twenty-five percent of public school ninth graders in Minnesota have thought about killing themselves and twenty percent of public school ninth graders in Minnesota have hurt themselves on purpose at some time[3]. Children need access to information and supports to prevent suicide.

In 2013, the Minnesota Legislature provided funding to expand the suicide prevention program TXT4Life[4]to additional areas of the state. TXT4Lifeis a suicide prevention program that was used by over 4,420 youth and young adults over the first two years of the service. The funding is about 25% of what is needed to expand the program statewide.

Crisis interventions are face-to-face, short-term intensive interventions during a mental health emergency to assist a child coping with immediate stressors and avoid unnecessary hospitalization. There are currently 16 mobile crisis teams in the state, with a limited number that operate 24/7. Resources are needed to increase the number of teams and expand the services to more home, school, and community settings.

[1] Minnesota Statute 245.697.
[2] Minnesota Statute 245.697 Subd. 2a.
[3] 2013 Minnesota Student Survey, http://education.state.mn.us/MDE/StuSuc/SafeSch/MNStudentSurvey/
[4] See also, TXT4Life Crisis Counseling Program, Crisis Connection.

Positive Behavior Intervention and Supports (PBIS)

In 2004, the Minnesota Department of Education created a state action plan for supporting schools to implement School Wide Positive Behavior Intervention and Supports (PBIS). There have been 473 schools trained for implementation. The benefits of PBIS programs in schools are teaching and learning environments that:

- Are more engaging, responsive, preventative, and productive
- Are less reactive, aversive, dangerous, and exclusionary
- Address classroom management and disciplinary issues (e.g. attendance, tardiness, anti-social behavior)
- Improve supports for students whose behavior or symptoms require more specialized assistance (e.g. emotional and behavioral disorders, mental health)
- Maximize academic engagement and achievement for all students

In the past, school-wide discipline has focused mainly on reacting to specific student misbehavior by implementing punishment-based strategies including reprimands, loss of privileges, office referrals, suspensions, and expulsions. Research has shown that the implementation of punishment, especially when it is used inconsistently and in the absence of other positive strategies, is ineffective.

Introducing, modeling, and reinforcing positive social behavior is an important step of a student's educational experience. Teaching behavioral expectations and rewarding students for following them is a much more positive approach than waiting for misbehavior to occur before responding. The purpose of school-wide PBIS is to establish a climate in which appropriate behavior is the norm. Data shows that PBIS is working to reduce the number of disciplinary actions taken in schools.

Currently, only 24% of schools across the state are implementing PBIS. There is a need to train additional cohorts. Further, experience has shown that a number of factors (including turnover in administrative and teaching staff) prompt development of recertification training for schools.

School Linked Mental Health Grants

State infrastructure grants support School Linked Mental Health Servicesthroughout Minnesota. There are currently 36 grantees. These school-connected clinical mental health treatments include interventions that:

- Increase accessibility for children and youth who are uninsured or underinsured
- Improve clinical and functional outcomes for students with a mental health diagnosis
- Improve identification of mental health issues for children and youth

The services connect or co-locate effective mental health services with schools and students at the local level. They are particularly effective in reaching children who have never accessed mental health services, particularly students of color.

School linked grants have achieved tremendous outcomes[5]. Dr. Glenace Edwall of the Minnesota Department of Human Services presented on Minnesota's achievements at the NAMI Cigna Forum on Health on June 4, 2014 in Washington, D.C[6].

[5]"Modeling after Minnesota: Achieving Positive Results for Students", Glenace Edwall, Psy. D., Ph.D., Director, Children's Mental Health Division, Minnesota Department of Human Service, National Alliance on Mental Illness, June 5,

We recommend:

- Increase funding for coordinated suicide prevention activities at the Departments of Health, Human Services and Education to assist schools and communities.
- Support full expansion of the TXT4Life program.
- Support full expansion of youth mobile crisis teams to provide services 24-hours a day and require trainings for mobile crisis teams specific to youth mental health issues and cultural practices.
- Provide funding for at least 40 additional PBIS schools per year (as in the proposed Olmsted plan).
- Provide funding to support maintenance for the previous cohorts (ongoing coaching, and new staff to refresh training)
- Provide ongoing support and increase funding for the School Linked Mental Health grants.
- Align Positive Behavior Interventions and Supports and the School Linked Mental Health Grant work. The alignment would establish a continuum of supports that are needed for students to be successful.

Outreach to Diverse Communities

Minorities have less access to, and availability of, mental health services. Minorities are less likely to receive needed mental health services. Minorities in treatment often receive a poorer quality of mental health care. Minorities are underrepresented in mental health research. The recognition of these disparities brings hope that they can be seriously addressed and remedied[7].Startling new findings make clear that disparities in mental health exhibit a decidedly different pattern from disparities in other kinds of health[8].

Increasing the proportion of racial minority providers is considered an important factor for reducing health disparities. This is even more important for mental health care, whereproviders from ethnic minorities are more poorly represented than in health care in general[9].

The racial and health disparities for children impacted by mental illness and living in poverty are compounded by the critical shortage of child psychologists, where there is estimated to be only one for every 7,000 children in the country, as reported in the Congressional Record H26 on January 8, 2014.

A state commitment to the outreach and educational support necessary to build a truly diverse mental health workforce is a critical policy recommendation for decreasing disparities in mental

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2014.http://www.nami.org/Template.cfm?Section=Top_Story&template=/ContentManagement/ContentDisplay.cfm&ContentID=168861

"Thousands of children to benefit from $45M for school-linked mental health", Department of Human Services press release, May 8, 2014.http://mn.gov/dhs/media/news/news-detail.jsp?id=252-128913

[6]http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Child_and_Adolescent_Action_Center/Childrens_Mental_Health_Forum/GlenaceEdwallSchoolLinked.pdf

[7]Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US).Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2001 Aug.

[8]Health Aff (Millwood). 2008 Mar-Apr; 27(2):393-403. doi: 10.1377/hlthaff.27.2.393. "New evidence regarding racial and ethnic disparities in mental health: policy implications".http://www.ncbi.nlm.nih.gov/pubmed/18332495

[9]"Review of the Minnesota Mental Health Workforce Recommendations Specific to African-American, Hmong, and Latino Communities," submitted June 30, 2014 by Willie B. Garrett Ed. D, and Alyssa K. Vang, Psyd, including Minnesota Statistics that "less than 3% of all mental health professionals in Minnesota are minorities, while people of color make up approximately 15% of the population."

health care. A more diverse workforce would likely provide not only more culturally appropriate treatment, but also language skills to match those of clients been served.

The Outreach to Diverse Communities Work Group commends the Governor and the Legislature for the diversity grant made available since 2007 to build capacity by increasing more licensed mental health practitioners and professionals from communities of color. This grant allows for free clinical supervision, and pays for study and test materials.

We recommend:

Workforce Development:

- Fully support implementation of the recommendations ofthe Mental Health Workforce Task Force to be outlined in their report to the Minnesota Legislature with particular attention to expanding financial incentives. Examples:
  - Scholarships, grants, stipends, and low interest loans[10] (20% of funding reserved for racial minorities).
  - Paid internships and training (20% reserved for racial minorities)
  - Promotion and funding of ethnic research by Minnesota State Colleges and Universities (MNSCU) educators.
- Education institutions (MNSCU) and training programsshould define and educate (i.e. create a roadmap for) minority students on the process of becoming a mental health professional.
- Recruit minorities at every level of contact(including other states and internationally).
- Establish a system of minority mentors at all levels of mental health practice, in rural and urban communities, and at all major behavioral health organizations which would include online or tele-mentoring.

Cultural and Linguistic Competence of the Mental Health Workforce:

- Immersion training in cultural and linguistic competence for all professional disciplines working with children that require state licensure. Forty to fifty hours of immersion training should be a requirement to obtain and maintain professional licenses that apply to professionals such as teachers, medical professionals, mental health professionals, corrections workers, and police officers.
- Establish a procedure for immigrants that have a comparable education or degree and have practiced as a professional in another country to receive credit for qualified foreign education and work experiencefor mental health professional licensure, including licensure testing in their second language[11].

Multi-Cultural Representation:

[10]https://www.google.com/?gws_rd=ssl#q=cultural+minority+Scholarships%2C+grants%2C+stipends%2C+and+low+interest+loans

[11]See *Credentialing Recognition in the United States for Foreign Professionals,* European Union (May 2013) at: http://www.migrationpolicy.org

- There should be multi-cultural representation on all state agency Requests for Proposals (RFPs) advisory group meetings related to diverse communities, including grants, funding, racial disparities, certification, credentialing processes for interpreters, and alternative testing and licensure of mental health professionals.
- Require 15% minority mental health professionals at workplaces to create a cultural presence and reflection of community diversity.

Interpreter Services:

- Minnesota health benefit plans (private and public) should include reimbursement specifically for interpreter services when a provider who speaks the language and understands the culture of the consumer of mental health services is not available.
- Establish a statewide tele-interpreter system.

Mental Health and Juvenile Justice

State Office of Juvenile Justice

The criminal justice system was initially designed to address the needs of adults who had committed criminal offenses. Unfortunately, the needs of juvenile offenders have not always been addressed in a comprehensive and inclusive manner. There is no over-arching entity that directs how services should be deliveredor that is evaluating outcomes.

The Governor should establish a State Office of Juvenile Justice, with an accountable, high-level leadership function in the Department of Human Services.

Duties of the Office should include:

- Provide direction in meeting unmet or underserved mental health needs of youth involved or at risk of involvement in the juvenile justice system.
- Lead collaboration of state, regional, and local juvenile correction systems.
- Identify funding opportunities and best practices to address mental health and substance use needs of youth in juvenile justice, including special attention to cultural and gender disparities.

School Based Diversion Program

In 2012, we recommended that to prevent the unnecessary engagement of youth in the juvenile there needs to focus on "Key Access Points"[12], where youth with unmet mental health needs come into contact with the justice system.Last year a new model was developed to address the issue of the school to prison pipeline. The Minnesota model is a school-based diversion program for students with co-occurring disorders.

We recommend:

- Partner with the Minnesota Chiefs of Police Association, six school sites and their local partners to plan to implement the model statewide to address the "school to prison pipeline" public policy issue.

[12] 2012 State Advisory Council Report to the Governor and Legislature, page 17.

Juvenile Detention Alternatives Initiatives

Counties across the state continue to make progress with youth charged with both criminal and status offences through Juvenile Detention Alternatives Initiatives (JDAI), which have led to alternatives to detention. This has led to fewer youth detained for longer periods which have resulted in decreased costs of placement.

We recommend:

- The number of Juvenile Detention Alternatives Initiatives (JDAI) is increasing in Minnesota. Additional resources are needed to expand implementation of JDAI to additional counties, andat the state level.

Families and Communities

Early Intervention

The Governor has emphasized early intervention of school and health resources in the lives of children. Good early childhood mental health is interwoven with a young child's development and overall health. Adverse Childhood Experiences[13] (ACEs[14]) experienced in childhood or as an adolescent can affect a person throughout his or her lifetime. ACEs are specifically linked to poor physical and mental health, chronic disease, lower educational achievement, lower economic success, and impaired social success in adulthood[15].

Early intervention can reverse the effects of ACEs. The Departments of Human Services (DHS), Health (MDH), and Education (MDE) have programs that are analyzing the earliest possible interventions to help parents be the best possible caregivers. Through such identification the departments may be able to develop new methods and mental health resources to address early intervention.

We recommend:

- The Department of Education should provide special education workers referrals to mental health professionals trained in multi-generational interventions to facilitate smoother transitions in accessing their services.
- Expand the number of mental health professionals trained in working with children ages 0-5 and increase support for their in-home services.

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[13] http://www.health.state.mn.us/divs/cfh/program/ace/content/document/pdf/acesum.pdf

[14] See also http://www.macmh.org/wp-content/uploads/2014/05/41_Baum-+Adolfson+-Maruska_Adverse-Childhood-Experiences.pdf

[15] Dave McCollum, a retired physician who integrated ACEs and trauma-informed practices in his emergency room work, narrated a slide show that reports on Adverse Childhood experiences among teenagers from the 2013 Minnesota Student Survey. In the 2013 study, 84% of the state's public schools participated in the survey. Only students in the 9th, 10th, and 11th grades answered the questions relating to adverse childhood experiences. The questions were similar to those on the original ACE Study, but did not include them all. Please view the 15-minute ACEs presentation accessed with the following link. It was developed for the Minnesota Association of Children's Mental Health. http://www.acesconnection.com/blog/the-numbers-in-this-minnesota-student-ace-survey-can-make-you-cry-14-min. Be sure to click the icon with 4 arrows next to the HD logo below the screen to enlarge the image.

