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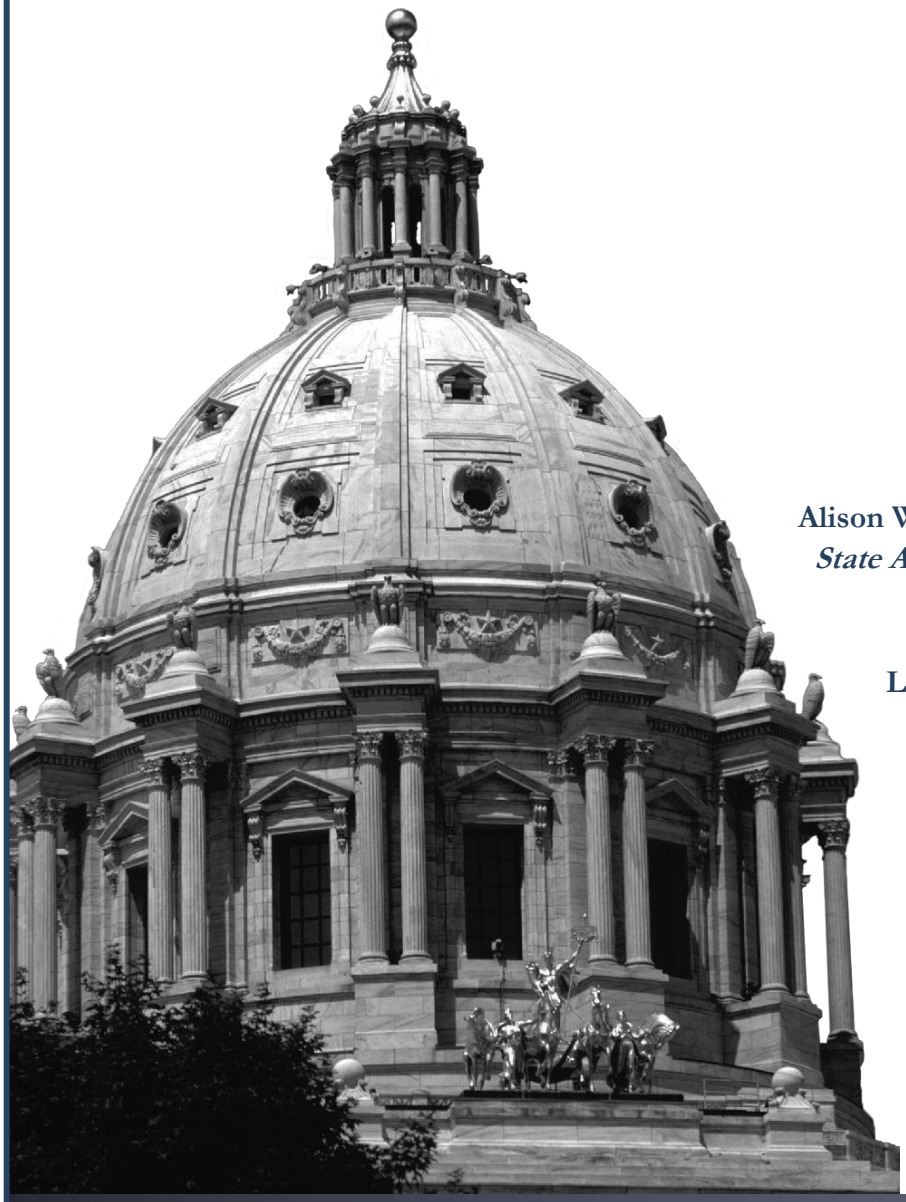
STATE ADVISORY COUNCIL ON MENTAL HEALTH
and Subcommittee on Children's Mental Health

2012 Report *to the* Governor and Legislature



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Introduction: Letter from the Chairs

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

The upcoming biennium will be challenging. The State must work within limited resources. To guide you in that work, we invite you to consider:

There are some overarching issues that permeate the themes of our report:

- Stigma of mental illnesses and mental health concerns continues to exist
- The population of Minnesota is becoming more culturally diverse and the mental health system must be equipped to address that diversity
- Services are to be delivered in a new way because of health care reform
- Research in the mental health field is growing exponentially; for example the impact of childhood trauma and adverse experiences in early childhood has been found to impact an individual's entire lifespan

Our recommendations represent a consensus of stakeholders from all aspects of the mental health system including: present or former recipients of mental health services (consumers), family members of adults, parents of children, mental health professionals, advocates, county staff, elected officials, state department representatives and others. Through our personal and professional experiences, we are promoting policies that are responsive to the needs of adults and children with mental health issues that are efficient and cost-effective.

The recommendations highlight the following:

- Improvement of mental health awareness, cultural sensitivity and competency among all communities to address disparities in the mental health system
- Opportunities to prevent the unnecessary engagement in Minnesota's juvenile justice system for children and youth who have mental health and/or co-occurring mental health and chemical dependency issues
- Services and systems to improve outcomes for children in schools
- Supports and services to maintain permanent housing and prevent homelessness
- Timely and affordable access to quality mental health care for all Minnesotans
- Strategies to empower local mental health advisory councils

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

We are pleased to present our 2012 Report to the Governor and Legislature.

Alison M Wolbeck

Alison Wolbeck
Chair, State Advisory Council on Mental Health

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COST TO PREPARE REPORT

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

Executive Summary

The State Advisory Council on Mental Health was established in 1987[1]. The Council is a bipartisan Governor-appointed body consisting of a broad array of stakeholders, including present recipients or former recipients of mental health services (consumers), family members of adults with mental illnesses and parents of children with emotional disturbances, providers of services, advocates, elected officials, state representatives and others as required by the law.

The Children's Subcommittee was established in 1989 in order to make recommendations to the Council on policies, laws, regulations, and services relating to children's mental health[2]. The Council and Subcommittee are to report to the Governor and Legislature before each even numbered biennial legislative session[3].

The State Advisory Council and Children's Subcommittee have established the following work groups:

- Outreach to culturally diverse communities
- Mental health and juvenile justice
- Mental health and schools
- Mental health and housing and homelessness
- Primary care and mental health reforms
- Local mental health advisory councils

Highlights of our recommendations include:

The **2007 Mental Health Initiative** established grants to counties to support an array of community-based services and support: these grants should not only be maintained, but expanded. The grants were designed to help ensure that people living with mental illnesses who are uninsured or underinsured have access to timely and effective treatment and supports remain continue to live at home. The grants include crisis response services and school linked mental health services. The positive effects of avoiding deep end services by early intervention make these services both person-centered and cost effective.

Outreach to Diverse Communities

Disparities in the availability and access to mental health services and service outcomes among diverse communities have been a focus of concern over the past three decades. Several studies and

[1] Minnesota Statute 245.697.
[2] Minnesota Statute 245.697 Subd. 2a.
[3] Minnesota Statute 245.697 Subd. 3.

reports have highlighted barriers to the treatment and delivery of mental health services in culturally and linguistically diverse communities. Some state initiatives have been implemented to address these barriers. However, the growing diversity and dispersal of ethnic minority communities throughout Minnesota heightens the need to ensure that all mental health staff and other professional providers practice the delivery of mental health services to children effectively in cross-cultural situations. In order to provide a framework for improving the accessibility and responsiveness of mental health services to Minnesotans in culturally and linguistically diverse communities we recommend:

An advisory group consisting of persons from diverse communities should be established to assist the Minnesota Department of Human Services (DHS) when developing Request for Proposals (RFP) projects that are designed to serve persons in diverse communities so that DHS can reach out to members of cultural groups for ideas about RFPs that are intended to support that group.

- Four hours of Continuing Education training in cultural and linguistic competence should be required annually for all professional disciplines working with children that require state licensure. These four hours of training would be a requirement to obtain and maintain professional licenses and would apply to professionals such as teachers, medical professionals, mental health professionals, corrections workers, and police officers.
- All state health plans should provide and receive 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 for the effective delivery of culturally competent mental health services. Presently, private provider agencies are not subsidized for interpreter services. They bear the expenses while health plans have a provision to pay for the interpreter services. Private and public plans should both cover these costs.
- There should be a study of how to better utilize new technology to communicate and disseminate mental health services information and instructions to persons of diverse cultures and languages.

Mental Health and Schools

School-Linked Mental Health grants are effective in preventing suspensions, expulsions, and involvement in the juvenile justice system.

Between 46%-59% of students served each quarter by their school-linked mental health program accessed mental health services for the first time. Many children with serious mental health needs were first identified through the school-linked mental health programs, including 45% of children who met the criteria for Serious Emotional Disturbance (3,749 children total).

Students of color served by school-linked mental health grants were significantly more likely to access mental health services for the first time compared to white students served (58% to 52%)[4]. In particular, a higher portion of Asian (69%) and Black (56%) students served accessed services for the first time compared to White students served (52%).

The benefits of school-linked mental health services include:

- Reduced barriers to learning
- Increased accessibility to mental health services
- Improved functioning of children with mental illnesses
- Reduced negative symptoms
- Less time spent out of class
- Less time away from work for parents transporting their children to treatment
- On site consultation with teachers
- Significantly reduced suspension and truancy rates

We recommend:

- Increase direct grant funding for school-linked mental health services.
- Add staff at the Department of Human Services (DHS) to strengthen program evaluation and quality improvement activities including annual site visits and the provision of follow-up technical assistance to grantees consistent with findings from site visits, grant contract reporting, and evaluation data.
- Appropriate state funds for Positive Behavioral Interventions and Supports, which has operated solely with federal funds to date.
- Support efforts of the Minnesota Department of Education and local schools and school systems to further implement School-Wide Positive Behavioral Intervention and Supports into Minnesota schools, and help target such efforts to schools that have high rates of referrals to the juvenile justice system.

Juvenile Justice

Research on **Adverse Childhood Experiences** (ACEs) and trauma, highlighted in the Juvenile Justice Section of our report has proven to show the connection between negative outcomes in youth and adulthood with the number of ACEs in childhood. Relationships between ACE scores emerged for health risk behaviors such as:

- Early smoking initiation, current smoking and smoking persistence;
- Early drinking initiation and problems with alcohol, drug abuse and addiction;
- History of sexually transmitted diseases and HIV risks; and
- Low physical activity, severe obesity, and poor self-rated health.

[4] (Chi-square=98.0 , p=.000)

ACE scores were predictors of mental health issues, including:

- Lifetime history of depression;
- Suicide attempts; and
- Reported amnesia for childhood experiences.

The trauma associated with early adversity can create a progression of effects, from:

- Social, emotional and cognitive impairments; leading to -
- Adoption of health-risk behaviors; leading to -
- Disease, disability and social problems; leading to -
- Early death.

The State Departments of Human Services, Health, and Education are collaborating in following up on ACE research.

We recommend that the State support the efforts of State agencies to incorporate ACE-related activities into State and State-supported practices. ACE-related information should be incorporated into screenings and assessments of youth at risk of, or who are entering the juvenile justice system. The Departments of Human Services, Education and Health should be charged with outreach to Minnesota's juvenile justice system at both organizational and service levels to develop understanding of the implications of ACEs and promote the development of trauma-informed practices. Juvenile justice intervention strategies should be responsive to trauma-related experiences of these youth.