- The Departments of Health, Human Services, and Education should improve their collection of data and their analysis of their early identification programs in order to develop methods to access additional programs and resources.
- Long-term intensive home visiting programs that enhance parent-child relationships.

Multi-Generational Mental Health

Parents with Mental Illness

A mother's mental illness can interfere with her ability to provide the sensitive care that a young child needs for healthy brain development[16]. Sensitive care is the caregiver's ability to be aware of the child's signals and needs, and to respond to these in a manner that is timely, meaningful, accurate to the emotion, and generally appropriate[17]. The factors that contribute to sensitive caregiving by mothers with mental illness are not well understood. However, research has shown that three factors affect a parent's caregiving quality:[18]

- Parental adverse childhood experiences.
- Parental reflective functioning (the ability for parents to understand and respond to the needs, wants, feelings, and desires of their children). Such understanding allows a mother to create both a physical and psychological experience of comfort and safety for her child.
- Parental social support.

The Department of Human Services Adult and Children's Mental Health Divisions has funded three programs to investigate the parenting needs of adult mothers with serious mental illness raising children under the age of five. While extensive data analysis has not yet occurred, we know that the parents with mental illness experienced an average of six to seven types of traumas as children.

Based on Minnesota data -- five or more Adverse Childhood Experiences (ACES) often lead to higher risk for mental health, physical health, and chemical health issues than do fewer ACEs.

As a result of the grant, two policies have already been changed:

- Adult mental health providers can now bill for child developmental and mental health screenings through Child and Teen Checkups (to be piloted by the three funded agencies);
- Adult Rehabilitative Mental Health Services (ARMHS) services now include parenting services.

Results indicate that between maternal reflective functioning(the ability for parents to understand and respond to the needs, wants, feelings, and desires of their children), significantly correlates with sensitive caregiving. Standard parenting classes that do not support both parenting skills and parental reflective functioning may be insufficient in changing parenting behavior of parents with clinical issues.Many parents with mental illness who have young children may need psychotherapies provided in their homes as opposed to outpatient offices. Funding for rate changes and the extra

[16] Campbell et al., 2004; Center on the Developing Child at Harvard University (CDCHU), 2009; Conroy et al., 2012; Wan, Warren, Salmon, & Abel, 2008. Maternal Depression Can Undermine the Development of Young Children

[17] Ainsworth, Bell & Stayton, 1974; Journal of European Psychology Students, 2010

[18] Sroufe, Egeland, Carlson, & Collins, 2005

time needed for transportation by the mental health professionals is needed to develop their in-home practice. Further study into the factors that contribute to the parenting sensitivity of mothers with serious mental illness is strongly recommended.

New Programs Needed for Teens

Particular attention should be focused on adolescents. This is because of what research tells us about their health and behavior in relation to the number of their adverse childhood experiences; what we know aboutbrain development during those years, and their future role as parents.

Responses to ACE Study questions that were included in the 2013 Minnesota Student Survey results for 8th, 9th and 11th graders were analyzed to create the Minnesota Adolescent ACE Study. It identified areas of health and safety for programs that build resilience. Resilience is the positive adaptation within the context of significant adversity.Helping these maturing youngsters develop tools to adapt to adverse experiences will pay dividends in a healthier adult population.

Building Healthy Communities

Despite all these findings, neither resilience nor disease is a certain outcome[19]. There is increasing understanding about resilience and what families, communities, and systems can do to protect children and support adults with ACEs. By reducing ACEs, we can reliably expect a reduction in many ACE-related health and social problems.

We recommend:

- TheState Departments of Human Services, Health, and Education should continue to develop policy and program recommendationsto improve multigenerational mental health outcomes.
- Funding to continue statewide promotion of training and learning opportunities to increase community health and safety, understanding of community leaders, and collaboration of partners about ACEs, trauma, and resilience.
- Funding for projects in local communities through Family Services and Children's Mental Health Collaboratives to develop solutions to regional problems leading to increased resilience and good community health.
- Provide training on effective parenting skills for parents with serious mental illness to mental health clinicians, early childhood and adult providers, and case managers.
- Periodic collection of state-specific data on the relationship of ACEs, health outcomes, and resiliency. Such data will help communities develop strategies to promote mental and emotional well-being
- Increasing support of programs and policies that nurture stable relationships between a consistent caregiver and infant/young child using a two-generation approach. These programs and policies support the adult caregivers in meeting their own needs so that they will be able to enter into secure reflective relationships (the ability for parents to understand and respond to the needs, wants, feelings, and desires of their children) with their children.
- Funding for rate changes and the extra time needed for transportation by mental health professionals to allow for in-home services for mothers with mental illness.
- DHS should initiate steps to develop a multigenerational approach to address the needs of families with children, especially where one or more of the caregivers have a mental illness.

[19]Research and articles

Housing and Homelessness

Housing Subsidies and Assistance Programs

People with a serious mental illness are often the poorest of the poor. The monthly maximum SSI benefit in 2013 for an individual was $710. The median monthly rent in Minnesota is $764.

With a federal Housing and Urban Development (HUD)Section 8 Housing Choice Voucher, or a state Bridges Subsidy Voucher, the renter pays 30% of his or her income for the rental unit.

Resources allocated to the Bridges program are for Minnesotans with serious mental illnesses that areat risk of homelessness or in an institutional level of care.

Bridges currently assists 707 households. In 2013 the Legislature appropriated an additional $400,000 to the Bridges base fund.The Minnesota Housing Finance Agency (MHFA) received 12 proposals for the funding for a total of over $1.4 million. The proposals were for 187 additional households.These figures demonstrate the overwhelming need for Bridges vouchers.

Permanent Supportive Housing Model

An Evidence Based Practice-Permanent Supportive Housing modelwill meet the expectations of the Olmstead Decision and Minnesota's Olmstead Plan. Among its principles are:

- Choice in housing and living arrangements
- Separation of housing and services
- Integration into the community
- Rights of tenancy
- Safe and affordable housing
- Flexible, voluntary, and recovery-focused services

An Evidence Based Practice Permanent Supportive Housing model coordinates housing and support services. This combination helps a person succeed in the community.

Examples of support services include:

- Assistance in accessing a psychiatrist or a psychologist
- Assertive Community Treatment (ACT) team
- Case management
- Medical care coordination
- Personal Care Assistance (Community First Services and Supports)
- Independent Living Skills, Home Health Aides
- Adult Rehabilitation Mental Health Services (ARMHS)
- Individual Placement and Support employment serves

Payment for the coordination of housing and support services has been a barrier to implementing Evidence Based Practice-Permanent Supportive Housing is not reimbursable through Medicaid.

Critical Time Intervention

Critical Time Intervention (CTI) is a time-limited model designed to provide services to keep people with severe mental illness from falling into homelessness after discharge from a hospital, a shelter, a prison, or other institutions. CTI provides emotional and practical support during this critical

transitional period, as well as strengthening the person's ties to natural supports of family, friends, and community resources which can remain available to the person after the CTI support has ended.

Homelessness

While the state has seen a substantial increase in the number of Minnesotans who are homeless since 2007, there has been an encouraging decline in the number of homeless veterans and people considered chronically homeless[20]. We now need to achieve similar results with families and at-risk youth where rates of homelessness have increased since 2007[21].

Minnesota's Plan to Prevent and End Homelessness[22] recommends the establishment of a statewide coordinated assessment plan. This will expedite both needed supports for homeless individuals most in need and the work of community support workers. A coordinated assessment pilot is currently operating in Ramsey County[23]. If the results match the expectations, we would support the expansion and modification of the pilot in a manner that would support coordinated assessments on a statewide basis.

We recommend:

- Additional resources to better address the unmet need of the Bridges Housing program to increase affordable housing opportunities for people with serious mental illnesses.
- Ongoing efforts by state and community stakeholders to find permanent solutions to potential impediments to the Evidence Based Practice Permanent Supportive Housing model and fund an Evidence Based Practice-Permanent Supportive Housing model that links funding for housing and services for people in supportive housing.
- There should be a housing continuum with a diverse array of services that best meets the needs and choices of people with a serious mental illness. We prefer scattered site supportive housing, as opposed to congregate, less integrated setting. This is contingent on the individual's choice.
- Critical Time Intervention supports for people being discharged hospitals, shelters, prisons, and other institutions that are at risk of re-institutionalization.
- Establish a coordinated assessment plan comparable to the Minnesota's Plan to Prevent and End Homelessness to better identify eligible homeless individuals for housing assistance and community supports in a timely manner.
- Full funding of the Homeless and Unaccompanied Youth Act.

Primary Care and Mental Health Reforms

Resources and Responses for Individuals with a Mental Health Crisis

Early intervention and crisis services save money by reducing hospitalizations or more serious consequences.

We recommend:

[20] Key Trends in Affordable Housing; April 10, 2014; Page 5.
[21] Wilder Research, "2012 Minnesota Homeless Study: Homeless Children and Their Families" (May 2014) http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota%202012%20Study/Homeless%20Children%20and%20Their%20Families.pdf
[22] Heading Home: Minnesota's Plan to Prevent and End Homelessness, December 2013
[23] http://www.ramsey.headinghomeminnesota.org/

Sustainable funding for mobile crisis teams for children and adults in all areas of the state.

- Funding for access to crisis stabilization and crisis residential services within an individual's community.
- Statewide training for law enforcement on mental illnesses, crisis de-escalation and local mental health resources for law enforcement.
    - Pre-certification training for new officers
    - On-going certification for current officers
    - 911 dispatcher training to ask the right questions, gather the necessary information, and refer to the appropriate resources
- Training for emergency room personnel on mental illness and crisis de-escalation.
- Funding for additional counties to divert individuals with mental illness or co-occurring disorders to treatment and services when they intersect with the criminal justice system (this is being done in Olmsted County).
- A statewide telephone number and text line for access to mobile crisis teams.

Timely Access to Psychiatric, Counseling, and Community Services

It takes too long for individuals with mental health disorders to access treatment They often wait months for appointments and services. The state should have a holistic approach that integrates mental health evaluation and treatment with primary health care throughout the lifespan.

We recommend:

- Workforce initiatives such as education and training grants and loan repayment/forgiveness programs for mental health professions.
- Develop models for collaboration of community health and mental health agencies in rural areas.
- Authority for mental health professionals to assist an individual with routine services such as medication monitoring, counseling, consultation, and in some cases, home visits.
- Expand mental health urgent care models, similar to the East Metro Urgent Care for Adult Mental Health.

Comprehensive Array of Home and Community Based Mental Health Services that Best Meet the Needs of Children and Adults

Children and adults living with mental illnesses often have difficulty accessing the services and supports they need to be healthy and successful. Those who have accessed community support typically have done so through the Community Alternatives for Disabled Individuals (CADI) waiver or Community First Services and Supports (CFSS) (formerly Personal Care Attendants [PCA][24]).

However, the nursing home level of care criteria used for CADI[25] and CFSS criteria[26] do not adequately account for the needs of individuals with mental illness, which will likely mean that fewer people with mental illnesses will be eligible for those services.

The current definition of dependency for CFSS (PCA) services limits eligibility to people who need "constant" cueing and supervision, i.e., hands-on physical assistance. Previously, people with mental

[24] Minnesota Statutes 256B.85 Community First Services and Supports (2013).
[25] Minnesota Statutes, section 144.0724, subdivision 11 (2013)
[26] Minnesota Statutes 256B.85, Subdivision 1.(c) (2013)

illness were eligible for PCA services when they are physically able to accomplish tasks with cuing and supervision that were necessary to maintain their independence, but might not be categorized as "constant."

We recommend:

- The State should remove the word "constant" for eligibility for CFSS (PCA) services so that individuals with mental illnesses who need prompting and cueing in order to accomplish essential tasks to remain independent in their homes can receive those services.