Mental Health Screening for youth in the juvenile justice and child welfare systems has been in place since 2005. In 2011 the legislature adopted the requirement that parents must choose to "opt in" to the screening, as opposed to the previous standard that parents would "opt out."

We recommend:

- The State examine whether the 2011 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.

Children born to mothers that are abusing drugs and/or alcohol during pregnancy may be at a distinct disadvantage throughout their development. However, statistics about such children are not being tracked statewide by either state Health or Human Service departments. We recommend that:

- A repository for information about children born to mothers that are actively using drugs and alcohol should be developed within the Department of Health so that we may gain a better understanding of the issue and develop interventions that may address the problem; and

- Treatment facilities and programs targeting youth at risk of involvement or in the juvenile justice system develop integrated mental health and chemical dependency treatment modalities into their programs so co-occurring disorders can be more effectively treated and risk of relapse and recidivism reduced.

Housing and Homelessness

Minnesota offers some housing programs for persons with mental illnesses. The programs offer important support to those individuals who meet the eligibility criteria but are unable to obtain a housing voucher from the federal Department of Housing and Urban Development (HUD).

Minnesota should focus its resources on evidence-based programs and models that help persons with mental illnesses obtain and retain permanent, safe and affordable housing with a flexible and voluntary array of support services. Effective supportive housing programs will result in a positive return of investment for the state.

Employment is a key factor in reducing long term homelessness and maintaining permanent supportive housing. Individual Placement Support (IPS) should be incorporated into plans to expand permanent supportive housing in Minnesota. No targeted funding for linking these two evidenced based practices exists in Minnesota.

The **Bridges subsidy program** provides vouchers to eligible individuals with a mental illness who are homeless, living in a shelter, outside, or in a place not intended for human habitation.

The **Bridges RTC Program** is a pilot program begun in the spring of 2012 by DHS, providing housing subsidies for people with mental illnesses ready for discharge from Anoka Metro Regional Treatment Center who do not meet the hospital level of care. The grants to the Seven County Metro Area and Greater Minnesota will support 81 households between 2012 and the end of the pilot on June 30, 2014.

We recommend:

- Support Housing with Supports for Adults with Serious Mental Illnesses (HSASMI): HSASMI is a DHS Adult Mental Health Division program operated in partnership with the Minnesota Housing Finance Agency (MHFA). HSASMI funds may be used for a range of supportive housing for persons with mental illnesses. The grants provide an operational subsidy for tasks associated with housing tenancy support services which are not covered by Medical Assistance or HUD funding but are critical to successful supportive housing.
- Funding streams should be developed to enable providers of supportive housing to provide the infrastructure and service coordination necessary to link employment and housing support services.
- An increased allocation should be made to the Bridges subsidy program.

- The effectiveness of the Bridges RTC Program be assessed and if found successful, the program and its funding should be extended.

Primary Care and Mental Health Reforms

In calendar year 2011, unmet needs were identified by local advisory councils throughout the state. The need for timely access to psychiatric and counseling services far outstripped all other identified unmet needs. This need was identified across the entire state, but especially in rural areas. Other unmet needs were noted in the areas of:

- Access to qualified mental health professionals.
- Access to appointments with existing mental health providers.
- Difficulty recruiting mental health providers (especially in rural areas).
- A need to develop same day, walk-in clinics (much like an urgent care model for physical health needs) to avert a mental health crisis and avoid the need for more costly emergency room treatment and/or psychiatric hospitalization.

We recommend:

- DHS data collection should analyze barriers to statewide access to mental health services, and county cost-efficiency regarding the following:
    - Mental health case management
    - Adult foster care
    - Adult Rehabilitative Mental Health Services [ARMHS]
    - Intensive Residential Treatment Services [IRTS]
    - Community Alternatives for Disabled Individuals [CADI]
    - Dental care access for individuals with mental illness
- Workforce initiatives such as education and training grants and loan repayment/forgiveness programs for mental health professions.
- Development of models and funding for the infrastructure needed to support community health agencies and mental health provider agencies to develop collaborative models in the rural areas.
- Continued support for the use of technology (such as interactive videoconferencing) to deal with critical provider shortages and long distance driving, especially in rural and remote areas of the state.

The current health service delivery system in Minnesota is predominately separate, disjointed, and expensive. Clients often deal with multiple health issues but rarely are these addressed in a coordinated and cost-effective manner. We recommend that policies and funding streams be modified in the following areas:

- Develop a single screening, evaluation and treatment plan across all areas. Current payment system must be modified to accommodate evaluation and consultation, not just treatment.
- Continue to expand programs that focus on collaboration.
- Better collaboration between county human services and the Veterans' Administration to provide timely access for veterans to community-based mental health services.
- Significant resources to expand Integrated Dual Disorder Treatment (IDDT)[5] programs in both inpatient and outpatient settings so that they are available throughout the state.

Mobile 24/7 crisis response teams reduce community costs and inpatient hospitalizations and stabilize individuals in acute crisis situations. Yet they are not implemented across the state, and resources are limited for those crisis response teams that are currently operating. We recommend:

- DHS data collection should identify the financial cost of establishing and operating mobile crisis response teams by county, the cost savings of hospital diversions by county where mobile crisis response teams exist, and the potential funding mechanisms to implement these teams in *all* counties of the state.

The 2007 Mental Health Initiative established grants to counties to support an array of community-based services and supports. However, data about how the funds are being used, the number of people receiving services, and outcomes for consumers, is not readily available to the legislature and the public. We recommend:

- DHS collect and analyze data about how counties are utilizing these grants, how many people are accessing services supported by the grants, and consumer outcomes (for example, reduction in the number and frequency of hospitalizations).

Children and adults living with mental illnesses often have difficulty accessing the services and supports they need to be healthy and successful. People who have been able to access services have typically done so through the Community Alternatives for Disabled Individuals (CADI) Waiver or the Personal Care Assistant program. However, proposed changes will likely mean significantly fewer people with mental illnesses will be eligible. We recommend:

- The development of a 1915(i) state plan option specifically for people with mental illnesses to provide services which are flexible in terms of type and intensity and broadening the 1915(i) state plan proposal so that it can effectively provide services to persons *before* they end up in psychiatric hospitals, prisons, jails, or nursing facilities.

- The 1915(i) state plan proposal for employment services should include the use of evidenced-based supported employment (Individual Placements and Support – IPS).

[5] http://www.centerforebp.case.edu/practices/sami/iddt

- 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.

- DHS should work with stakeholders to develop a 1915(i) option for children.

- The State should modify Minnesota's PCA program to ensure that people living with a mental illness who need PCA services are able to access them. Specifically, the definition of dependency in the PCA program should be changed to include persons who need prompting and cuing to accomplish activities of daily living, as the program used to permit.

DHS should address barriers to accessing Adult Rehabilitative Mental Health Services (ARMHS). Current rate structure limits have made ARMHS unsustainable for providers and some providers are no longer offering this service.

Local Advisory Councils

We recommend:

- The Department of Human Services develop a plan that coordinates the role of the State Advisory Council and other entities associated with providing technical assistance to Local Advisory Councils and, in consultation with the State Advisory Council, develop a process of ensuring that Local Advisory Councils are reporting their unmet needs to the State and their county boards; and
- A portion of State funding should support of the work of Local Advisory Councils. Counties shall report the amount of financial support they are providing to their Local Advisory Councils.

1. Outreach to Diverse Communities

Background

Disparities in the availability and access to mental health services and service outcomes among diverse communities have been a focus of concern, debate and research over the past three decades. Several studies and landmark reports have highlighted barriers to the treatment and delivery of mental health services in culturally and linguistically diverse communities[6]. Some state initiatives have been implemented to address these barriers[7].

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[6] *Eliminating Disparities in Mental Health: An Overview*. NAMI Multicultural Action Center (2006) http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Annual_Minority_Mental_Healthcare_Symposia/DisparitiesOverview.pdf

[7] Ohio: http://www.mh.state.oh.us/what-we-believe/cultural-competence.shtml
California: http://www.dmh.ca.gov/Multicultural_Services/CRDP.asp

Such initiatives include the Ethnic Minority and Cultural Infrastructure grants in 2007 and 2009 to support the increased availability of mental health services for persons from diverse communities within the state of Minnesota. The Outreach to Diverse Communities Work Group commends the Governor and the Legislature for this initiative. However, the growing diversity and dispersal of ethnic minority communities throughout Minnesota heightens the need to ensure that all mental health staff and other professional providers practice the delivery of mental health services to children effectively in cross-cultural situations.

The Outreach to Diverse Communities Work Group makes the following recommendations to the Governor and Legislature which will provide a framework for improving the accessibility and responsiveness of mental health services to Minnesotans in culturally and linguistically diverse communities.

Recommendations

1. An advisory group consisting of persons from diverse communities should be established to assist the Minnesota Department of Human Services (DHS) when developing Request for Proposals (RFP) projects that are designed to serve persons in diverse communities so that DHS can reach out to members of cultural groups for ideas about RFPs that are intended to support that group.
2. Four hours of Continuing Education training in cultural and linguistic competence should be required annually for all professional disciplines working with children that require state licensure. These four hours of training would be a requirement to obtain and maintain professional licenses and would apply to professionals such as teachers, medical professionals, mental health professionals, corrections workers, and police officers.
3. All state health plans should provide and receive 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 for the effective delivery of culturally competent mental health services. Presently, private provider agencies are not subsidized for interpreter services. They bear the expenses while health plans have a provision to pay for the interpreter services. Private and public plans should both cover these costs.
4. There should be a study of how to better utilize new technology to communicate and disseminate mental health services information and instructions to persons of diverse cultures and languages.

2. Mental Health and Schools

Background

Children and youth often face barriers to accessing mental health treatment such as transportation, insurance coverage and shortage of mental health professionals. We know that children and youth with mental health concerns have poor academic outcomes, experience a greater rate of suspension and expulsion, as well as the use of seclusion and restraints. More must be done to improve the outcomes for children and youth with mental illnesses in educational settings.

Innovations in education and in children's mental health are growing rapidly. Two examples are **School Linked Mental Health Services (SLMH)** and **Positive Behavioral Interventions and Supports (PBIS**).

School Linked Mental Health Services (SLMH) is an evidence-based intervention. These services are a great opportunity for mental health promotion and prevention as well as early identification and intervention. In Minnesota, twenty (20) SLMH agencies in specific school districts are receiving grants from the Department of Human Services (DHS) to provide licensed mental health professionals and/or clinically supervised mental health practitioners in each participating school. SLMH services were created as part of the 2007 Mental Health Initiative.

Most SLMH services are provided in schools, but non-school locations can be offered in accord with family choice. Clinical services offered include diagnostic assessments, individual, group and family psychotherapy, and skills training services. When insurance is available, clinical services are billed to both private and public insurance to help reimburse the costs. The grant pays for clinical services for students who lack insurance coverage as well as "ancillary and supportive services" for all students regardless of insurance status. SLMH services are not a replacement for either community-based mental health services or services provided by school staff to students experiencing mental health difficulties.

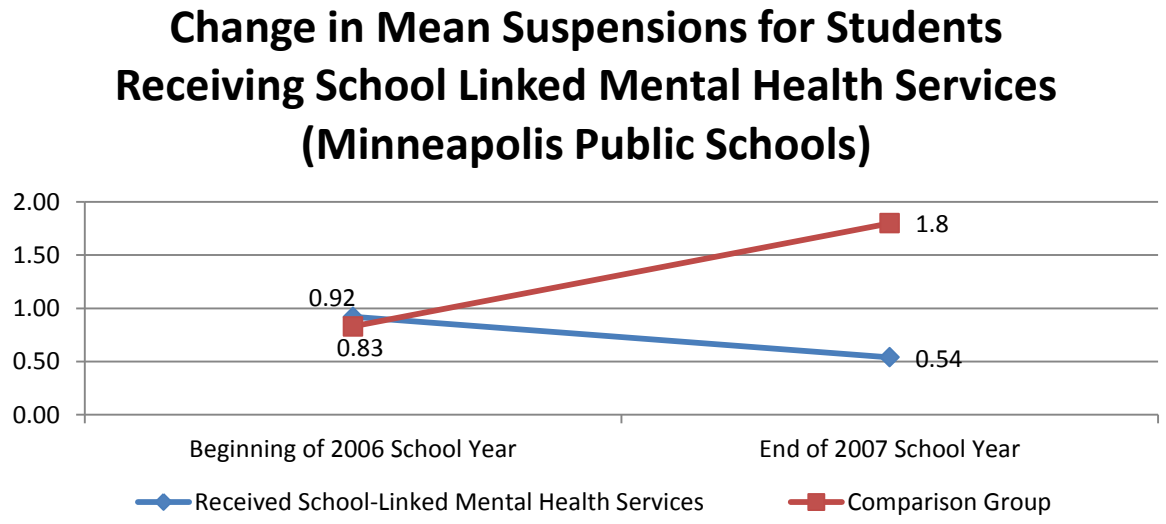
Ancillary and supportive services are highly associated with positive student outcomes. Examples include consultation with teachers and parents about individual students, training school staff to recognize the signs and symptoms of mental health conditions and how to refer students to the SLMH program.

SLMH grant programs have demonstrated success in achieving one of the most critical goals: **To increase access to children's mental health services**. SLMH services have consistently provided access to students whose mental health needs had not previously been recognized. Between 46% to 59% of students served each quarter by their SLMH program accessed mental health services for the first time, including 45% of children who met the criteria for Serious Emotional Disturbance (3,749 children total).

For some students from cultural and ethnic minority communities, school based access to mental health services is especially important. Overall, students of color served by SLMH were significantly more likely to be accessing mental health services for the first time compared to White students served (58% to 52%)[8]. In particular, a higher number of Asian (69%) and Black (56%) students served had accessed services for the first time.

The benefits of SLMH services include:

- Reduced barriers to learning
- Increased accessibility to mental health services
- Improved functioning of children with mental illnesses
- Improve symptoms and functioning
- Less time spent out of class
- Less time away from work for parents transporting their children to treatment
- On site consultation with teachers
- Significantly reduced suspension and truancy rates



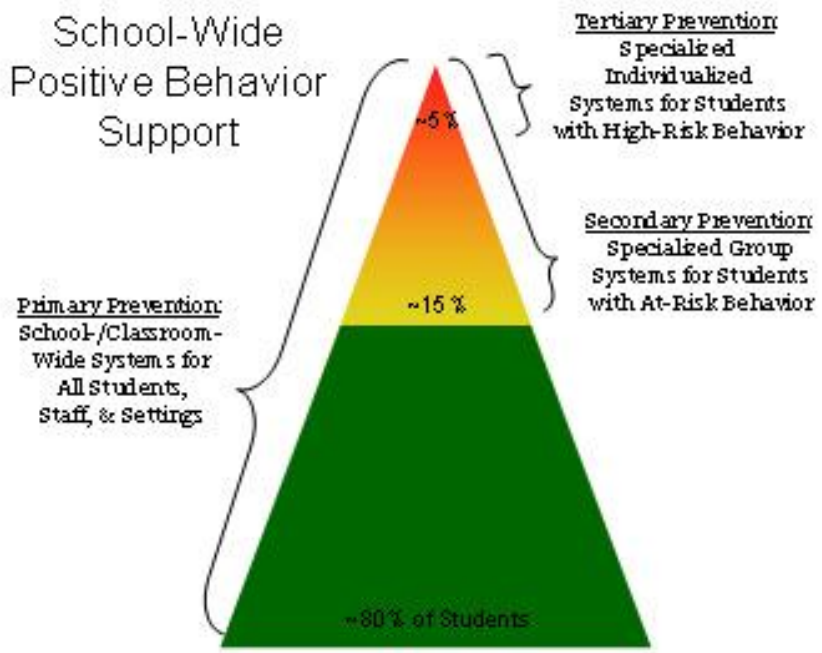
[9]

School linked programs have improved access to diagnosis of and treatment for the mental health problems of children and adolescents. Expanded school linked mental health services are vital to meeting the needs of students.

[8] (Chi-square=98.0 , p=.000)

[9] Sander, M.A., Everts, J. & Johnson, J. (2011). *Using Data to Inform Program Design and Implementation and Make the Case for School Mental Health. Advances in School Mental Health Promotion*, 4 (4), 13-21 http://www.ingentaconnect.com/content/cbf/asmhp/2011/00000004/00000004/art00003

Positive Behavior Interventions and Supports (PBIS)



Positive Behavior Interventions and Supports (PBIS) is a broad range of systematic and individualized strategies for achieving important social and learning outcomes while preventing problem behavior (OSEP Center on PBIS, 2010). PBIS refers to a systems change process for an entire school or district. The underlying theme is teaching behavioral expectations in the same manner as any core curriculum subject[10].

School-Wide Positive Behavioral Interventions & Supports provides an operational framework for achieving these outcomes. More importantly, School-Wide Positive Behavioral Interventions & Supports are NOT a curriculum or practice, but IS a data-based, decision making framework to guide selection and implementation of the best evidence-based academic and behavioral practices for improving important academic and behavioral outcomes for all students[11] .

Recent research indicates that School-Wide Positive Behavioral Interventions & Supports are associated with decreased exclusionary, reactive, and punitive discipline. Horner, Sugai, Todd, & Lewis-Palmer, 2005, demonstrated similar findings with another school district with nineteen elementary schools. Between the 1997-98 and 2001-2002 academic years, thirteen of the schools implemented school-wide positive behavior support and six schools did not. They compared the percentage of third graders who met statewide reading standards in the academic year 1997-98 with the percentage in the academic year 2001-2002. Ten out of the thirteen schools (77%) that adopted

[10] See http://www.pbis.org/common/cms/documents/WhatIsPBIS/WhatIsSWPBS.pdf, http://pbismn.org/PBISschools.html and http://www.cms.k12.nc.us/cmsdepartments/PBIS/Pages/default.aspx).

[11] Examples may include peer mentoring programs or calming techniques for individual students.

school-wide positive behavior support practices had improved outcomes. The change in percentage of students meeting standards ranged from 2% to over 15% in these schools. Only one of the six schools (16%) that not did implement school-wide positive behavior support showed improvement.[12]

Since its introduction in 2004, 370 of the 2,000 schools in Minnesota have begun implementing PBIS. In order to increase the number of students benefitting from an improved educational and mental health environment it is essential to enhance the amount of resources dedicated to administration of the grants. This enhancement would enable the state to successfully develop, implement, evaluate and expand programs across the state and assist schools and agencies to financially sustain the delivery of PBIS and SLMH services to students.

Recommendations

The Mental Health and Schools Work Group proposes the following recommendations:

1. Increase funding for School Linked Mental Health for direct grants, and for additional staff at DHS to strengthen program evaluation and quality improvement activities including annual site visits and the provision of follow-up technical assistance to grantees consistent with findings from the site visits, grant contract reporting, and evaluation data.

2. Appropriate state funds to maintain effective and efficient infrastructure for both Positive Behavioral Services and Supports and School Linked Mental Health services.

3. Increase the number of programs across the state integrating Positive Behavioral Services and Supports and School Linked Mental Health services.

Anecdote

School Linked Mental Health services are in the Aitkin Public Schools. One mother shared how her daughter has Attention Deficit Hyperactivity Disorder (ADHD), learning disabilities and anxiety. She was having trouble in school and at home. With SLMH Services she has learned how to deal with her frustration and anxiety. They have helped her deal with her past problems and she is now more positive about herself. As soon as she feels frustrated or anxious she knows that there is someone at school who is qualified to help her and she is now learning strategies to help her. The family lives 20 miles out of town and they have jobs that do not have flexible schedules. The SLMH program has reduced barriers to their daughter obtaining needed mental health services.

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[12] Horner, R.H, Sugai, G., Todd, A.W., and Lewis-Palmer, T. (2005). *Illinois Positive Behavior Interventions and Supports Project: 2003-2004 Progress Report.* University of Oregon: Center on Positive Behavior Interventions and Supports & Illinois State Board of Education. http://docs2.pbisillinois.org/Online_Library/Downloads/Reports/FY04%20PBIS%20Report.pdf. See also: http://www.bazelon.org/LinkClick.aspx?fileticket=URI2hc1RS7A%3D&tabid=333

3. Mental Health and Juvenile Justice

Focus of this report:

The focus of this report is: "Opportunities to prevent the unnecessary engagement in Minnesota's Juvenile Justice System for children and youth who have mental health and/or co-occurring mental health and chemical dependency issues."

Background

The 1999 US Surgeon General's report on mental health found that approximately 21% of all children and youth experience a mental health disorder and that half are severe enough to cause impairment at home, school, or in the community[13]. A 2006 study by the National Center for Mental Health and Juvenile Justice found that 70% of youth in juvenile justice suffer from a mental health disorder. Over one-third experience a disorder so severe that it impairs their ability to function[14].

Unrecognized and/or untreated mental health problems significantly contribute to a youth's chances of becoming engaged in the juvenile justice system. The lack of early identification of mental health needs and corresponding provision of treatment services to address these needs often results in increased and more costly juvenile justice involvement in the lives of these children and youth. 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, and the likelihood of further and deeper engagement in the justice system increases, often up through adulthood.

Key issues:

A. Impact of early trauma on brain development and implications for risk factors associated with future juvenile justice involvement (Adverse Childhood Experiences)

A study on Adverse Childhood Experiences was conducted at Kaiser Permanente from 1995 to 1997 (http://www.cdc.gov/ace/). More than 17,000 participants completed a standardized physical examination. The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. Progress in preventing and recovering from the nation's worst health and social problems is likely to benefit from understanding that many of these problems arise as a consequence of adverse childhood experiences.