Integration of People with Mental Illnesses into Department of Natural Resources Programs and Services

Physically disabled people with handicap placards can get into state parks for a reduce fee, regardless of their income. Individuals with mental illness disabilities have to pay the full rate.

Given the state's goal in the "10 x 10" project; to increase the lifespan of people with mental illnesses by 10 years, within 10 years; access to state parks and programs makes good health sense, promotes integration into the community, and reflects parity in the provision of services.

We recommend:

- The Governor, Legislature, and the Department of Natural Resources should support a legislative initiative to make statutes and rules governing the Department of Natural Resources "disability neutral" in their application to people with disabilities.

Psychiatric Consultation to Primary Care Practitioners

Primary care practitioners are often the first place people turn to for mental health issues. However, many primary care providers lack the training and resources necessary to provide mental health care, especially for more serious mental illnesses.

Psychiatric consultation to primary care providers by psychiatrists, psychologists, and psychiatrically trained advanced practice registered nurses is a service available under Medical Assistance, though it is underutilized. Primary care practitioners are not able to receive consultation from all of the professionals who would be qualified to provide this service.

We recommend:

- Modify Minnesota law to allowing any mental health professional to provide mental health consultation to primary care practitioners in order to increase the availability of this service.
- Outreach should be provided to primary care practitioners and mental health professionals about the availability of psychiatric consultation to encourage more providers to utilize this service.

Schools and Mental Health

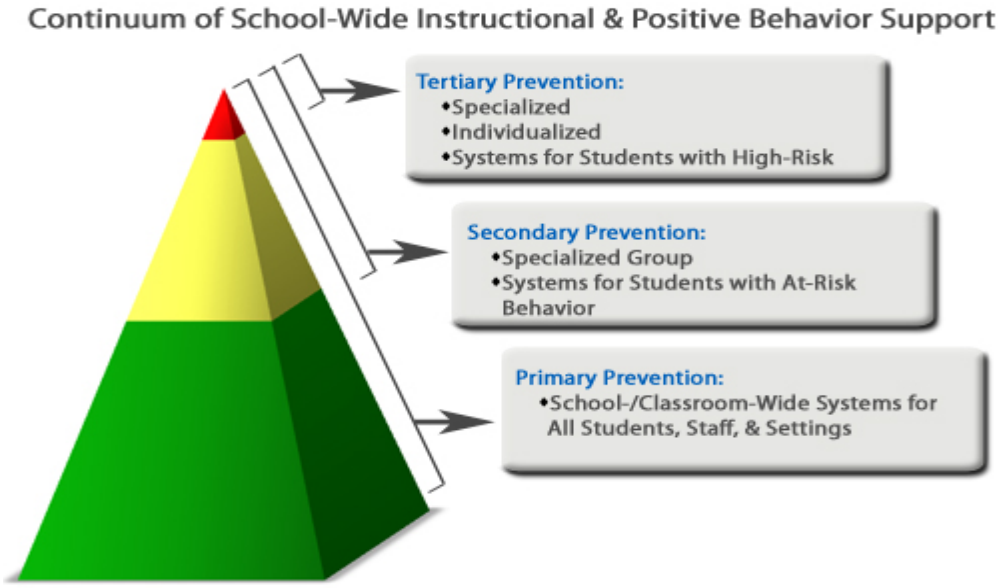
Supporting children's mental health is critical to their success in school. This requires strengthening the alignment of the mental health and school systems, assuring the accessibility of mental health and wellness supports.

This report makes recommendations on three main topics:

- Suicide Prevention
- Positive Behavior Intervention Supports (PBIS)
- School Linked Mental Health Activities

These recommendations bring a balance of hope and concern in the state of Minnesota. Hope because previous funding created many important mental programs and services that have effected positive change in the lives of students. However; there is concern that is not enough. The majority of students and schools still do not have access to these services. Minnesota can do better by expanding the reach and depth of these programs.

In order to articulate the continuum of supports available in schools we have framed our recommendations using a Multi-tiered System of Support (MTSS) model. In this three-tiered prevention and intervention model all students receive supports at the universal or primary tier (green level below). If the universal supports are not sufficient for some students, more intensive behavioral services are provided in the form of specialized groups for students (selected or secondary tier – yellow level below). More highly individualized plans would be at the intensive or tertiary tier (red level below).

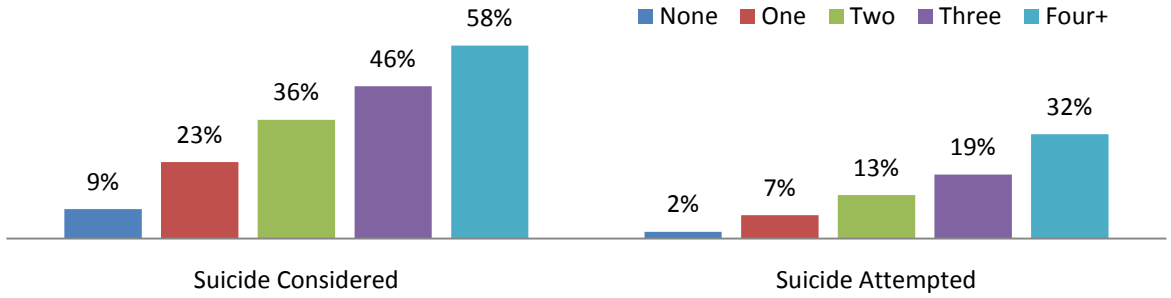


Goal 1: Increased education on suicide prevention and decrease stigma of mental illness.

All children need access to information and supports to prevent suicide. Teen suicide in Minnesota is a real problem. Suicide is the second leading cause of death for youth in Minnesota.Twenty-five percent of public school ninth graders in Minnesota have thought about killing themselves and twenty percent of public school ninth graders in Minnesota have hurt themselves on purpose at some time[27].

In the 2013 Minnesota Student ACE Study, the distribution of considered and attempted suicide among Minnesota 8th, 9th, & 11th grade regular public school students increased dramatically by ACE Score in the 12-month period prior to the study[28].

(Left to right: number of ACEs of students)



TEXT4Life

In 2013, the Minnesota Legislature provided funding to continue TXT4Life,and expand it to additional areas of the state. Over the first two years of TXT4Life program, 4,420 youth and young adults used the service. The funding is about 25% of what is needed to expand the program statewide.

Mobile Crisis Teams

Crisis interventionsare face-to-face, short-term intensive interventions during a mental health emergency to assist a child coping with immediate stressors and avoid unnecessary hospitalization. There are currently 16 mobile crisis teams throughout the state, with a limited number that operate 24/7. Resources are needed to increase the number of teams and expand the services so that the teams can serve children in home, schools, and community settings.

We recommend:

- Support full expansion of TEXT4Life.
- Support full expansion of mobile crisis teams for youth that provide services 24 hour service, and require trainings for mobile crisis teams specific to youth mental health issues and cultural practices.

[27] 2013 Minnesota Student Survey, http://education.state.mn.us/MDE/StuSuc/SafeSch/MNStudentSurvey/

[28]http://acestoohigh.com/2013/01/28/minnesota-ace-survey-finds-more-than-50-state-residents-experienced-at-least-2-types-of-childhood-adversity/ and http://www.health.state.mn.us/news/pressrel/2013/ace012813.html and http://www.health.state.mn.us/divs/cfh/program/ace/content/document/pdf/acesum.pdf

Additional recommendations:

- Increase funding for coordinated suicide prevention activities at the Departments of Health, Human Services and Education to assist schools and communities.
- Fund the implementation of programs and policies that build social connectedness and promote positive mental and emotional health (e.g., Youth Mental Health First Aid, Check and Connect, and Sources of Strength).
- Provide incentives to schools to participate in the Minnesota Student Survey to have the important information needed to target and plan prevention activities and track successes.
- Fund trainings for school staff to recognize students at potential risk of suicide and refer to appropriate services (e.g., QPR, ASIST, SafeTALK, and Youth Mental Health First Aid).
- Ensure that schools have a plan of support for students at risk of suicide.

Goal 2: Expand and sustain School Wide Positive Behavior Intervention and Supports (PBIS) and School Linked Mental Health Grants

Positive Behavior Intervention and Supports

In 2004, the Minnesota Department of Education created a state action plan for supporting schools to implement School Wide Positive Behavior Intervention and Supports (PBIS). There have been 473 schools trained for implementation. The benefits of PBIS programs in schools are teachingand learning environments that:

- Are more engaging, responsive, preventative, and productive
- Are less reactive, aversive, dangerous, and exclusionary
- Address classroom management and disciplinary issues (e.g. attendance, tardiness, anti-social behavior)
- Improve supports for students whose behavior or symptoms require more specialized assistance (e.g. emotional and behavioral disorders, mental health)
- Maximize academic engagement and achievement for all students

PBIS is a framework for achieving these outcomes. It guides selection, integration, and implementation of Evidence Based practices for achieving positive academic and behavior outcomes for all students.

In the past, school-wide discipline has focused mainly on reacting to specific student misbehavior by implementing punishment-based strategies including reprimands, loss of privileges, office referrals, suspensions, and expulsions. Research has shown that the implementation of punishment, especially when it is used inconsistently and in the absence of other positive strategies, is ineffective.

Introducing, modeling, and reinforcing positive social behavior is an important step of a student's educational experience. Teaching behavioral expectations and rewarding students for following them is a much more positive approach than waiting for misbehavior to occur before responding. The purpose of school-wide PBIS is to establish a climate in which appropriate behavior is the norm.

Data shows that PBIS is working to reduce the number of disciplinary actions taken in schools.

	Number of Disciplinary Actions					
Year	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	5 year reduction
State Data	50,306	50,611	49,679	49,604	44,854	-5,452
Osseo	2,143	2,228	1,815	1,491	1,566	-577
Burnsville	984	683	648	744	586	-398

Currently, only 24% of schools across the state are implementing PBIS. There is a need to train additional cohorts. Further, experience has shown that a number of factors (including turnover in administrative and teaching staff) prompt development of recertification training for schools.

In the proposed State Olmstead Plan[29], PBIS programs are seen as an essential resource for Minnesota to ensure that "students with disabilities receive an equal opportunity to a high quality education in the most integrated setting that prepares them to participate in the community, including employment and postsecondary education.

The state proposes to "build staff capacity at the school level to effectively improve school-wide systems of possible behavior interventions and support….By June 30, 2014 and each subsequent year, there will be a minimum of forty additional schools per year using the Evidence Based proactive of Positive Behavior Intervention and Supports (PBIS) so that students are supports in the more integrated setting."

The Subcommittee applauds this recognition of the kind of impact on the lives of students that PBIS brings to the school environment. We continue our long-standing support for expansion of PBIS and believe that its inclusion as part of the Olmstead Plan will ensure that growth.

We recommend:

- Provide funding for at least 40 additional PBIS schools per year (as in the proposed Olmsted plan)
- Provide funding to support maintenance for the previous cohorts (ongoing coaching, and new staff to refresh training)

School Linked Mental Health Grants

There is an abundance of evidence that most children in need of mental health services do not receive them, and those that do, receive them primarily through the school system[30]. Education systems and individual schools are critical partners within comprehensive systems of care for children and youth with mental health needs and their families. Available research suggests that for some youngsters schools are the main providers of mental health services.

[29]The Olmstead Plan with proposed modifications submitted to United States District Court dated July 10, 2014, subsequently rejected by District Court Judge Donovan Frank. See "Federal Judge Rejects State's Disability Reform Plan," Minneapolis Star Tribune, September 20, 2014.

[30]Burns, Costello, Angold, Tweed, Stangl, Farmer and Erkanli. Children's mental health service use across service sectors, Health Affairs, 1995.

State infrastructure grants support school-linked mental health services throughout Minnesota. There are currently 36 grantees. These school-connected clinical mental health treatments include interventions that:

- Increase accessibility for children and youth who are uninsured or underinsured
- Improve clinical and functional outcomes for students with a mental health diagnosis
- Improve identification of mental health issues for children and youth

This initiative connects or co-locates effective mental health services with schools and students at the local level. This project has proven particularly effective in reaching children who have never accessed mental health services. Many children with serious mental health needs are first identified through this program.

The increased access was particularly important for students from cultural and ethnic minority communities. Overall, students of color served have been significantly more likely to access mental health services for the first time compared to white students.

The current grants have achieved outstanding outcomes[31]. Dr. Glenace Edwall of the Minnesota Department of Human Services presented on Minnesota's achievements at the NAMI Cigna Forum on Health on June 4, 2014 in Washington, D.C[32]. Current funding would double the state's capacity for school-linked mental health, making services available in 840 schools to approximately 13,900 students annually by 2017. More than half of those students will receive mental health services for the first time. The proposal invests $7.4 million in the next biennium and $4.9 in the fiscal years 2016 and 2017[33].

We recommend:

- Provide ongoing support and increase funding for the School Linked Mental Health grantsin order to provide access to this opportunity for all schools.
- Increase staff support to assist grantees to achieve quality services
- Align Positive Behavior Interventions and Supports with School Linked Mental Health Grant programs. The alignment to focus on evidence based practices for students in school settings to support social and emotional development to achieve success at home, school and in the community.

[31]**"**Modeling after Minnesota: Achieving Positive Results for Students", Glenace Edwall, Psy. D., Ph.D., Director, Children's Mental Health Division, Minnesota Department of Human Service, National Alliance on Mental Illness, June 5, 2014.
http://www.nami.org/Template.cfm?Section=Top_Story&template=/ContentManagement/ContentDisplay.cfm&ContentID=168861

[32]http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Child_and_Adolescent_Action_Center/Childrens_Mental_Health_Forum/GlenaceEdwallSchoolLinked.pdf

[33]"Thousands of children to benefit from $45M for school-linked mental health", Department of Human Services press release, May 8, 2014.http://mn.gov/dhs/media/news/news-detail.jsp?id=252-128913

Outreach to Diverse Communities

Minorities have less access to, and availability of, mental health services. Minorities are less likely to receive needed mental health services. Minorities in treatment often receive a poorer quality of mental health care. Minorities are underrepresented in mental health research. The recognition of these disparities brings hope that they can be seriously addressed and remedied[34].Startling new findings make clear that disparities in mental health exhibit a decidedly different pattern from disparities in other kinds of health[35].

Startling new findings make clear that disparities in mental health exhibit a decidedly different pattern from disparities in other kinds of health[36].

This report from The Outreach to Diverse Communities Committee of the Subcommittee on Children's Mental Health reviews the evidence of disparities in mental health care and suggests ways to eliminate those disparities and improve access to quality care.

Diversity in the Mental Health Workforce

Increasing the proportion of racial minority providers is considered an important factor for improving health disparities. This is even more important for mental health care, whereproviders from ethnic minorities are more poorly represented than in health care in general[37]. Minority clients also have trust issues with providers who are not of their ethnicity.

The racial and health disparities for children impacted by mental illness and living in poverty are compounded by the critical shortage of child psychologists, where there is estimated to be only one for every 7,000 children in the country as reported in the Congressional Record H26 on January 8, 2014.

A state commitment to the outreach and educational support necessary to build a truly diverse mental health workforce is a critical policy recommendation for decreasing disparities in mental health care. A more diverse workforce would likely provide not only more culturally appropriate treatment, but also language skills to match those of clients been served.

The Outreach to Diverse Communities Work Group commends the Governor and the Legislature for the diversity grant made available since 2007 to build capacity by increasing more licensed mental health practitioners and professionals from communities of color. This grant allows for free clinical supervision, pays for study and test materials.

Further recommendations:

Immersion Training In Cultural and Linguistic Competence:

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[34]Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US).Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2001 Aug.
[35]Health Aff (Millwood). 2008 Mar-Apr; 27(2):393-403. doi: 10.1377/hlthaff.27.2.393. "New evidence regarding racial and ethnic disparities in mental health: policy implications".http://www.ncbi.nlm.nih.gov/pubmed/18332495
[36]Health Aff (Millwood). 2008 Mar-Apr; 27(2):393-403. doi: 10.1377/hlthaff.27.2.393. "New evidence regarding racial and ethnic disparities in mental health: policy implications".http://www.ncbi.nlm.nih.gov/pubmed/18332495
[37]"Review of the Minnesota Mental Health Workforce Recommendations Specific to African-American, Hmong, and Latino Communities," submitted June 30, 2014 by Willie B. Garrett Ed. D, and Alyssa K. Vang, Psyd, including Minnesota Statistics that "less than 3% of all mental health professionals in Minnesota are minorities, while people of color make up approximately 15% of the population."

- Immersion training in cultural and linguistic competence for all professional disciplines working with children that require state licensure. Forty to fifty hours of immersion training should be a requirement to obtain and maintain professional licenses that apply to professionals such as teachers, medical professionals, mental health professionals, corrections workers, and police officers.
- Fully support implementation of the recommendations of the Mental Health Workforce Task Force to be outlined in their report to the Minnesota Legislature, with particular attention to expanding financial incentives, such as:
  - Scholarships, grants, stipends, and low interest loans[38] (20% of funding reserved for racial minorities).
  - Paid internships and training (20% reserved for racial minorities).
  - Internships leading to employment.
  - Establish high schools for the behavioral sciences
  - Promotion and funding of ethnic research by Minnesota State Colleges and Universities (MNSCU) educators.

Developing Career Ladders:

- Education institutions (MNSCU) and training programsshould define and educate (i.e. create a roadmap for) minority students on the process of becoming a mental health professional.
- Provide online resources.
- Recruit minorities at every level of contact(including other states and internationally).
- Develop a behavioral health certification program for interpreters with a career ladder congruent with attaining B.A. and M.A. degrees in mental health careers.
- Establish a system of minority mentors at all levels of mental health practice, in rural and urban communities, and at all major behavioral health organizations which would include online or tele-mentoring.

Cultural and Linguistic Competence of the Mental Health Workforce:

- Establish a procedure for immigrants that have a comparable education or degree and have practiced as a professional in another country to receive credit for qualified foreign education and work experiencefor mental health professional licensure, including licensure testing in their second language[39].
- Require 15% minority mental health professionals at workplaces to create a cultural presence and reflection of community diversity.
- Provide supervisor training in culturally competent treatment methods, including intentional forms of evaluation from this perspective.
- Establish a statewide tele-interpreter system.

Multi-Cultural Representation:

[38]https://www.google.com/?gws_rd=ssl#q=cultural+minority+Scholarships%2C+grants%2C+stipends%2C+and+low+interest+loans

[39]See *Credentialing Recognition in the United States for Foreign Professionals,* European Union (May 2013) at: http://www.migrationpolicy.org

- There should be multi-cultural representation on all state agency Requests for Proposals (RFPs) advisory group meetings related to diverse communities, including grants, funding, racial disparities, certification, credentialing processes for interpreters, and alternative testing and licensure of mental health professionals.

Interpreter Services:

- Minnesota health benefit plans (private and public) should include reimbursement specifically for interpreter services when a provider who speaks the language and understands the culture of the consumer of mental health services is not available. Currently, private provider agencies are not specifically reimbursed for mental healthinterpreter services, creating an uneven service delivery system in culturally diverse communities.

Youth Mental Health First Aid Training:

- Youth Mental Health First Aid Trainingfor professionalsthat regularly interact with young people from diverse communities to provide them with the knowledge of signs and symptoms and tools needed to intervene appropriately to prevent a mental health crisis, including teachers, police and fire, emergency management services, medical professionals, mental health professionals, juvenile justice, corrections officers, religious leaders, and other community members.

Minnesota Historical and Cultural Heritage Funding:

- Minnesota Historical and Cultural Heritage for youth to express artistically, culturally and linguistically: Peer to peer supports, mobile crisis services, TXT4Life, and mental health awareness messaging utilizing new technologies, including:
    - Access to video production capabilities
    - Social media
    - Television
    - Radio Billboards
    - Public Health Advertising Campaigns
    - Community murals and paintings
    - The written word and poetry
    - Sculpture
    - Song, dance, and other performing arts.

Mental Health and Juvenile Justice

Focus of This Report:

The dual focus of this report is to offer anover-arching recommendation that could fundamentally change the way we look at issues of Juvenile Justice in Minnesota, and to outline the progress made on issues presented in the 2012 Report to the Governor and Legislature.

Office of Juvenile Justice

The criminal justice system was initially designed to address the needs of adults who had committed criminal offenses. Unfortunately, the needs of juvenile offenders have not always been addressed in a comprehensive and inclusive manner. Currently, Minnesota has three separate approaches to youth who are felons and non-felons in the criminal justice system: The Community Corrections Act (CCA), the State's Department of Corrections (DOC), and State-Corrections Department/County Probation Offices (DOC/CPO). While each of these systems has merits that contributed to their development, there is no over-arching entity that directs how services should be delivered, aside from current statute, or that is evaluating the outcomes.

As a part of this system, it is imperative that the mental health needs of juvenile offenders are addressed early in their involvement with the criminal justice system. The lack of early identification of mental health needs and the corresponding provision of treatment services to address these needs often results in increased and more costly juvenile justice involvement. Once a youth becomes involved in the juvenile justice system and is detained or incarcerated, access to effective and successful mental health treatment is less likely to occur. This corresponds with a likelihood of further and deeper engagement in the justice system; often up to, and through, adulthood.

A state-level office focusing on crime prevention and interventions for offenders could help local jurisdictions improve the quality of their juvenile justice prevention and intervention strategies as well as monitor progress.

A recent report finding a need for the leadership is the NAMI Minnesota Juvenile Justice Work Group Report to the Minnesota Legislature (March 2014).

The NAMI report recommended that the State establish an Office for Juvenile Justice (OJJ). No single agency provides a home for Minnesota's juvenile justice system. Rather, juvenile justice practices and policies are locally determined in all 87 of Minnesota's counties. In addition, aspects of the system are housed across many agencies, from law enforcement, to the courts, to corrections.

A state-level office focusing on crime prevention and interventions for offenders could help local jurisdictions improve the quality of their juvenile justice prevention and intervention strategies as well as monitor progress.

A single committee meeting for less than a year cannot possibly determine and recommend policy changes to address all of the barriers to improving outcomes for youth at risk of, or already experiencing, juvenile justice system involvement. The systemic problems are complex, there are many systems involved, and more data analysis is needed to tell policymakers what types of changes truly need to occur. A State Office of Juvenile Justice (OJJcouldexamine and address issues in-depth and over time, and monitor progress.

Like other states, Minnesota is already home to a Juvenile Justice Advisory Committee (JJAC). A new juvenile justice-related entity should not replicate or compete with the JJAC's work. With that in mind, some possible responsibilities for the OJJ could include:

- Collect and analyze data to allow for data-driven decisions regarding which treatments, services, and other interventions are needed in Minnesota to improve outcomes for youth at risk of, or already experiencing, juvenile justice system involvement.
- Encourage appropriate use of validated screenings and assessments to identify needs and gaps.
- Provide guidance and technical assistance to help local jurisdictions implement and improve their juvenile justice prevention and intervention strategies.
- Ensure the availability of training to support the use of promising, best, and Evidence Based practices at the local level.
- Clearly define the roles of the various state agencies and their departments that have some responsibility for youth in the juvenile justice system.

Some issues are as of yet unresolved to make this recommendation politically viable. In particular, the OJJ would have to be incorporated into an existing agency to make the proposal financially feasible.

It will take time to figure out where overall locus of accountability should reside for the Office of Juvenile Justice and action is needed now. The Department of Human Services appears to have the personnel and resources that could be brought to bear on this issue. Based upon the Department's experience in the delivery of other human services this added duty at least in the short term may make the most sense.

We recommend:

- Endorse the recommendations of the NAMI Minnesota Juvenile Justice Work Group Report to the Minnesota Legislature of March 2014 to create a State Office of Juvenile Justice.
- Establish an accountable, high-level leadership function and staff position(s) of an Office of Juvenile Justice in the Department of Human Services to meet the mental health needs of youth involved in the juvenile justice system, or who are at risk of entering the juvenile justice system.
  - This Office should have the span of authority to work across the functions of the Department, especially within Chemical and Mental Health Services and Children and Family Services.
  - Duties should include:
    - Lead for collaboration with juvenile correction systems in Minnesota, including work with state, regional, and local juvenile justice systems.
    - Responsible for reviewing recommendations for key mental health policies, programs, and reports and consider implementation of these recommendations.
    - Identify resources, including evidence based and promising best practices that are effective in addressing the mental health and substance use needs of youth in juvenile justice.
    - Include special attention to evidence based and promising practices for population disparities to include cultural and gender considerations.