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[13] U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS

[14] Jennie L. Shufelt, M.S., Joseph J. Cocozza, Ph.D., *Youth with Mental Health Disorders in the Juvenile Justice System: Results from a Multi-State Prevalence Study.* National Center for Mental Health and Juvenile Justice (2006). http://www.ncmhjj.com/pdfs/publications/PrevalenceRPB.pdf

Research shows that early trauma may have a direct impact on brain development in early childhood. The adverse impacts of such trauma may also be associated with the increased risk for development of behaviors that may lead to involvement in the juvenile justice system[15].

In September 2011, the Minnesota Children's Cabinet began to discuss how to translate this research into State practices. Several efforts are now underway within an ACE team (Minnesota's State Departments of Health, Human Services, and Education) to implement strategies that are based on findings from the ACE study.

The ACE study measured the prevalence of adverse experiences, and investigated the cumulative impact of ACEs, such as emotional abuse, physical abuse, contact sexual abuse, familial substance abuse, familial mental illness, domestic violence, and household criminal behavior.

Relationships between ACE scores emerged for health risk behaviors such as:

- Early smoking initiation, current smoking and smoking persistence;
- Early drinking initiation and problems with alcohol; drug abuse and addiction;
- History of sexually transmitted diseases and HIV risks; and
- Low physical activity; severe obesity; and poor self-rated health.

ACE scores also were predictors of mental health issues, including:

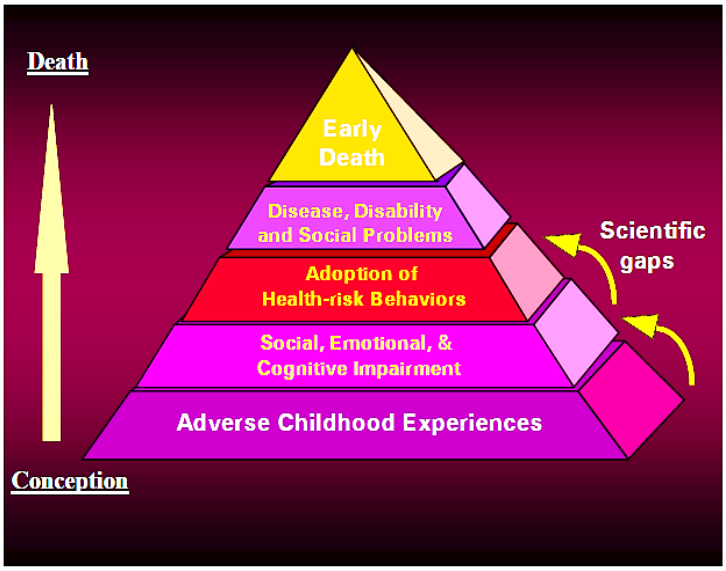
- Lifetime history of depression;
- Suicide attempts; and
- Reported amnesia for childhood experiences.

Antidepressant and mood stabilizer prescriptions similarly varied with ACE scores. Multiple ACEs eventually correlated to chronic disease, morbidity and mortality, heart disease, autoimmune diseases, liver disease, chronic obstructive pulmonary disease, and early death.

The ACE team has proposed an interpretive framework to describe – and hypothesize -- the cumulative effects of ACEs. This ACE Pyramid proposes a set of developmental relationships in which the trauma associated with early adversity creates a progression of effects, from:

- Social, emotional and cognitive impairments; leading to -
- Adoption of health-risk behaviors; leading to -
- Disease, disability and social problems; leading to -
- Early death.

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



ACE Pyramid, courtesy of Centers for Disease Control and Prevention

Implications for juvenile justice:
The consistent and powerful findings related to ACE have a number of implications for working with the juvenile justice population. These include:

1. Young people engaging in high risk behaviors that may lead to involvement with the justice system are highly likely to have significant histories of adverse childhood experiences.

2. Understanding the ACE background of youth in the justice system can lead to improved diagnostic assessments and better planning for their treatment and supervision in the justice system. Many behaviors which might have been interpreted as oppositional or as evidence of conduct disorders might be better understood as reflecting direct or indirect effects of trauma.

3. ACE data leads to improved understanding of how early trauma may disrupt brain development, leading to more difficulty in self-regulation, greater difficulties in age-appropriate reasoning and problem solving, and likelihood of responding to stressful experiences with inappropriate coping mechanisms.

4. Initiatives such as detention alternatives and restorative justice fit well within a framework that incorporates responsibility and restitution, yet also builds capacity for empathy and strong social support; in order to:
   - Help youth return to or achieve appropriate development;
   - Reduce their likelihood of recidivism; and
   - Increase their capacity for pro-social behavior.

Recommendations:

1. Support the efforts of State agencies to incorporate ACE-related activities into State and State-supported practices;

2. Charge the Department of Human Services, Department of Education and the Department of Health with outreach to Minnesota's juvenile justice system at both organizational and service levels to develop understanding of the implications of ACEs and promote the development of trauma-informed practices.

3. Incorporate ACE-related information into screenings and assessments of youth at risk of, or who enter the juvenile justice system; and

4. Develop and implement juvenile justice-related intervention strategies that are responsive to trauma-related experiences of these youth.

B. Key Access Points

Efforts to prevent the unnecessary engagement of youth in the Juvenile Justice system need to focus on the key 'access points' where youth with unmet mental health needs come into contact with the justice system. Strategies are needed to divert youth from entry into the justice system, or once a youth is engaged, help prevent detention, incarceration or long-term out of home placement. Two 'access points' to identify and address unmet mental health problems and reduce juvenile justice engagement are:

1. Schools; and
2. Referral for *initial detention, subsequent incarceration, or out of home placement*.

1. Schools as Access Points

Schools are often where students with mental health needs may first come to the attention of the juvenile justice system. Current research reveals that punishing problem behaviors without a proactive student support system is associated with increases in aggression, vandalism, truancy and dropping out. While schools have a duty to maintain a safe and disciplined learning environment, zero tolerance policies and other school responses to discipline issues, often for students with behavioral health disorders, frequently lead to more severe consequences and referral to the juvenile justice system.

Several efforts are underway in Minnesota in partnership with schools and school systems that seek to address mental health issues that may otherwise result in a youth's entry into the Juvenile Justice system that are described in the Mental Health in the Schools chapter of this report: **School Wide Positive Behavioral Interventions and Supports (SW-PBIS) and School-linked Mental Health Services**.

SAMHSA-MacArthur Foundation Policy Academy

Early in 2012, Minnesota was one of eight states selected to participate in an innovative national project: Improving Diversion Policies and Programs for Justice Involved Youth with Co-Occurring Mental Health and Substance Use Disorders: An Integrated Policy Academy/Action Network Initiative. This effort, sponsored by the Substance Abuse and Mental Health Services Administration and the John D. and Catherine T. MacArthur Foundation, aims to increase the number of youth diverted out of the juvenile justice system to appropriate community-based behavioral health services who have co-occurring mental and substance use disorders. Minnesota's project selected school-based diversion as the focus of its efforts[16]. Draft outcomes for the initiative are to:

- Reduce the number of school arrests, suspensions, or expulsions for students with behavioral health needs
- Improve school attendance of students with behavioral health needs
- Increase screening, assessment and treatment referrals
- Increase graduation rates for students with co-occurring disorders

Recommendation:

Support the development of this new service approach and the determination of its effectiveness in meeting stated outcomes.

2. **Juvenile Justice Detention, Incarceration and Placement as Access Points**

Detention is a crucial early phase in the juvenile justice process. Though the typical stay in juvenile detention is brief—the average length of stay nationally is around 20 days and many youth spend only a few nights in these locked facilities—detention is pivotal to the juvenile justice process for several reasons. An estimated 400,000 young people every year are admitted to detention nationwide[17] and approximately 26,000 young people are held on any given night[18].

Detained youth are more likely to be formally charged, found delinquent, and committed to youth corrections facilities than similarly situated youngsters[19]. According to one Florida

[16] http://www.prainc.com/states-selected-to-participate-in-samhsa-macarthur-foundation-policy-academy-action-network-initiative/

[17] Felitti, V., Anda, R., Nordenberg, D., Williamson, D., Spitz, A., Edwards, V., Koss, M., and Marks, J. (1998). The relationship of adult health status to childhood abuse and household dysfunction. American Journal of Preventive Medicine, 14, 245-258.

[18] Mueser, K.T., Drake, R.E., Turner, W.C., & McGovern, M.P. (2006). Comorbid substance use disorders and psychiatric disorders. In W. R. Miller & K. M. Carroll (Eds.), Rethinking substance abuse: What the science shows, and what we should do about it (pp. 115-133). New York: Guilford Press.

[19] The Office on Child Abuse and Neglect, Children's Bureau, ICF International. (2009). Available: http://www.childwelfare.gov/pubs/usermanuals/substanceuse/chapterthree.cfm

study, youth detained pending court were three times as likely to be committed to a corrections facility as youth with identical offending histories who were not detained[20]. Detention, therefore, might be thought of as the slippery slope into juvenile justice's deep end.

Detention is also associated with negative long-term life outcomes. Youth who spend time in custody are less likely to:

- Complete high school
- Avoid re-arrest
- Find employment, and
- Form stable families.

They are also more likely to abuse drugs and alcohol[21].

Once youth are formally detained in the juvenile justice system, even if the result of behaviors resulting from unidentified or unmet mental health needs, it often begins a path toward frequent re-engagement in the system with poor long term outcomes. Access to successful mental health treatment is usually not available.

The **Juvenile Detention Alternative Initiative (JDAI)** is demonstrating that alternatives to detention, incarceration, and long-term out of home placement can successfully result in improved access to effective mental health treatments for youth and their families. JDAI is a national systems change initiative of the Annie E. Casey Foundation which was implemented in Minnesota's three largest metro counties in 2006: Ramsey[22], Dakota[23], and Hennepin[24]. It has become a statewide effort to create equity, efficiency and effectiveness in juvenile justice practice particularly due to the significant over representation of youth of color in detention, especially American Indian and African American youth. St. Louis County became Minnesota's first expansion site for this model in January 2009[25].

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[20] Osher, F. C. (2006). Integrating Mental Health and Substance Abuse Services for Justice-Involved Persons with Co-Occurring Disorders. Available: http://gainscenter.samhsa.gov/pdfs/ebp/IntegratingMentalHealth.pdf

[21] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. (2002). http://www.samhsa.gov/data/2k4/detainedYouth/detainedYouth.htm

[22] Juvenile Justice Decision Points Study: Strategies to Improve Minnesota's Juvenile Justice Data. http://www.ojp.state.mn.us/cj/publications/Reports/2010JuvenileJusticePolicyReportSections/1_Vision_Table%20of%20Contents.pdf, http://www.ramseyjdai.org/.