- Collect and analyze data pertaining to the mental health and substance use needs of youth in juvenile justice.
- Secure and utilize technical assistance from national experts and learn from other states that have addressed this issue.
- Ensure that juvenile justice staff who work with these populations, both in facilities as well as in a community based settings, are versed in the mental health needs of juvenile offenders.
- Continue researching funding opportunities regarding mental health and substance use services and supports to youth in correctional facilities, with special attention to cultural and gender specific considerations.

Update on recommendationsfrom the 2012 Report to the Governor and Legislature

Adverse Childhood Experiences

Adverse Childhood Experiences[40] (ACEs).[41] include: Exposure to trauma, significant loss of a primary caregiver, disruptions in relationships with primary caregivers, parental mental illness, substance abuse, and domestic violence, and other social and environmental stressors.

ACEs are specifically linked to poor physical and mental health, chronic disease, lower educational achievement, lower economic success, and impaired social success in adulthood. Often these consequences are related to lifestyle choices.Harvard University's Center on the Developing Child[42] relates ACEs to toxic stress that can impact brain development and a person's mental and physical health throughout life.

In our 2012 Report, we identified as a key issue the impact of early trauma on brain development and implications for risk factors associated with future juvenile justice involvement (Adverse Childhood Experiences).

We had offered these recommendations:

- Support the efforts of State agencies to incorporate ACE-related activities into State and State-supported practices.
- Charge the Departments of Human Services, Education, and Health with outreach to Minnesota's juvenile justice system at both the organizational and service levels to develop understanding of the implications of ACEs and promote the development of trauma-informed practices.
- Incorporate ACE-related information into screenings and assessments of youth at risk of, or who enter, the juvenile justice system.
- Develop and implement juvenile justice-related intervention strategies that are responsive to trauma-related experiences of these youth.

[40] http://www.health.state.mn.us/divs/cfh/program/ace/content/document/pdf/acesum.pdf
[41] See also http://www.macmh.org/wp-content/uploads/2014/05/41_Baum-+Adolfson+-Maruska_Adverse-Childhood-Experiences.pdf
[42] Center on the Developing Child at Harvard University (2010). *The Foundations of Lifelong Health Are Built in Early Childhood.* http://www.developingchild.harvard.edu

Adverse Childhood Experiences (ACEs)

Since 2012, the Department of Human Services has worked diligently to incorporate Adverse Childhood Experiences[43] (ACEs)[44]related material and trauma informed care as a part of its dialogue for all family and youth related services. It has encouraged presentations and seminars statewide and to specific audiences including the law enforcement and justice systems as well as educators to convey information about the impact of adverse childhood experiences that lead to planning trauma informed programs and practices.

The 2013 Minnesota Student Survey (MSS) added ACE questions to surveys completed by 8th, 9th, and 11th grade students[45]. This aimed to begin understanding how ACEs impact health outcomes and behaviors during adolescence, when ACEs either recently happened, or are still happening. Many behaviors that impact health over the life course start in adolescence and continue through adulthood. The adverse impacts of trauma may also be associated with the increased risk for development of behaviors that may lead to involvement in the juvenile justice system[46].

This outreach and research has formed the basis for strategy development. Studies of ACEs in youth and adolescents have shown that ACEs can lead to an earlier onset of drinking alcohol and binge drinking, drug use, depression, and anti-social behavior. So, the earlier they can be prevented or controlled, the better.

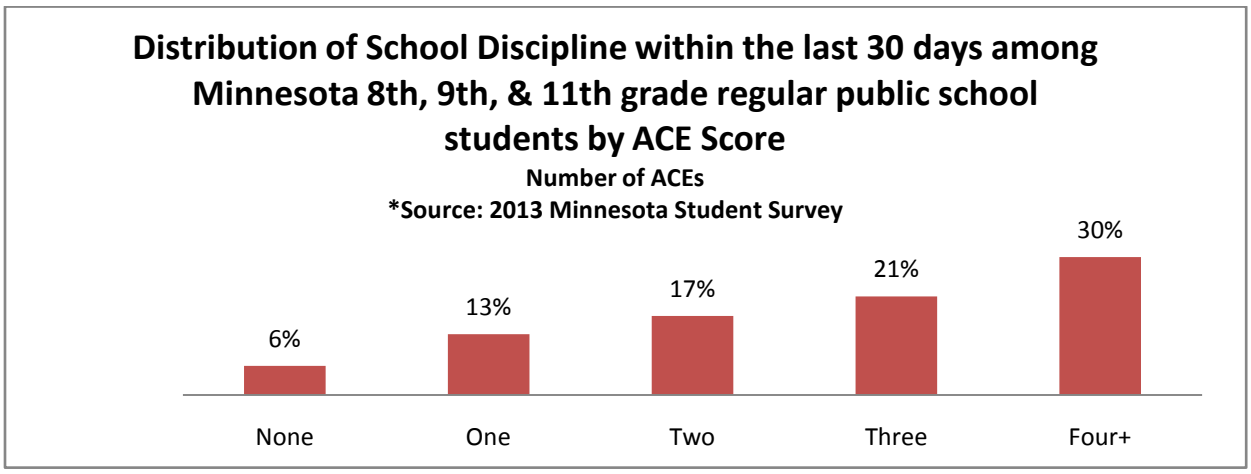
The following shows the rate of students who reported school discipline one or more times within the last 30 days by their ACE scores. Rates increase with higher ACE scores.

[43]http://www.health.state.mn.us/divs/cfh/program/ace/content/document/pdf/acesum.pdf

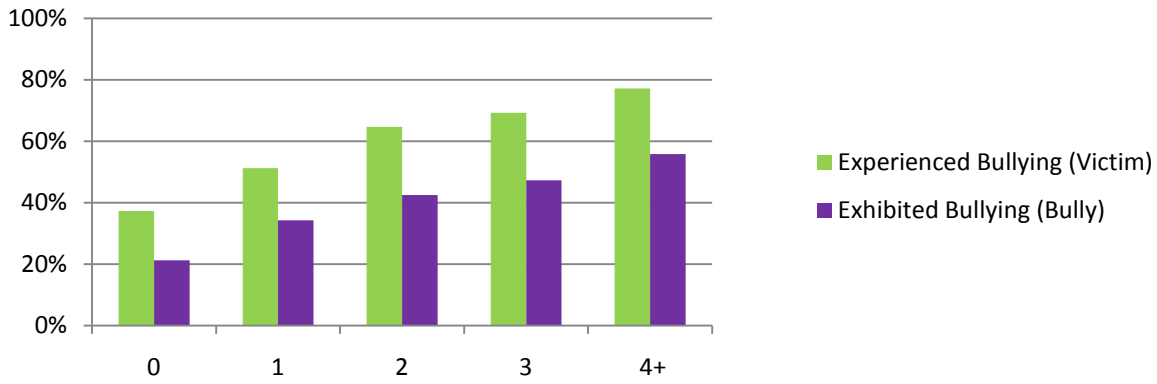
[44] See also http://www.macmh.org/wp-content/uploads/2014/05/41_Baum-+Adolfson+-Maruska_Adverse-Childhood-Experiences.pdf

[45]Dave McCollum, a retired physician who integrated ACEs and trauma-informed practices in his emergency room work, narrated this captivating slide show. It reports on Adverse Childhood experiences among teenagers from the 2013 Minnesota Student Survey. The survey is administered every three years, and is a joint project of the state departments of education, health, human services and public safety. In the 2013 study, 84% of the state's public schools participated in the survey. Only students in the 9th, 10th, and 11th grades answered the questions relating to adverse childhood experiences. The questions were similar to those on the original ACE Study, but did not include them all. Please view the 15-minute ACEs presentation accessed with the following link. It was developed for the Minnesota Association of Children's Mental Health. http://www.acesconnection.com/blog/the-numbers-in-this-minnesota-student-ace-survey-can-make-you-cry-14-min. Be sure to click the icon with 4 arrows next to the HD logo below the screen to enlarge the image.

[46]Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks JS. Relationship ofchildhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhoodexperiences (ACE) study. *American Journal of Preventive Medicine* 1998; 14:245–258. http://www.ncbi.nlm.nih.gov/pubmed/9635069?dopt=Abstract

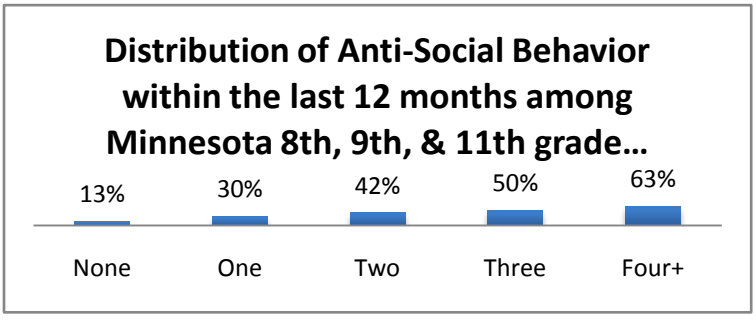


Within the 30 days prior to the study, bullying behavior showed a relationship to ACE scores, as delineated below:



Anti-social behavior includes damaging or destroying property, hitting, beating up another person, or taking something from a store without paying for it. The following figure shows the distribution of anti-social behavior by student's ACE scores.

Rates increased as the ACE score increased, as delineated below:



Schools as Access Points – 2012 Recommendations:

In 2012, we stated that efforts to prevent the unnecessary engagement of youth in the Juvenile Justice system need to focus on the Key 'Access Points,[47] where youth with unmet mental health needs come into contact with the justice system.

We recommended that the State support the development of a new SAMHSA-MacArthur Foundation service approach and the determination of its effectiveness in meeting stated outcomes.

- Last year a new model was developed to address the issue of the school to prison pipeline. The Minnesota model is designed to assist schools and their partners to become more selective about making referrals to the juvenile justice system and to instead develop school and community based alternatives for addressing student behavioral incidents. The Minnesota model is a school-based diversion program for students with co-occurring disorders. It is a blueprint for shared decision making, new partnerships and alternatives that keep students in school and out of the juvenile justice system.The next step in this process is to partner with the Minnesota Chiefs of Police Association, six school sites, and their local partners to further plan, implement and evaluate the model, then move forward with statewide distribution. There is great interest in this model across the state in hopes of addressing the "school to prison pipeline" public policy issue.

Juvenile Justice Detention, Incarceration, and Placement as Access Points – 2012 Recommendations:

Counties across the state continue to make progress with youth charged with both criminal and status offences through the Juvenile Detention Alternatives Initiative (JDAI). Some of the changes we have seen are an implementation of admission criteria for secure detention, which had led to alternatives to detention being developed. This has led to fewer youth detained for longer periods which have resulted in decreased costs of placement.

The results achieved through JDAI and related efforts in Hennepin, Dakota, Ramsey, and St. Louis Counties should be closely examined through joint efforts of the Departments of Human Services and Corrections, in addition to the participating counties. Additional resources are needed to increase capacity, strengthen processes, expand implementation of JDAI to additional counties, and begin the process of institutionalizing JDAI at the state level.

- Several counties are currently working to identify dually involved youth (those youth involved in both the child protection and criminal justice systems), and how best to address their individual needs. Ramsey County has begun their Youth Engagement Program which provides a holistic approach to working with youth who struggle with truancy and chronic runaway behavior. This approach is designed to assess and evaluate the primary family issues and attempt to remove the barriers that contribute to the behavior.Efforts to sustain successful progress and translate these successes into statewide efforts should be initiated by the State.

Minnesota's Mental Health Screening Program - 2012 Recommendations:

- That the State examine whether the 2011 legislative change requiring parental consent for screening juvenile justice youth has resulted in fewer eligible youth being screened, and if so, restore the "opt out" screening requirement.
  - The Children's Mental Health Division suspected that the "opt in" language likely had a detrimental effect on the numbers of youth screened for mental health needs. In 2013,

[47] 2012 State Advisory Council Report to the Governor and Legislature, page 17.

language was proposed and presented to the legislature that would reinstate the "opt out" of the mental health screening process as opposed to the "opt in" that currently exists, this language was struck out of the bill thus preventing a pre-post comparison of number screened.