[23] http://www.co.dakota.mn.us/LawJustice/CPCP/JDAI/default.htm

[24] http://hennepin.us/portal/site/HennepinUS/menuitem.b1ab75471750e40fa01dfb47ccf06498/?vgnextoid=eaf4d5d48c263210VgnVCM20000048114689RCRD

[25] http://www.co.st-louis.mn.us/slcportal/LinkClick.aspx?fileticket=1cmCr6YNbRY%3D&tabid=74

The core elements of a JDAI model include:

1. Collaboration among the local juvenile court, probation agency, prosecutors, defenders, and other governmental entities, as well as community organizations—including a formal partnership to cooperatively plan, implement, and assess detention reforms.
2. Collection and utilization of data to diagnose the system's problems and proclivities, assess the impact of various reforms, and assure that decisions are grounded in hard facts—rather than anecdotes.
3. Objective admission screening to identify which youth actually pose substantial public safety risks, which should be placed in alternative programs, and which should simply be sent home.
4. New or enhanced non-secure alternatives to detention targeted to youth who would otherwise be locked up and—whenever possible—based in neighborhoods where detention cases are concentrated.
5. Case processing reforms that expedite the flow of cases through the system, reduce lengths of stay in custody, expand the availability of non-secure program slots, and ensure that interventions with youth are timely and appropriate.
6. Flexible policies and practices to deal with "special" detention cases, such as violations of probation and failures to appear in court, that in many jurisdictions lead automatically to detention even for youth who pose minimal risks to public safety.
7. Persistent and determined attention to combating racial disparities, including careful study to identify specific strategies to eliminate bias and ensure a level playing field for kids of color.
8. Intensive monitoring of conditions of confinement for youth in secure custody to ensure that detention facilities are safe and appropriate care is provided.

Hennepin County efforts:

In 2006, Hennepin County began to implement the Juvenile Detention Alternatives Initiative (JDAI) to decrease the number of youth unnecessarily detained in secure confinement, to reduce racial disparities in the juvenile system, and to minimize youth failures to appear for court hearings. This was done in conjunction with a Juvenile Court/County Board leadership group charged with reducing the use of out of home placements for children and youth in Hennepin County.

Hennepin County's work on these reform efforts illustrates how youth with mental health needs can be provided with successful alternatives to detention, incarceration, and long-term engagement in the justice system. Through this work, Hennepin County Department of Community Corrections and Rehabilitation (DOCCR) began to shift from residential correctional thinking to a community-based treatment philosophy.

- **Objective Tools and Policies**: DOCCR began the use of a Risk Assessment Instrument (RAI), accompanied by a new probation policy limiting the circumstances

under which Arrest & Detain (A&D) warrants can be issued. Rather than resorting to a detainable warrant, probation officers cross-reference the youth's risk level and degree of violation severity to determine the least restrictive response most suitable for the specific situation.

- **Out-of Home Placement Policies**: A Correctional Out-of-Home Placement workgroup recommended that Hennepin County reduce the number of correctional placements and related costs, and reallocate those cost savings toward the creation of community based services that are more effective and less expensive

- **Community-Based Array of Services**: The initial cost savings resulting from reductions in juvenile detention and correctional placement allowed for reinvestment into community-based programming, including:
  - Multi-Systemic Therapy (MST): An intensive in-home treatment program.
  - Wraparound: A family-based intervention in which the youth and their families identify goals important to their family's success.
  - Functional Family Therapy (FFT): A short-term, highly structured in-home intervention for "treatment resistant" families of youth involved in the juvenile justice system.
  - Aggression Replacement Training (ART): A cognitive-behavioral intervention to alter the behavior of aggressive youth, reduce anti-social behaviors, and develop alternative pro-social skills.
  - "Radius" Girls Programming: Gender-responsive services to adolescent girls on probation. To live a healthy, productive, and law-abiding life in the community.
  - The Girls Circle: A structured support group for girls offered through the County Home School.
  - Multidimensional Treatment Foster Care (MTFC): An alternative to institutional, residential, and group care placements for youth with severe and chronic criminal behavior.
  - Return to Success (RTS): Aftercare planning that is a critical component in reducing the risks associated with delinquency behavior among youth who are returning from residential treatment, in collaboration between juvenile probation, the courts, mental health professionals, schools, parents, and treatment staff from residential facilities.

Reform Results: Since the initiation of juvenile justice reform in Hennepin County, the average daily population (ADP) of juveniles in detention has decreased by over 60% and % and the number of annual admissions to the Juvenile Detention Center has decreased by 49%. Prior to reforms, over 300 youth were in correctional placement at any given time (60% of whom were in long term residential treatment centers), often hundreds of miles from their own community. By June 2010, 33% fewer youth were in out-of-home placements. Contracted residential facility locations were significantly closer to youths' home

communities and short-term programs were more frequently ordered. Youth who are no longer detained are now served by alternatives to detention[26].

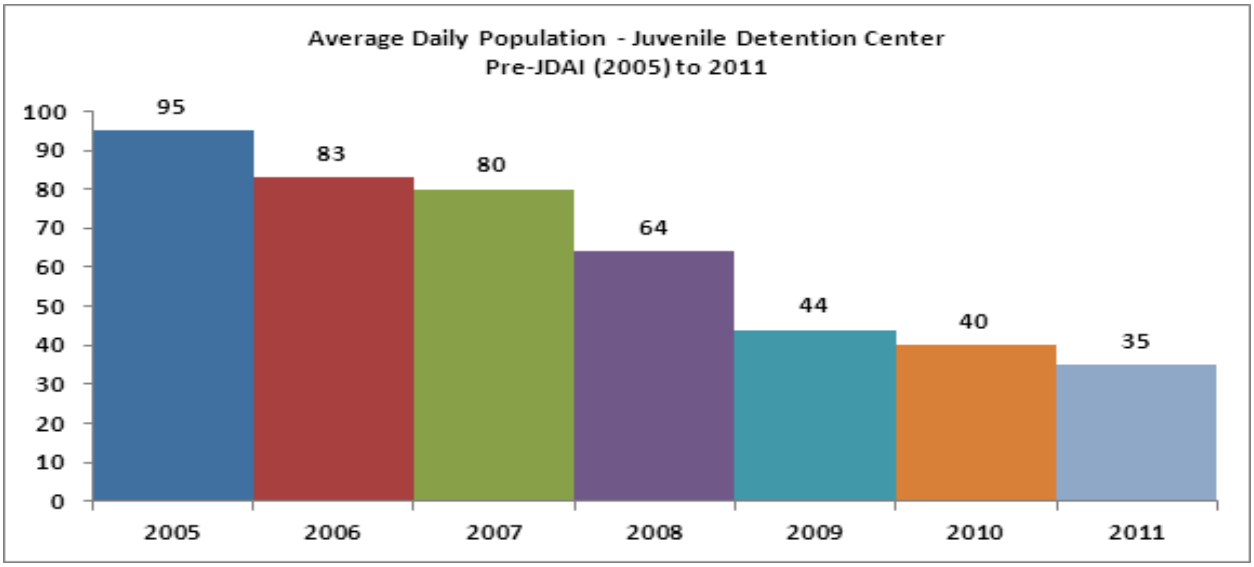
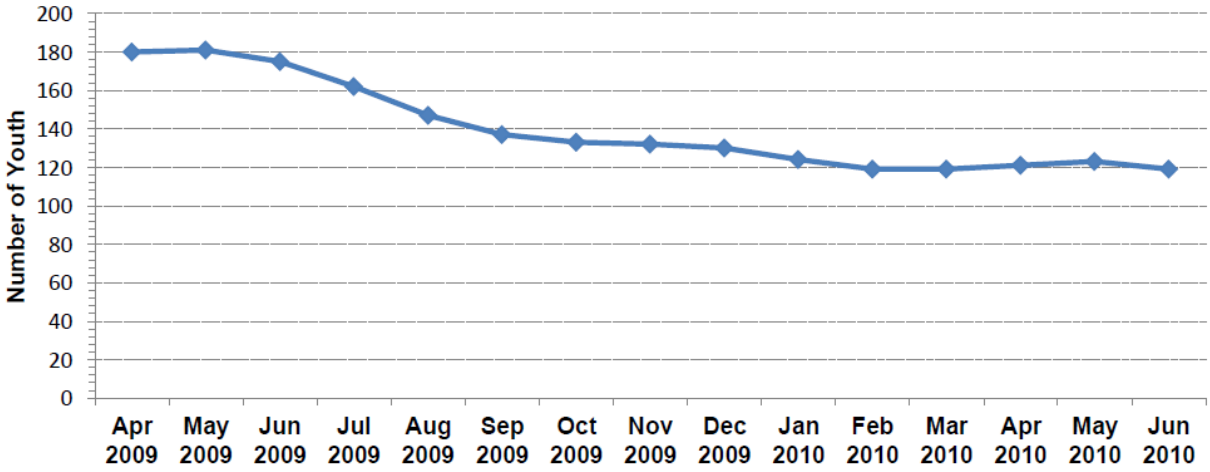


Figure 1. Number of DOCCR youth in RTC placement on the last day of each month April 2009 through June 2010.



Recommendations:

1. The results achieved through JDAI and related efforts in Hennepin and other counties should be closely examined through joint efforts of the Minnesota Departments of Human Services and Corrections, and the participating counties.

[26] "Bringing the Community back into Juvenile Corrections", Jerome Driessen, Area Director for Juvenile Services, Hennepin County Department of Community Corrections, Corrections Today (February/March 2011). http://www.readperiodicals.com/201102/2316996791.html

2. Efforts to sustain successful progress and translate these successes into statewide efforts should be initiated by the State.

C. Minnesota's Mental Health Screening Program

As noted in our *2010 Report to the Governor and Legislature*, 2003 legislation required youth in juvenile justice and child welfare to receive children's mental health screening[27]. According to the Department of Human Services, since 2005, approximately 31,800 screenings of youth in the juvenile justice population have taken place through this initiative. Screening of youth in the juvenile justice and child protection populations is a positive contribution to identifying youth with mental health needs. The Department of Human Services distributes grant funds to counties that subsidize the screenings activities and assist with needed treatment services for uninsured youth. The funds are allocated based on the number of screenings reported by each county.

However, in 2011 the Minnesota Legislature amended the screening requirement so that parents must give prior consent, or "opt in", in order to have the screening conducted unless a court order is provided. Previously, screening would take place unless parents chose to "opt out."[28]

The Department of Human Services is collecting data that helps illustrate the mental health needs of youth in juvenile justice. The data shows that only half of the youth deemed eligible for screening are actually screened (though the number of youth screened as a proportion of those eligible has been increasing):[29]

	Juvenile Justice Only	Child Welfare Only	Total Screens Performed/year
2005	5,357	3,864	9,221
2006	5,167	4,081	9,248
2007	4,364	4,366	8,730
2008	4,340	5,438	9,778
2009	4698	6,624	11,322
2010	4,319	6,690	11,009
2011	3,563	7,104	10,667

As in 2010, there remains incomplete data reporting from county to county. Although counties (except Hennepin) will be moving to reporting through the Court Services Tracking System which should help in generating reports on demographics and whether the youth meet exemption categories, there also is not information regarding follow-up assessments and access to services resulting from the screenings being conducted. In addition, the numbers of documented "eligible

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

[28] Minnesota Statutes 245.4874, subdivision 1. http://www.house.leg.state.mn.us/comm/docs/HF1500-A3Amendment_H1500A3.pdf.

[29] Statistics provided by the Minnesota Department of Human Services Children's Mental Health Division.

youth" are only those on active probation. Those in diversion programs for petty offenses are not being counted.

Recommendations:

1. Examine whether the 2011 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.

2. Institute statewide data collection and service follow-up and implement protocols and data tracking regarding follow-up post screening, and referral to and engagement in services.

3. Add ethnicity data to the screening system to help identify disparities.

4. Increase the number of children and youth who are screened within eligible populations by providing additional technical assistance and highlighting screening results statewide.

5. 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.

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

The issues of chemical dependency and mental health are often intertwined. A 2002 Report to Congress indicated that a majority of persons with co-occurring disorders do not receive effective treatment. The report found that when co-existing conditions are not identified or addressed, it results in either no treatment or unsuccessful treatment attempts due to the complexity of interacting conditions[30].

Rates of substance abuse disorders in clients with severe mental illness have been described as ranging from as low as 20% to as high as 60%[31]. However, even the highest estimates of co-occurring disorders in the general population are small when compared to the co-occurring disorders prevalence-rate in jails and prisons. The factors that contribute to overrepresentation of co-occurring disorders in justice involved persons include high rates of substance use, abuse, and dependence among persons with mental illnesses,[32] coupled with increased enforcement of illegal

[30] Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, November 2002. *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. http://www.samhsa.gov/reports/congress2002/index.html.

[31] Mueser, K.T., Drake, R.E., Turner, W.C., & McGovern, M.P. (2006). *Rethinking substance abuse: What the Science shows, and What We Should Do About It* (pp. 115-133). New York: Guilford Press.

[32] Grant, B.F.; Hasin, D.S.; Chou, P.; Stinson, F.S.; and Dawson, D.A. Nicotine dependence and psychiatric disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of*

drug use, possession, and/or sales statutes leading to arrest[33]. Young men in predominantly urban centers typically have the highest co-morbidity rates. Evidence indicates that substance use and abuse frequently precipitates disruptive behavior, symptom exacerbations, and re-hospitalizations in clients with dual disorders[34].

Many children entering the mental health and juvenile justice systems have or have had significant issues pertaining to substance abuse. As noted above, substance abuse by either the child or significant persons in their life often contributes to Adverse Childhood Experiences (ACEs). Research has shown a correlation between ACEs and mental health problems and risky behavior later in life.

Also, the Office on Child Abuse and Neglect, Children's Bureau, ICF International (2009) reported that the lives of millions of children are touched by substance use disorders (SUDs)[35]. The 2007 National Survey on Drug Use and Health reports that 8.3 million children live with at least one parent who abused or was dependent on alcohol or an illicit drug during the past year. This includes 13.9 percent of children aged two years or younger, 13.6 percent of children aged three to five years, 12.0 percent of children aged six to 11 years, and 9.9 percent of youths aged 12 to 17 years[36] .These children are at increased risk for abuse or neglect, as well as physical, academic, social, and emotional problems.

Children born to mothers that are abusing drugs and/or alcohol during pregnancy appear to be at a distinct disadvantage throughout their development[37]. However, while births of children to mothers who screen positive for drugs or alcohol may be reported to counties for maltreatment, statistics about children born to mothers that are abusing drugs and/or alcohol during pregnancy are not being tracked statewide by either the State Departments of Health or Human Services.

General Psychiatry 61:1107–1115, 2004. PMID: 15520358. http://archpsyc.jamanetwork.com/article.aspx?articleid=482090

[33] See Congressional Staff Briefed on Law Enforcement Responses to People with Mental Illnesses, Justice Center, The Council of State Governments. http://consensusproject.org/features/congressional-staff-briefed-on-law-enforcement-responses-to-people-with-mental-illnesses.

[34] Mueser, Noordsy, Drake & Fox, 2003. http://www.dshs.wa.gov/pdf/dbhr/mh/resourceguide/cobestpract.pdf

[35] United States Department of Health and Human Services. Office on Child Abuse and Neglect, Children's Bureau, ICF International (2009). *Protecting Children in Families Affected by Substance Use Disorders.* http://www.childwelfare.gov/pubs/usermanuals/substanceuse/index.cfm

[36] Substance Abuse and Mental Health Services Administration. (2008). *Results from the 2007 National Survey on Drug Use and Health: National Findings* (Office of Applied Studies, NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD. http://www.samhsa.gov/data/nsduh/2k7nsduh/2k7Results.htm

[37] U.S. Department of Health and Human Services, Administration for Children and Families. *How Parental Substance Use Disorders Affect Children.* Office on Child Abuse and Neglect, Children's Bureau. ICF International (2009). http://www.childwelfare.gov/pubs/usermanuals/substanceuse/chapterthree.cfm

Recommendations:

1. A repository for information about children born to mothers that are actively using drugs and alcohol should be developed within the Department of Health so that we may gain a better understanding of the issue and develop interventions that may address the problem.

2. 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 these co-occurring disorders can be more effectively treated and risk of relapse and recidivism reduced.

4. Housing and Homelessness

The availability of safe and affordable housing which meets the needs of a person living with a mental illness can be the foundation for stability and recovery. The absence of stable and affordable housing can often lead to a crisis and reduce the effectiveness of treatment.

An array of housing options that reflects the different needs of tenants is essential. We cannot continue to house people in intensive, expensive settings when a person does not need that level of care. In such cases, the intensive settings are only utilized because a less expensive setting that can meet the tenant needs is not available.

While the need for affordable and safe housing is evident, the resources available are not sufficient to meet the full need. Research shows that there are several models that help people with mental illnesses live in the community in a cost effective manner:

Permanent Supportive Housing Evidenced-Based-Practice: Minnesota has recognized and adopted the Permanent Supportive Housing Evidenced-Based-Practice, PSH-EBP[38]. The housing is permanent and supportive services are available to the tenant. The core principles of PSH-EBP are:

- Choice in housing.
- Separation of housing and services.
- The housing is decent, safe, and affordable.
- The housing is integrated into the greater community.
- The same rights and responsibility of tenancy apply as for any other renter.
- Access to housing and services are voluntary and offer flexibility.

[38] http://mn.gov/dhs/search/?v:sources=mn-dhs-stellent&render.list-show=10&query=dhs16_164139.doc.. See also: Travis, Gary. Minnesota Department of Human Services, *Permanent Supportive Housing: An Evidence Based Practice* (2012). http://www.dhs.state.mn.us/dhs16_169152.pdf

Individual services may include case management, service coordination, medication management and monitoring, transportation, move-in assistance, outreach services, independent living skills training, and job skills training.

See the SAMHSA Tool Kit at:
http://store.samhsa.gov/product/SMA10-4510?WT.ac=AD20100918HP_SMA10-4510:

In January 2012, Wilder Research published ***Return on Investment in Supportive Housing in Minnesota***. Wilder reported that for every dollar invested in supportive housing, there was a return to the taxpayer of $1.32 when all program costs and individual wage increases were tabulated. The study reported that supportive housing returned at least $123 million to Minnesota taxpayers in 2010. Wilder Research points out that this was a conservative estimate of the return because it did not include the potential savings that could result from improved health, fewer emergency room visits, and fewer hospital days[39].

The State of Minnesota cites supporting research in its report: ***Reform 2020: Pathways to Independence:***

> Section 6.2.6 - **Supporting Research:**
> In Chicago, Illinois, persons experiencing homelessness who were receiving inpatient hospital care for chronic medical conditions were randomly assigned to receive usual care or access to recuperative care (respite) and supportive services in permanent housing settings. The intervention group had 29% fewer hospitalizations, 24% fewer emergency room visits, and 45% fewer days in nursing homes.
>
> In Portland, Maine, during the year after receiving Housing First-type supportive services, formerly homeless persons with a diagnosis of a long-term disability (mental illness, chemical dependency, physical disability, co-occurring disorder) experienced:
>
> - 77% fewer inpatient hospitalizations
> - 62% fewer emergency room visits
> - 60% fewer ambulance transports
> - 38% fewer psychiatric hospitalizations
> - 62% fewer days in jail
> - 68% fewer police contacts[40]

[39] The link to the Wilder Return on Investment report is http://www.wilder.org/Wilder-Research/Publications/Studies/Return%20on%20Investment%20in%20Supportive%20Housing%20in%20Minnesota/Return%20on%20Investment%20in%20Supportive%20Housing%20in%20Minnesota,%20Summary.pdf
[40] www.dhs.state.mn.us/Reform2020

Individual Placement Support (IPS): The evidence based practice of supportive employment known as Individual Placement Support[41] is a framework for how employment services are embedded within clinical mental health treatment services in collaboration with the public rehabilitation program, which is Vocational Rehabilitation Services (VRS) in Minnesota. IPS principles can likewise be used to embed employment services into supportive housing. IPS helps people become employed in the competitive labor market. IPS is nearly three times more effective than other vocational approaches in helping people with mental illnesses to work.

Several studies have found a reduction in community mental health treatment costs for IPS program participants[42]. Other studies have found a reduction in psychiatric hospitalization days and emergency room usage after people were working in supportive employment. People who obtain competitive employment through IPS supportive employment have increased income, improved self-esteem, improved quality of life, and reduced mental health symptoms[43]. Approximately half of the people who enroll in IPS supportive employment become steady workers and remain competitively employed a decade later[44].

Minnesota Programs to Assist People with Mental illnesses: Minnesota offers some housing programs for persons with Mental illnesses. The programs offer important support to those individuals who meet the eligibility criteria but are unable to obtain a housing voucher from the federal department of Housing and Urban Development (HUD). These programs are:

Bridges: A rental assistance program which provides a housing subsidy for people with mental illnesses that is operated by the Minnesota Housing Finance Agency in partnership with the Department of Human Services Adult Mental Health Division. Last year, Bridges served 588 households with a median annual household income of $9,234[45].

Bridges RTC Pilot Program: In the spring of 2012 Minnesota began a pilot program providing housing subsidies for people ready for discharge from Anoka Metro Regional Treatment Center.

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[41] http://www.dartmouth.edu/~ips/ and http://www.cimh.org/LinkClick.aspx?fileticket=hvO3EpDcU5o%3D&tabid=793

[42] http://homeless.samhsa.gov/Resource/Individual-Placements-in-Supported-Employment-Promising-Results-48847.aspx

[43] Dartmouth Psychiatric Research Center. *Making the Case for IPS Supported Employment.* (October 2, 2012). http://www.dartmouth.edu/~ips/

[44] Johnson and Johnson Dartmouth Community Mental Health Program. *Supported Employment Policy Bulletin - #2.* http://www.oregon.gov/oha/amh/adult-initiative/docs/se-policy-bulletin2.pdf. See also: NAMI Kentucky. *Vision.* (February 1, 2011). http://www.nami.org/Content/Microsites157/NAMI_Kentucky/Home143/NAMI_Kentucky1/February_newsletter_2011_winter_edition.pdf

[45] 2011 Minnesota Housing Annual Report and Program Assessment. http://www.mnhousing.gov/idc/groups/administration/documents/document/mhfa_012258.pdf

The grants to the Seven County Metro Area and Greater Minnesota will support 81 households between 2012 and the end of the pilot on June 30, 2014[46] .