- Institute statewide data collection and service follow-up. Implement protocols and data tracking regarding follow-up post screening and referral to and engagement in services.
  - Statewide data collection and service follow up is already in place in the juvenile justice system; however, no information has been collected from the child welfare system as statute does not allow the Department of Human Services to directly collect this data. In 2013, language was introduced that would have removed this restriction, but this language was struck from the bill that was passed. The Children's Mental Health Division is issuing a bulletin in 2014 that will establish policy that requires county child welfare staff to collect and report data on screening and follow up services.
- Add ethnicity data to the screening system to help identify disparities.
  - In its planned 2014 bulletin, the Children's Mental Health Division will be requiring the reporting on ethnicity data for analysis.
- Increase the number of children and youth who are screened within eligible populations by providing additional technical assistance and highlighting screening results statewide.
  - Technical assistance has been provided to many counties statewide on how to increase screening numbers. The largest gains were noted in the metro counties and ranged from 5% to 10% increases.
- Develop enforcement strategies and consequences to ensure the screening of third time petty offenders to promote earlier identification of mental health issues for youth who are at risk of committing more serious juvenile offenses.
  - No enforcement strategies have been developed at this time.

Recommendation Concerning Integrated Mental Health and Chemical Dependency Efforts (Co-Occurring Disorders).

- Arepositoryforinformationaboutchildrenborntomothersthat have been activelyusingdrugsandalcohol shouldbedevelopedwithintheDepartmentofHealthsothatwemaygaina betterunderstandingoftheissuesanddevelopinterventionsthatmayaddresstheproblems.
  - A great deal of work is being done to gain a better understanding of this issue. The Departments of Human Services and Health are working on a project about these children and their mothers, as well as including this issue in the Minnesota State Substance Abuse Strategy.
- Treatment facilities and programs that target youth at risk of involvement or engaged in the juvenile justice system need to develop integrated mental health and chemical dependency treatment modalities into their programs so that co-occurring disorders will be more effectively treated and the risk of relapse and recidivism reduced.
  - Unfortunately there has been little statewide progress made in the development of dual diagnosis treatment as it pertains to youth in the juvenile justice system. It is our hope that this issue will be researched further during the coming legislative session.

Families and Communities

Early Intervention

The Governor has identified early intervention of school and health resources in the lives of children. Good early childhood mental health is interwoven with a young child's development and overall health. Early intervention is the key to reverse or mitigate the effects of Adverse Childhood Experiences[48] (ACEs).[49][50]

Environmental factors that impact future mental health begin during a mother's pregnancy. In the first years of life, infants and toddlers make adaptations to their environmental experiences. They can shape the architecture of the brain and chemically alter the structure of genes. Infants experiencing stressors in their environment may begin a series of adaptations that interfere with social and emotional development.

We observed a need for early identification of mental health challenges experienced by their clients and patients. The Departments of Human Services (DHS), Health (MDH), and Education (MDE) have programs that are analyzing the earliest possible interventions to help parents be the best possible caregivers. Through such identification the departments may be able to develop new methods and mental health resources to address early intervention.

We recommend increasing support of programs such as the MDH Home Visiting Programs and policies that nurture safe, stable relationships between a consistent caregiver and infant/young child using a two-generation approach. These programs support the adult caregivers in meeting their own needs so that they will be able to enter into secure reflective relationships with their children. Children will then be able to build a strong foundation that will support their healthy social-emotional development and the mental health of future generations.

We found school programs beyond the 3Rs (Reading, Writing, and Arithmetic) that can build a positive climate for all students and teachers (our Schools and Mental Health Work Group has specific recommendations for DHS and MDE programs regarding Positive Interventions and Supports. See page 34).

In addition, we believe that an important partner in generating referrals to early intervention resources from Early Childhood Screening is the MDE, especially its Infant and Toddler Intervention/Preschool Special Education programs.

Informing special education workers of mental health professionals trained in Early Childhood interventions will lead to smoother transitions in accessing their services.Collaboration in the field between representatives of such programs can produce earlier interventions with better outcomes that reduce long range costs for social and health services.

In August 2011, twenty contracts from the Department of Human Services Children's Mental Health Division covering services in 83 of 87 counties began focusing on developing a statewide

[48] http://www.health.state.mn.us/divs/cfh/program/ace/content/document/pdf/acesum.pdf
[49] See also http://www.macmh.org/wp-content/uploads/2014/05/41_Baum-+Adolfson+-Maruska_Adverse-Childhood-Experiences.pdf
[50] See footnote 45.

early childhood mental health workforce to provide clinically appropriate mental health services to children from birth to five and their families[51]. The goal is to ensure that all Minnesota children with mental health conditions under the age of five have access to evidence based, culturally competent, developmentally appropriate, family-centered early childhood mental health services.

Through December 2013, 2,334children and their families received clinical services. However, a shortage of available, trained clinicians and great distances mean that many families find it difficult to access these services. Expansion of the number of mental health professionals trained in working with children ages 0-5 is needed as well as increasing support for their in-home services.

With improved data collection and analysis,the Departments of Health and Human Services can develop methods to access untapped mental health resources.

We recommend:

- Funding for projects in local communities through Family Services and Children's Mental Health Collaboratives to develop solutions to regional problems leading to increased resilience and good community health.
- Long-term intensive home visiting programs that enhance parent-child relationships.
- Continued support for the State Health Improvement Program with its focus on locally developed activities.

Multi-generational Mental Health

"A two-generation approach to public policies brings together worlds that are often separated (focusing only on children or only on parents) to modify or create new policies that focus on the needs of parents and children together. Two-generation policies reflect strong research findings that the well-being of parents is a crucial ingredient in children's social-emotional, physical, and economic well-being. And at the same time, parents' ability to succeed in school and the workplace is substantially affected by how well their children are doing.[52]"

Services to children involve parental approval and participation. Often, services to children bring in the family, but when parents need services, they are treated separately and individually.

Parents with Mental Illness

It has been consistently demonstrated that mental illness negatively impacts a mother's ability to provide the sensitive care a young child needs for healthy brain development[53] (sensitive care is the caregiver's ability to be aware of the child's signals and needs, and to respond to these in a manner that is timely, meaningful, accurate to the emotion, and generally appropriate[54]). The factors that

[51] http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs16_178159.pdf
[52] Thriving Children, Successful Parents: A Two-Generation Approach to Policy by Stephanie Schmit, Hannah Matthews, and Olivia Golden, CLASP, July 9, 2014
[53] Campbell et al., 2004; Center on the Developing Child at Harvard University (CDCHU), 2009; Conroy et al., 2012; Wan, Warren, Salmon, & Abel, 2008. Maternal Depression Can Undermine the Development of Young Children
[54] Ainsworth, Bell & Stayton, 1974; Journal of European Psychology Students, 2010

contribute to sensitive caregiving by mothers with mental illness are not fully understood. However, research has shown that three factors affect a parent's caregiving quality:[55]

- Parental adverse childhood experiences,
- Parental reflective functioning (the ability for parents to understand and respond to the needs, wants, feelings, and desires of their children. Such understanding allows a mother to create both a physical and psychological experience of comfort and safety for her child).
- Parental social support.

The Department of Human Services Adult and Children's Mental Health Divisions has funded three programs to investigate the parenting needs of adult mothers with serious mental illness raising children under the age of five. Expansion of such services would be based upon outcomes of current funding.

While extensive data analysis has not yet occurred, we know that the parents with mental illness experienced an average of six to seven types of traumas as children. Based on Minnesota data -- five or more Adverse Childhood Experiences (ACES) often lead to higher risk for mental health, physical health, and chemical health issues than do fewer ACEs.

As a result of the grant, two policies have already been changed:

- Adult mental health providers can now bill for child developmental and mental health screenings through Child and Teen Checkups (to be piloted by the three funded agencies);
- Adult Rehabilitative Mental Health Services (ARMHS) services now include parenting services.

Catherine Wright of the Department of Human Services has just completed an exploratory study that investigated the relationships between maternal reflective functioning(the ability for parents to understand and respond to the needs, wants, feelings, and desires of their children)[56], maternal adverse childhood experiences, social support satisfaction, and sensitive caregiving in mothers with diagnosed severe mental illness who were parenting preschool-aged children. Results indicate that parental reflective functioning significantly correlates with sensitive caregiving.

Standard parenting classes that do not support both parenting skills and parental reflective functioning may be insufficient in changing parenting behavior of parents with clinical issues.Many parents with mental illness who have young children may need psychotherapies provided in their homes as opposed to outpatient offices. Funding for the extra time needed for transportation by the mental health professionals and rate changes to allow for such services is needed to develop their in-home practice.

Further study into the factors that contribute to the parenting sensitivity of mothers with serious mental illness is strongly recommended.

[55] Sroufe, Egeland, Carlson, & Collins, 2005

[56] Maternal reflective functioning, attachment, and the transmission gap: a preliminary study.Slade A, Grienenberger J, Bernbach E, Levy D, Locker A (2005)

New Programs Needed for Teens

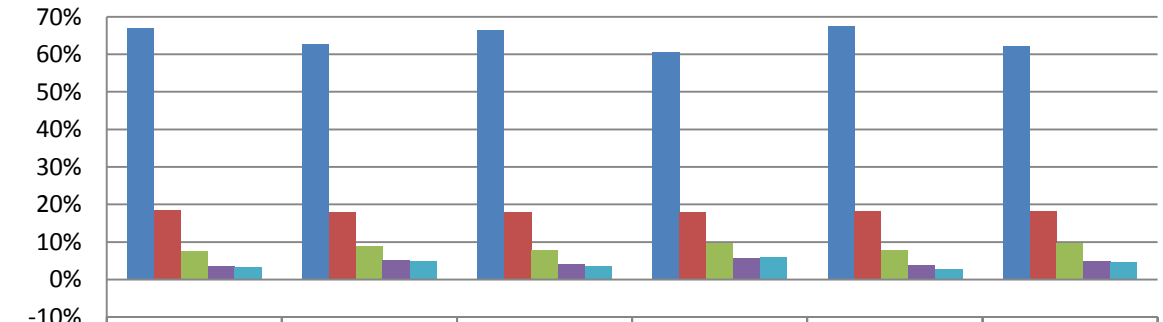
Particular attention should be focused on adolescents. This is because of what research tells us about their health and behavior in relation to the number of their adverse childhood experiences; what we know aboutbrain development during those years, and their future role as parents.

Responses to ACE Study questions that were included in the 2013 Minnesota Student Survey results for 8th, 9th and 11th graders were analyzed to create the Minnesota Adolescent ACE Study. It identified areas of health and safety for programs that build resilience. Resilience is the positive adaptation within the context of significant adversity.Helping maturing adolescents develop tools to adapt to adverse experiences will pay dividends in a healthier adult population.

Although the main focus of ACEs research is on how ACEs impact health into adulthood, this study had a different focus. It focused on how ACEs impact health outcomes and behaviors earlier in life, during adolescence, and while ACEs either recently happened, or are still happening. Many behaviors that impact health over the life course start in adolescence and continue through adulthood.