Housing with Supports for Adults with Serious Mental Illnesses (HSASMI): HSASMI is a DHS Adult Mental Health Division program operated in partnership with the Minnesota Housing Finance Agency[47]. HSASMI funds may be used for a range of supportive housing for persons with mental illnesses. The grants provide an operational subsidy to cover service coordination and front desk services. A front desk and/or security staff may perform tasks associated with housing tenancy support services, such as a concierge-like watchful eye to alert supportive service providers when a tenant appears to need assistance or attention which is not covered by Medical Assistance or HUD funding, but is critical to successful supportive housing. HSASMI funding fills the revenue shortfall between the cost of operating the housing development and the rents paid by eligible tenants. In the calendar year of 2011, 740 units were operating or being developed across Minnesota[48].

Other cost-effective supportive housing mechanisms that have been discussed:

The Minnesota Interagency Council on Homelessness' Medical Assistance Workgroup made recommendations in December 2011 in the report: *Integrating Medical Assistance and Supportive Housing: Recommendations for Minnesota's Medicaid Program*[49]. These included using the 1915(i) state plan amendment option which could provide needed community-based services to eligible persons with mental illnesses. The 1115 Waiver for supportive housing services could be another option to provide service coordination between housing, health care and employment; such as integrating individual services, medication monitoring and management, independent living skills training, jobs skills training, and outreach.

Heading Home, Minnesota's Roadmap to End Homelessness is a collaborative effort to share knowledge, skills, and resources to procure housing and services for Minnesota's homeless. Fifty seven percent of homeless adults have a mental illness. Heading Home is developing a broad spectrum of housing and services, utilizing cost effective and/or evidenced-based models to help people retain permanent housing[50].

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[46] Minnesota Department of Human Services. *Bridges Program Guide Addendum for Bridges RTC.* http://www.mnhousing.gov/idc/groups/public/documents/document/mhfa_012285.pdf

[47] Minnesota Housing Finance Agency. *Housing Trust Fund, Ending Long-Term Homelessness Initiative Fund & Housing with Supports for Adults with Mental illnesses Operating Subsidy Program Guide.* (April 2012). http://www.mnhousing.gov/idc/groups/public/documents/document/mhfa_003854.pdf.

[48] See Travis, footnote 35, slide 2.

[49] Minnesota Housing Finance Agency. *Housing Trust Fund, Ending Long-Term Homelessness Initiative Fund & Housing with Supports for Adults with Mental illnesses Operating Subsidy Program Guide.* (April 2012). http://www.mnhousing.gov/idc/groups/public/documents/document/mhfa_003854.pdf

[50] Minnesota Housing Finance Agency. *Heading Home, Minnesota's Roadmap to End Homelessness.* http://www.mnhousing.gov/idc/groups/administration/documents/webcontent/mhfa_010562.pdf

Recommendations:

1. Minnesota should focus its resources on evidence-based programs and models that assist persons with mental illnesses obtain and retain access to permanent, safe and affordable housing with available, flexible and voluntary array of support services. Supporting effective programs will result in a positive return of investment for the state.

2. HSASMI, Housing Supports for Adults with Serious Mental Illnesses, is essential for Minnesota to provide the funding that covers the critical coordination of housing services and mental health community services. We strongly recommend that the State of Minnesota maintain the allocation that supports this fundamental component for successful housing options.

3. Employment is a key factor in reducing long term homelessness and maintaining permanent supportive housing. Individual Placement Support should be incorporated into plans to expand permanent supportive housing in Minnesota. No targeted funding for linking these two evidenced-based practices exists in Minnesota. Funding streams should be developed to enable providers of supportive housing to provide the infrastructure and service coordination necessary to link these services.

4. An increased allocation should be made to the Bridges subsidy program, which could be used to provide vouchers to eligible individuals with a mental illness who are literally homeless[51], living in a shelter, outside, or in a place not intended for human habitation.

5. The Bridges RTC funding will end on June 30, 2014. We recommend that the effectiveness of the funding be assessed and, if found successful, the program and its funding should be extended.

5. Primary Care and Mental Health Reforms

Focus of this report: Timely and affordable access to quality mental health care for all Minnesotans.

Need area #1: Timely Access to Psychiatric and Counseling Services

[51] Homelessness is defined as sleeping in a place not designed for or used as a regular sleeping accommodation, including a car, park, abandoned building, bus or train station, airport, camping ground, etc.; or exiting an institution where they: resided for ≤ 90 days **AND** were residing in an emergency shelter or place not meant for human habitation immediately prior to entering the institution.

In calendar year 2011, county mental health plans required by the Adult Mental Health Division of the Department of Human Services asked for a list of unmet needs identified by their local advisory council.

The need for timely access to psychiatric and counseling services far outstripped all other identified unmet needs. This need was identified across the entire state, but especially in rural areas. Specifically, unmet needs were noted in the areas of:

- Access to qualified mental health professionals.
- Access to appointments with existing mental health providers.
- Difficulty recruiting mental health providers (especially in rural areas) .
- A need to develop same day, walk-in clinics (much like an urgent care model for physical health needs) to avert a mental health crisis and avoid the need for more costly emergency room treatment and/or psychiatric hospitalization.

The State Advisory Council on Mental Health has noted timely access to psychiatric and counseling services as an unmet need in previous reports to the Governor and Legislature. Previous recommendations to address this need have included:

- Workforce initiatives such as education and training grants and loan repayment/forgiveness programs for mental health professions
- Development of models and funding for the infrastructure needed to support community health agencies and mental health provider agencies to develop collaborative models in the rural areas
- Continued support for the use of technology (such as interactive videoconferencing) to deal with critical provider shortages and long distance driving, especially in rural and remote areas of the state

The State Advisory Council on Mental Health encourages the Governor and Legislature to make addressing these needs a top priority in the next biennial budget funding year.

Need Area #2: Integration of Services for Primary Care, Mental Health and Chemical Dependency

The current health service delivery system in Minnesota is predominately separate, disjointed, and expensive. Clients often deal with multiple health issues but rarely are these addressed in a coordinated and cost-effective manner. We recommend that policies and funding streams be modified in the following areas:

1. **Develop a single screening, evaluation and treatment plan across all areas.** The absence of a uniform evaluation of individuals with moderate to severe mental health disorders is possibly the most serious deficiency in Minnesota's health care system. Screening

has improved (for instance, utilizing MMPI[52] , PHQ-9[53] , and substance abuse questionnaires), but screening is not the same as evaluation. A screen is simply a method to identify individuals who require a face-to-face evaluation by a trained mental health professional or a nurse practitioner working in consultation with medical/psychiatric professionals. The opportunity exists to save money by performing an adequate evaluation (1-3 hours) up front, avoiding inappropriate medication and treatment. The current payment system must be modified to accommodate evaluation and consultation, not just treatment.

2. **Continue to expand programs that focus on collaboration.** These include the Minnesota 10 by 10[54] Project which addresses both physical and mental health issues, the DIAMOND Project[55], and the projects begun by the Co-Occurring State Incentive Grant (COSIG)[56].

3. **Better collaboration between county human services and the Veterans' Administration** to provide timely access for veterans to community-based mental health services.

4. **Provide significant resources to expand Integrated Dual Disorder Treatment** (IDDT)[57] programs in both inpatient and outpatient settings so that they are available throughout the state. There are only a handful of these evidence-based treatment options for those struggling with both issues. As a result, individuals are frequently involved with the criminal justice system rather than in appropriate treatment.

Need Area #3: Available Data for the Governor and Legislature that Assesses Both Mental Health Needs and Benefits as well as Cost Implications and Outcomes.

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[52] See http://en.wikipedia.org/wiki/Minnesota_Multiphasic_Personality_Inventory and http://psychcentral.com/lib/2011/minnesota-multiphasic-personality-inventory-mmpi/all/1/

[53] See http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/ and http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf.

[54] Minnesota Department of Human Services. Minnesotans taking action for healthier, longer lives (MN 10 by 10). http://www.dhs.state.mn.us/dhs16_147992. See also SAMHSA's Wellness Initiative, http://www.promoteacceptance.samhsa.gov/10by10/default.aspx

[55] http://www.icsi.org/colloquium_-_2007/diamond_panel.html, and http://www.icsi.org/health_care_redesign_/diamond_35953/what_is_diamond_/diamond_frequently_asked_questions_/

[56] http://www.dhs.state.mn.us/id_028650

[57] http://www.centerforebp.case.edu/practices/sami/iddt

1. **Mobile 24/7 crisis response teams [CRT]**[58] are very effective in reducing community costs and inpatient hospitalizations and in stabilizing individuals in acute crisis situations. CRT provides assessments, on-site crisis counseling and stabilization, one-time medication management with psychiatric providers, referral to services, and assistance with psychiatric hospitalizations or diversions. Yet they are not implemented across the state, and resources are limited for those CRT programs that are currently operating.

   We recommend:
   - DHS data collection should identify:
     - The financial cost of establishing and operating mobile crisis response teams by county
     - Cost savings of hospital diversions by county where mobile crisis response teams exist, and
     - Potential funding mechanisms to implement these teams in all counties of the state.

2. **The 2007 Mental Health Initiative** established grants to counties to support an array of community-based services and supports[59] . These grants were designed to help ensure that people living with mental illnesses who are uninsured or underinsured have access to timely and effective treatment and supports. However, data about how the funds are being used, the number of people receiving services, and outcomes for consumers, is not readily available to the legislature and the public.

   We recommend:
   - DHS collect and analyze data about how counties are utilizing these grants, how many people are accessing services supported by the grants, and consumer outcomes (for example, reduction in the number and frequency of hospitalizations).

3. Counties and adult mental health initiative regions identified many unmet mental health needs throughout the state. There are similar concerns that ran throughout the collected data, giving rise to further questions and concerns.

   We recommend:
   - DHS data collection should analyze barriers to statewide access to mental health services, and county cost-efficiency regarding the following:
     - Mental health case management

[58] Department of Human Services. *Children's Crisis Response Services*: http://www.dhs.state.mn.us/dhs16_144768.
Adult Mental Health Crisis Response Services: http://www.dhs.state.mn.us/id_004961
Mental Health Crisis Phone Numbers: http://www.dhs.state.mn.us/dhs16_169026

[59] Department of Human Services. *Governor's Mental Health Initiative 2007*. http://www.dhs.state.mn.us/id_056871

- Adult foster care
- Adult Rehabilitative Mental Health Services [ARMHS]
- Intensive Residential Treatment Services [IRTS]
- Community Alternatives for Disabled Individuals [CADI]
- Dental care access for individuals with mental illness

Need Area #4: A Comprehensive Array of Appropriate Home and Community-Based Mental Health Services that Best Meets 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. People who have been able to access services have typically done so through the CADI waiver[60] or the PCA (Personal Care Assistant[61]) program. However, proposed changes to the Nursing Level of Care Criteria, which determines eligibility for these programs, do not account for the needs of people with mental illnesses and will likely mean significantly fewer people with mental illnesses will be eligible.