ACEs often occur together. About one-third of Minnesota adolescents report ACEs and half of those reported experiencing more than one ACE. Females report a higher prevalence of at least one ACE compared to males. (See Figure 1)

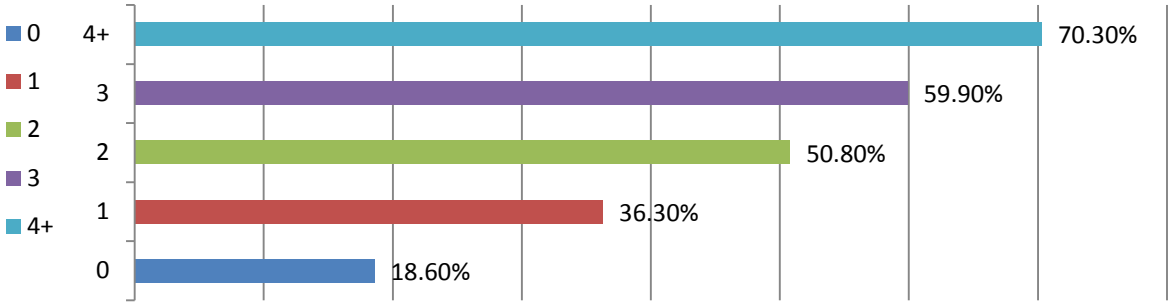
Figure 1



	Male	Female	Male	Female	Male	Female
	8th Grade		9th Grade		11th Grade	
None	67%	63%	66%	61%	67%	62%
One	19%	18%	18%	18%	18%	18%
Two	8%	9%	8%	10%	8%	10%
Three	4%	5%	4%	6%	4%	5%

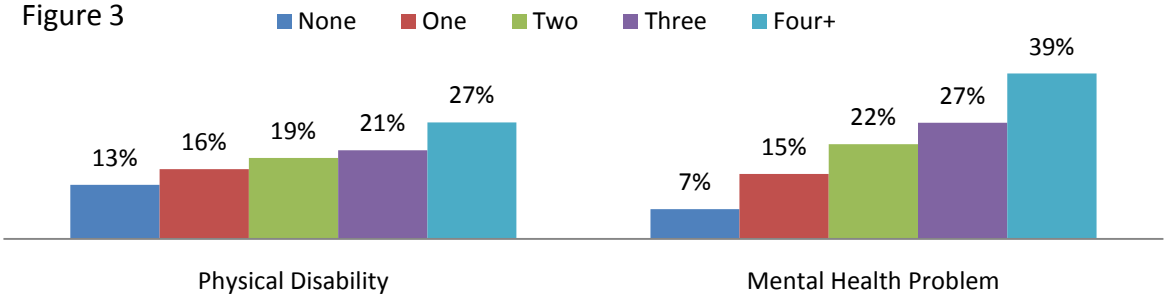
MENTAL HEALTH - The percentage of those students who reported significant problems in the 12 months prior to the study (feeling very trapped, alone, sad, blue, depressed or hopeless about the future) increased as their degree of trauma experienced in growing up increased. Percentages are of those with the given score. (Figure 2 below)

Figure 2



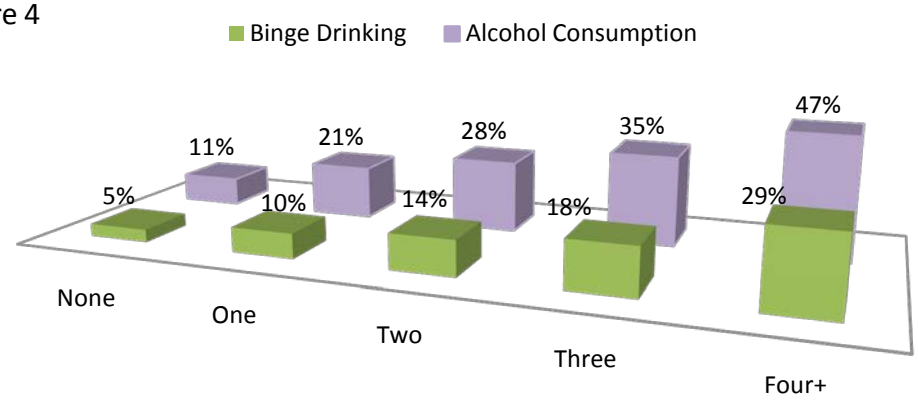
Long-term physical disabilities and mental health problems increased as ACE Scores increased. In all following charts, percentages are of those with the given score. (Figure 3)

Figure 3



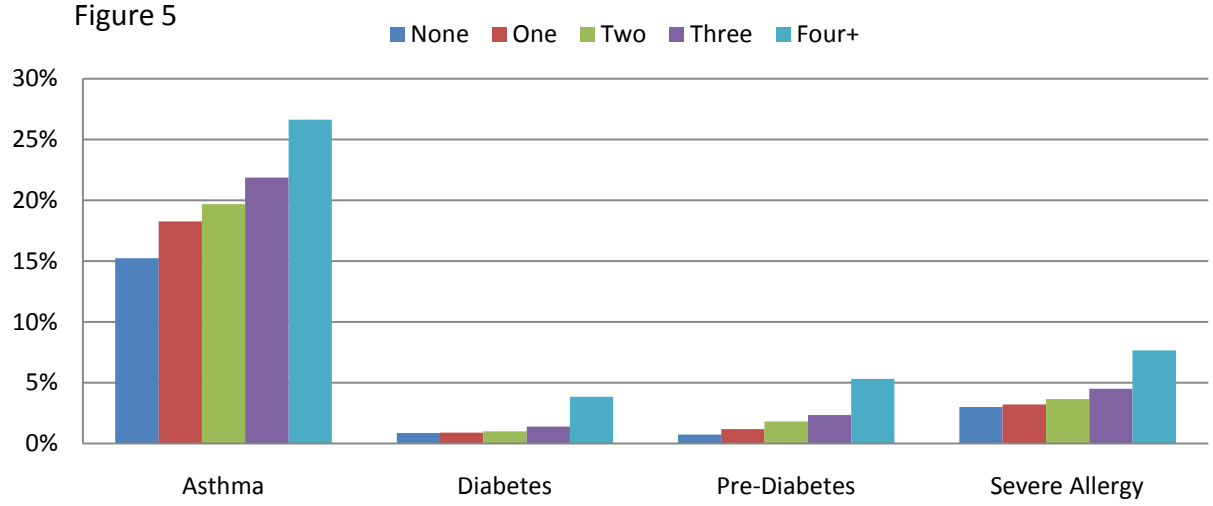
SUBSTANCE ABUSE – Binge drinking, cigarette smoking and alcohol use in the 30 days prior to the study also reflected a relationship to higher ACE scores. (Figure 4)

Figure 4



PHYSICAL HEALTH – A number of students reported physical disabilities or long-term health problems (such as asthma, cancer, diabetes, epilepsy, etc.). (Figure 5)

Figure 5



Other results from the 2013 Minnesota Student Survey are presented in the sections on Juvenile Justice and Mental Health and Schools and Mental Health.

Building Healthy Communities

Despite all these findings, adversity is not the end of the story. In the face of adversity, neither resilience nor disease is a certain outcome[57]. There is increasing understanding about resilience and what families, communities, and systems can do to protect children and support adults with ACEs.By reducing ACEs, we can reliably expect a reduction in many ACE-related health and social problems.

We recommend:

- Periodic collection of state-specific data on the relationship of ACEs, health outcomes, and resiliency to help communities develop strategies to promote mental and emotional well-being.
- Funding to continue statewide promotion of training and learning opportunities to increase community health and safety, understanding of community leaders, and collaboration of partners about ACEs, trauma, and resilience.
- Action to respond to multi-generational studies regarding parents with serious mental illness - in stages - so that the several agencies serving families can coordinate and collaborate on developing plans and policies.
- Funding for rate changes and the extra time needed for transportation by mental health professionals to allow for in-home services for mothers with mental illness.
- The Departments of Human Services, Education, and Health have begun to collaborate on early intervention strategies. We recommend that they likewise identify their programs that provide services and resources to teens and young adults. Research is

[57] Research and articles.

needed for identification and creation of successful resilience building approaches for this segment of our population. Programs that successfully build resilience should be enhanced through collaboration by the departments. While communicating the long-term outcomes associated with ACEs, approaches to build resilience should be included.

- Starting points to help lead to longer-term plans:
  - Continue research of parents with serious mental illness using a larger sample.
  - Ensure that parents struggling with serious mental illness receive clinical mental health services.
  - Support programs that nurture safe, stable relationships between a consistent caregiver and an infant or young child using a two-generation approach.
  - Expand the number of mental health professionals trained in working with parents with serious mental illness who have children ages 0-5 and increase support for their in-home services.
  - Provide special education workers referrals to mental health professionals trained in multi-generational interventions to facilitate smoother transitions in accessing their services.
  - Provide training on effective parenting skills for parents with serious mental illness to mental health clinicians, early childhood and adult providers, and case managers.
  - DHS should develop a program plan and supplemental budget proposal for the second half of the biennium to implement strategies, policies, and programs to help families and their children thrive when one or more parent has a mental illness.

Housing and Homelessness

Housing stability is critical for people who live with a mental illness[58]. It is imperative to develop strategies and provide resources for them to live in the community.

People with a serious mental illness are often the poorest of the poor. The monthly maximum SSI benefit in 2013 for an individual was $710.41. Thirty percent of this amount is $213[59]. At the same time, the median monthly rent in Minnesota is $764, based on the most recent American Communities Survey data[60].

Housing Subsidies and Assistance Programs

When a person with a mental illness has a voucher, such as a federal Housing and Urban Development (HUD)Section 8 Housing Choice Voucher, or a Minnesota Bridges Subsidy Voucher, the renter pays 30% of his or her income for the rental unit. To be eligible for a Bridges vouchers a person must have a serious mental illness and be at risk of homelessness or in an institutional level of care. Housing subsidies alleviate cost burdens; however, the demand for these vouchers exceedingly outnumbers the supply. The wait time to obtain a voucher can take years.

Bridges currently assists 707 households. In 2013 the Legislature appropriated an additional $400,000 to the Bridges base fund. The Minnesota Housing Finance Agency (MHFA) received 12 proposals for the funding for a total of over $1.4 million. The proposals were for 187 additional households.These figures demonstrate the overwhelming need for Bridges vouchers.

Minnesota has some other limited programs to assist people with serious mental illness, other disabilities, and the homeless.

The Housing Trust Fund Rent Assistance served 1,652 households in 2013. For rental assistance funding, there are three options: tenant-based, sponsor-based, and project-based rental assistance. Housing Trust Fund rental assistance is intended to be temporary in nature and to provide assistance through an Administrator to an individual household or through the owner of an Agency-financed development approved to receive project-based rental assistance.

Moving Home Minnesota is a Medicaid program that provides services to help eligible participants transition from an institution to community living. These services are provided in addition to services otherwise available under Medical Assistance. Participants work with a transition coordinator to identify needs and wants and arrange for appropriate services and supports. The goal is to create a person-centered plan for transition and successful, independent living in the community. Moving Home Minnesota focuses on supporting a person during the first year of transition from an institution to the community so he or she can remain in the community with supports and services available under Medical Assistance programs.

58See the Bazelon Center for Mental Health Law report on: The Americans with Disabilities Act (ADA) and integrated housing opportunities for people with mental illness, *A Place of My Own: How The ADA Is Creating Integrated Housing Opportunities For People With Mental Illnesses.* The report is available to download on the Bazelon Center's website: www.bazelon.org/portals/0/Where We Stand/Community Integration/Olmstead/A Place of My Own. Bazelon Center for Mental Health Law.pdf

59Social Security Administration. "SSI Federal Payment Amounts For 2013." http://www.ssa.gov/OACT/COLA/SSI.html

60Census Bureau. "American Community Survey 2012." http://www.census.gov/acs/www/data_documentation/data_main/

Permanent Supportive Housing Model

While the above programs provide some form of housing, we adamantly endorse utilizing an Evidence Based Practice-Permanent Supportive Housing model (Evidence Based Practice-Permanent Supportive Housing). An Evidence Based Practice-Permanent Supportive Housingwill meet the expectations of the Olmstead Decision and Minnesota's Olmstead Plan.

An Evidence Based Practice Permanent Supportive Housing model coordinates housing and support services. This combination helps a person succeed in the community.

Among its principles are:

- Choice in housing and living arrangements
- Separation of housing and services
- Integration into the community
- Rights of tenancy
- Safe and affordable housing
- Flexible, voluntary, and recovery-focused services

Examples of support services include:

- Assistance in accessing a psychiatrist or a psychologist
- Assertive Community Treatment (ACT) team
- Case management
- Medical care coordination
- Personal Care Assistance (Community First Services and Supports)
- Independent Living Skills, Home Health Aides
- Adult Rehabilitation Mental Health Services (ARMHS)
- Individual Placement and Support employment serves

Payment for the coordination of housing and support services has been a barrier as Evidence Based Practice-Permanent Supportive Housing is not reimbursable through Medicaid.

Critical Time Intervention

Critical Time Intervention (CTI) is a time-limited model designed to keep people with severe mental illness from falling into homelessness after discharge from a hospital, a shelter, a prison or other institutions. CTI provides emotional and practical support during this critical transitional period, as well as strengthening the person's ties to natural supports of family, friends, neighbors and community resources, which can remain available to the person after the CTI support has ended.

Reform of Group Residential Housing and Minnesota Supplemental Aid

The Council supports efforts to reform Group Residential Housing and GRH and Minnesota Supplemental Aid (MSA) Housing Support. State reform could leverage additional federal support. We believe efforts to increase the flexibility of these programs while maintaining their integrity will serve more individuals and better utilize available resources.

Homelessness

While the state has seen a substantial increase in the number of Minnesotans who are homeless since 2007, there has been an encouraging decline in the number of homeless veterans and

peopleconsidered chronically homeless[61]. We need to achieve similar results with families and at-risk youth where rates of homelessness have increased since 2007[62].

Minnesota's Plan to Prevent and End Homelessness recommends the establishment of a statewide coordinated assessment plan.[63] This will expedite both needed supports for homeless individuals most in need and the work of community support workers. A coordinated assessment pilot is currently operating in Ramsey County[64]. If the results match the expectations, we would support the expansion and modification of the pilot in a manner that would support coordinated assessments on a statewide basis.

The federal Projects for Assistance in Transition from Homelessness (PATH) program that provides outreach and related services to persons with SMI who are homeless and is one of the earliest programs designed to end homelessness for persons with mental illness. The state was recently awarded a federal Section 811 demonstration program. The Section 811 Demonstration will provide housing opportunities for people served by PATH and the Moving Home Minnesota Programs by providing 85 units of project-based rental assistance. Minnesota homelessness continues to grow and there are many unmet needs[65], but the above programs provide critical support to many households.

The Family Homeless Prevention and Assistance Program (FHPAP): assisted 9,314 households in 2013.FHPAP currently funds 19 grantees that serve all 87 counties in Minnesota. Funds are used for a broad range of activities aimed at homelessness prevention, minimizing episodes of homelessness, and eliminating repeat episodes of homelessness.

Ex-Offenders

Other individuals with multiple barriers to housing continue to be at high risk of homelessness. The housing of ex-offenders with mental health issues may be the most challenging placements faced by county workers and agencies[66]. Recidivism escalates when the ex-offender does not have access to a place to which he or she can call home[67]. The Department of Corrections plans to establish a tracing system to better facilitate pre-release plans being completed in a timely manner. The offender would return to the community with connections to people and agencies in place[68].

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[61] Key Trends in Affordable Housing; April 10, 2014; Page 5

[62] Wilder Research, "2012 Minnesota Homeless Study: Homeless Children and Their Families" (May 2014) http://www.wilder.org/Wilder-Research/Publications/Studies/Homelessness%20in%20Minnesota%202012%20Study/Homeless%20Children%20and%20Their%20Families.pdf

[63] Minnesota Plan to Prevent and End Homelessness (http://www.headinghomeminnesota.org/sites/default/files/MICHPLAN.pdf) page 40.

[64] http://www.ramsey.headinghomeminnesota.org/

[65] Key Trends in Affordable Housing; April 10, 2014; Page 46.

[66] According to a report from the Treatment Advocacy Center on the treatment of people with serious mental illness, there are now 10 times more people with serious mental illness in state prisons (207,000) and county jails (149,000) than there are in state mental hospitals (35,000). The report includes a state-by-state assessment of treatment of people with mental illness in jails and prisons. In 44 of the 50 states, the largest single "mental institution" is a prison or jail.

[67] "Status of Ex-Offender Re-entry in Cities" A 79 City Survey (2009) http://usmayors.org/pressreleases/uploads/REENTRYREPORT09.pdf (includes Minneapolis)

[68] Heading Home: Minnesota's Plan to Prevent and End Homelessness, December 2013, pages 29-31

We recommend:

- Additional resources to better address the unmet need of the Bridges Housing program to increase affordable housing opportunities for people with serious mental illnesses.
- Ongoing efforts by state and community stakeholders to find permanent solutions to potential impediments to the Evidence Based Practice Permanent Supportive Housing model and fund an Evidence Based Practice-Permanent Supportive Housing model that links funding for housing and services for people in supportive housing.
- There should be a housing continuum with a diverse array of services that best meets the needs and choices of people with a serious mental illness. We prefer scattered site supportive housing, as opposed to congregate, less integrated setting. This is contingent on the individual's choice.
- Critical Time Intervention supports for people being discharged hospitals, shelters, prisons, and other institutions that are at risk of re-institutionalization.
  Reform of Group Residential Housing and Minnesota Supplemental Aid Housing Support that will increase access and provide additional flexibility.
- Establish a coordinated assessment plan comparable to the Minnesota's Plan to Prevent and End Homelessness to better identify eligible homeless individuals for housing assistance and community supports in a timely manner.
- If successful, support the expansion of the Ramsey County pilot for coordinated assessments on a statewide basis.
- Full funding of the Homeless and Unaccompanied Youth Act.

Primary Care and Mental Health Reforms

Need Area #1: Appropriate Resources and Responses for Individuals with a Mental Health Crisis

Crisis Response Teams (CRT) (Adult and Children's) are now available in most counties of Minnesota. Investing in early intervention and crisis services saves money by helping reduce hospitalizations or other serious consequences[69]. Some data has been collected from the CRTs; however, data continues to be unavailable because there is not a set of rules or best practices for the CRTs.

We recommend:

- Sustainable funding for mobile crisis teams for children and adults in all areas of the state.
- Funding for access to crisis stabilization and crisis residential services within an individual's community.
- Statewide training for law enforcement on mental illnesses, crisis de-escalation and local mental health resources.
    - Pre-certification training for new officers
    - On-going certification for current officers
    - 911 dispatcher training to ask the right questions, gather the necessary information, and refer to the appropriate resources
- Training for emergency room personnel on mental illness and crisis de-escalation.
- Funding for additional counties to divert individuals with mental illness or co-occurring disorders to treatment and services when they intersect with the criminal justice system (this is being done in Olmsted County).
- A statewide telephone number and text line for access to mobile crisis teams.

Need Area #2: Timely Access to Psychiatric, Counseling, and Community Services

It takes far too long for individuals with mental health issues to access treatment. They often wait months for appointments and services[70]. The state should have a holistic approach that integrates mental health evaluation and treatment with primary health care throughout the lifespan. Federally Qualified Health Centers (FQHCs) use such an approach to provide comprehensive services to underserved populations.

We recommend:

- Workforce initiatives such as education and training grants and loan repayment/forgiveness programs for mental health professions.
- Funding to develop models for collaboration of community health and mental health agencies in rural areas.

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[69]Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014., p.8 http://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf

[70] Minnesota Department of Human Services. Plan for the Anoka Metro Regional Treatment Center, February 18, 2014.

- Authority for mental health professionals to assist an individual with routine services such as medication monitoring, counseling, consultation, and in some cases, home visits.
- Expand mental health urgent care models, similar to the East Metro Urgent Care for Adult Mental Health.

Need Area #3: A Comprehensive Array of Home and Community Based Mental Health Services that Best Meet the Needs of Children and Adults

Children and adults living with mental illness often have difficulty accessing the services and supports they need to be healthy and successful. Those who have accessed community support typically have done so through the Community Alternatives for Disabled Individuals (CADI) waiver or with Community First Services and Supports (CFSS) (formerly Personal Care Attendants [PCA][71]).

However, the nursing home level of care criteria used for CADI[72] and CFSS criteria[73]do not adequately account for the needs of individuals with mental illness, which will likely mean that fewer people with mental illness will be eligible for those services.

The current definition of dependency for CFSS (PCA) services limits eligibility to people who need "constant" cueing and supervision, i.e., hands-on physical assistance. Previously, people with mental illness were eligible for PCA services when they are physically able to accomplish tasks with cuing and supervision that were necessary to maintain their independence, but might not be categorized as "constant". The definition for CFSS should remove the word "constant."

MINNESOTA STATUTE 256B.85 COMMUNITY FIRST SERVICES AND SUPPORTS

*Subdivision 1.**Basis and scope.*

(a) Upon federal approval, the commissioner shall establish a medical assistance state plan option for the provision of home and community-based personal assistance service and supports called "community first services and supports (CFSS)."

(b) CFSS is a participant-controlled method of selecting and providing services and supports that allows the participant maximum control of the services and supports. Participants may choose the degree to which they direct and manage their supports by choosing to have a significant and meaningful role in the management of services and supports including by directly employing support workers with the necessary supports to perform that function.

(c) CFSS is available statewide to eligible individuals to assist with accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related procedures and tasks through hands-on assistance to accomplish the task or ***constant*** *supervision and cueing to accomplish the task; and to assist with acquiring, maintaining, and enhancing the skills necessary to accomplish ADLs, IADLs, and health-related procedures and tasks.*

We recommend:

- The MnCHOICES assessment tool needs to be carefully analyzed and amended as needed to make it viable for people with mental illnesses and related disorders. Currently, it is geared toward individuals with physical and developmental disabilities.

[71]Minnesota Statutes 256B.85 Community First Services and Supports (2013).
[72]Minnesota Statutes, section 144.0724, subdivision 11 (2013)
[73]Minnesota Statutes 256B.85, Subdivision 1.(c) (2013)

- The State should remove the word "constant" for eligibility for CFSS (PCA) services so that individuals with mental illnesses who need prompting and cueing in order to accomplish essential tasks to remain independent in their homes can receive those services.

Need Area #4: Olmstead Integration of People with Mental Illnesses into Department of Natural Resources Programs and Services

Individuals with mental health disabilities are not treated equally with people with physical disabilities for access to Department of Natural Resources (DNR) services. For example, physically disabled people with handicap placards can get into state parks for a reduce fee, regardless of their income. Individuals with mental health disabilities have to pay the full rate[74].

Given the state's goal in the "10 x 10" project; to increase the lifespan of people with mental illnesses by 10 years within 10 years; access to state parks and programs makes good health sense, promotes integration into the community, and reflects parity in the provision of services.

We recommend:

- The Governor, Legislature, and the Department of Natural Resources should support a legislative initiative to make statutes and rules governing the Department of Natural Resources "disability neutral" in their application to people with disabilities.

Need Area #5: Psychiatric Consultation to Primary Care Practitioners

People often turn to their primary care providers when they are concerned about the mental health of themselves or their loved one. Others may be unable to get an appointment with a mental health provider due to workforce shortages. Additionally, there is a movement towards more integration of primary and mental health care. However, many primary care providers lack the training and resources necessary to provide mental health care, especially for more serious mental illnesses.

Psychiatric consultation to primary care providers by psychiatrists, psychologists, and psychiatrically trained advanced practice registered nurses is a service available under Medical Assistance. But this service is underutilized and primary care practitioners are not able to receive consultation from all of the professionals who would be qualified to provide this service.

Minnesota has carefully defined "mental health professionals" with a common set of standards of educational competencies and supervised experience practicing in the state regardless of their professional discipline[75].

We recommend:

- Allowing any mental health professional to provide mental health consultation to primary care practitioners in order to increase the availability of this service and to modify Minnesota Statute 256.0625 as follows:

  Minnesota Statute 256.0625, Subd. 48. Psychiatric consultation to primary care practitioners. Medical assistance covers consultation provided by a mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (6), and section

[74] Minnesota Statutes 85.052 (2013) and Minnesota Statutes 85.053 (2013)

[75] Baseline of Competency: Common Licensing Standards for Mental Health Professionals, Department of Human Services Report to the Legislature, January 15, 2007.

245.4871, subdivision 27, clauses (1) to (5) psychiatrist, a psychologist, or an advanced practice registered nurse certified in psychiatric mental health via telephone, e-mail, facsimile, or other means of communication to primary care practitioners, including pediatricians. The need for consultation and the receipt of the consultation must be documented in the patient record maintained by the primary care practitioner. If the patient consents, and subject to federal limitations and data privacy provisions, the consultation may be provided without the patient present.

- Outreach should be provided to primary care practitioners and mental health professionals about the availability of psychiatric consultation to encourage more providers to utilize this service.

MinnesotaState Advisory Council on Mental Health

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