We recommend:

- The development of a 1915(i) state plan option specifically for people with mental illnesses to provide services which are flexible in terms of type and intensity. DHS has already begun this process and we offer the following recommendations and comments based on their proposal:

  - The criteria to qualify for the proposed services are too restrictive. We support broadening the 1915(i) state plan proposal so that it can effectively provide services to persons before they end up in psychiatric hospitals, prisons, jails, or nursing facilities.

  - The 1915(i) state plan proposal for employment services should include the use of evidenced-based supported employment (Individual Placements and Supports – IPS).

    - If the "MNChoices" assessment tool is used to determine eligibility for the 1915(i) option, MNChoices needs to be carefully analyzed and amended as

[60] Department of Human Services, Community Alternatives for Disabled Individuals Waiver. http://www.dhs.state.mn.us/id_003905#. *Laws of Minnesota 2012, Chapter 247, Article 4, Section 43* changed the 10% reduction to "low needs" individuals on the CADI Waiver to 5% if the Federal Government approves the Nursing Facility Level of Care waiver and federal financial participation is authorized for the alternative care program and requires lead agencies to consult with providers to review individual service plans and identify changes or modifications to reduce the utilization of services while maintaining the health and safety of the individual receiving services. *Effective July 1, 2012, contingent on federal approval and federal financial participation.*

[61] *Laws of Minnesota 2012, Chapter 247, Article 4, Section 49* requires the Commissioner of Human Services to study the feasibility of licensing personal care attendant services and issue a report no later than January 15, 2013.

needed to make it viable for people with mental illnesses and related disorders.

- DHS should work with stakeholders to develop a 1915(i) option for children.

➢ The State should modify Minnesota's PCA program to ensure that people living with a mental illness who need PCA services are able to access them.

- Specifically, the definition of dependency in the PCA program should be changed to include persons who need prompting and cuing to accomplish activities of daily living, as the program used to permit. Currently, Minnesota limits eligibility to persons who need constant cuing and supervision or hands-on physical assistance. Many individuals with mental illnesses need prompting and cuing in order to accomplish essential tasks to remain independent in their homes, but are able to physically accomplish these tasks if provided with such assistance.

➢ DHS should address barriers to accessing Adult Rehabilitative Mental Health Services (ARMHS). Current rate structure limits have made ARMHS unsustainable for providers and some providers are no longer offering this service.

6. Local Advisory Councils

Background

The Adult and Children's Mental Health Acts of 1987 and 1989 included the requirement that counties have local mental health advisory councils (LACs)[62]. The stated purpose for the creation of LACs is to enable county commissioners to hear recommendations about the local mental health systems made by providers, stakeholders and their citizens who use and are affected by mental health services[63].

The State Advisory Council (Council) is charged with coordinating the work of LACs[64] and the Department of Human Services is required to assure that counties are fulfilling their requirements under the Mental Health Acts[65]. In this way the recommendations of LACs can be utilized in developing mental health policy for the state.

[62] Minnesota Statute 245.466 Subd. 5. and Minnesota Statute 245.4875 Subd. 5.
[63] Minnesota Statute 245.466 Subd. 5 (b) (2) and Minnesota Statute 245.466 Subd. 5 (c).
[64] Minnesota Statute 245.697 Subd. 2 (8)
[65] Minnesota Statute 245

At this time, we observe that:

1. There are LACs that are moving in positive directions. People are making a difference. A major factor is the involvement of individuals living with a mental illness (consumers) and family members.

2. Starting and sustaining LACs requires a successful grassroots effort involving consumers and family members. County and provider partners can facilitate this effort, and with other stakeholders their support is crucial.

3. Despite attempts with various strategies, coordination of the work of LACs has yet to become a well-defined activity of the State Advisory Council. The mandate to "coordinate" can take many meanings. Given that the key role of the LAC is assessment of services and resources, coordination of common reporting formats and sharing of information would seem to have the highest priority. Without grassroots input from across the state, the State Advisory Council on Mental Health is missing an important element in advising the Governor and Legislature.

Some barriers to the existence of effective LACs include:

1. Lack of county social services staff support for LACs.
2. Lack of financial support for expenses and for stipends needed to enable attendance by LAC members.
3. Transportation difficulties
4. Meeting times and locations might be determined for the convenience of county staff and not for members of the public.
5. Infrequency of meetings.
6. Lack of an understanding on the part of the LAC members of their role and purpose, including the duty to annually report to their county board.

The legislative mandate of 25 years ago gave some flexibility to counties as to how they could establish their LACs. For examples, counties can:

- Combine adult and children's LACs
- Form multi-county LACs
- Use another council or body as the LAC as long as the requirements for the LAC are met (for example, a Children's Local Mental Health Collaborative or Adult Mental Health Initiative).

This flexibility has its pros and cons. It can reduce the number of meetings and time commitment for staff with competing obligations. However, LACs that are combined by adult and children's mental health, by counties, or in other bodies, might not meet all of the statutory requirements. For example, children's mental health issues could get overlooked in a combined LAC. Multi-county LACs might not have stakeholder representatives from each county. LACs assimilated into other

groups might serve the purpose of the larger group and marginalize the voice of consumers and family members. Their focus may be too broad to advocate for the concerns of consumers and family members.

Reports on gaps and successes in delivery of mental health services have been undertaken separately by the Department of Human Services, Regional Initiatives, Children's Collaboratives, LACs, other county organizations and advocacy groups. These efforts are not coordinated, and the reports are not easily accessible.

We recommend:

1. The Department of Human Services Adult and Children's Mental Health Divisions, in consultation with the State Advisory Council, develop a plan that defines the roles of the State Advisory Council and other entities associated with providing technical assistance to and coordination of LACs.

2. The Department of Human Services, in consultation with the State Advisory Council, develop a process of ensuring that LACs are reporting their unmet needs to the State and their county boards.

3. A portion of State funding should support of the work of LACs. Counties shall report the amount of financial support they are providing to their LACs.

Minnesota State Advisory Council on Mental Health

MEMBER	AFFLIATION
Ron Allen Stewartville	Rep. of consumers of mental health services Term expires: January 2016
Rep. Bob Barrett Shafer	Rep. of Minnesota House of Representatives Term expires: January 2015
Melissa Balitz Hastings	Rep. of family members of persons with mental illnesses Term expires: January 2016
Kevin Belker Bloomington	Rep. of parents of children with an emotional disturbance; Term expires: January 2016
Laurel Briske Manager, Maternal-Child Health Section	Rep. of the Minnesota Department of Health
Matthew Burdick Minneapolis	Rep. of National Alliance on Mental Illness – Minnesota (NAMI) Term expires: January 2016.
Claire Courtney Dept. of Employment and Economic Development	Rep. state vocational services agency
Paula DeSanto Minneapolis	Rep. of providers of mental health services Term expires: January 2015
Leann Dorr Bemidji	Rep. of consumers of mental health services Term expires: January 2016
Troy Hanson New Prague	Rep. of family physicians Term expires: January 2016
Harriett Haynes Minneapolis	Rep. of discipline of psychology Term expires: January 2015
Iden Hill	Rep. of consumers of mental health services Term expires: January 2015
Patty Holycross Cohasset	Rep. of family members of persons with mental illnesses: Term expires: January 2016
Tom Johnson Roseville	Rep. of the Mental Health Association of MN Term expires: January 2016
James Jordan St. Paul	Rep. of discipline of psychiatry Term expires: January 2015

Marmie Jotter Hibbing	Rep. of discipline of social work Term expires: January 2015
Karalee LaBreche Lakeland	Rep. of discipline of nursing Term expires: January 2016
Ken Moorman Baudette	Rep. of county commissioners (rural) Term expires: January 2015
Joanie Murphy Morris	Rep. of county social services directors Term expires: January 3, 2015
Jody Nelson Minneapolis	Rep. of the discipline of marriage and family therapy Term expires: January 2016
Julie Ortiz Minneapolis	Rep. of parents of children with an emotional disturbance; Term expires: January 2015
Senator Kathy Sheran Mankato	Rep. of the Minnesota State Senate Term expiries: January 2015
Patricia Siebert Minneapolis	Rep. of MN Disability Law Center Term expires: January 2016
Rachel Voller St. Paul	Rep. of Mental Health Consumer/Survivor Network Term expires: January 2015
Kitty Westin Minneapolis	Rep. of family members of persons with mental illnesses; Term expires: January 2015
Nona Wilson St. Cloud	Rep. of the discipline of licensed professional clinical counseling. Term expires: January 2016
Alison Wolbeck Moorhead	Chair of Advisory Council Rep. of consumers of mental health services Term expires: January 2015
Ka Mai Xiong Brooklyn Park	Rep. of family members of persons with mental illnesses; Term expires: January 2015
Vacant	Rep. of county commissioners (urban) Term expires: January 2015
Vacant	Rep. of state Medical Assistance program
Vacant	Rep. of consumers of mental health services Term expires: January 2016
Vacant	Rep. of consumers of mental health services Term expires: January 2015

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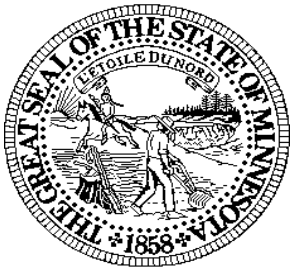

Minnesota State Advisory Council on Mental Health

Subcommittee on Children's Mental Health

MEMBER	AFFLIATION
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Laurel Briske Manager, Maternal-Child Health Section	Rep. of the Minnesota Department of Health
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Kristy Collier Minnetonka	Rep. of persons knowledgeable about the needs of children with emotional disturbances of minority races and cultures Term expires: January 2016
Glenace Edwall Director, Children's Mental Health Division Department of Human Services	Rep. of state mental health agency
Deborah Fjeld Coon Rapids	Rep. of parents of who have children with emotional disturbances Term expires: January 2015
Sarah Fuerst Woodbury	Rep. of providers of mental health services to pre-adolescent children Term expires: January 2015
BraVada Garrett-Akinsanya Golden Valley	Rep. of people experienced in working with children with emotional disturbances who have committed status offenses Term expires: January 2016
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Linda Hansen Dakota County Juvenile Services Center	Rep. of local corrections department Term expires: January 2016

Troy Hanson New Prague	Rep. of State Advisory Council on Mental Health; Term expires: January 2015
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Tanis Henderson Grand Rapids	Rep. of persons knowledgeable about the needs of children with emotional disturbances of minority races and cultures. Term expires: January 2015
Lisa Hoogheem St. Paul	Chair of Children's Subcommittee Rep. of educators currently working with children with emotional disturbances Term expires: January 2016
Jeffrey Lind Bemidji	Rep. of county social services agencies Term expires: January 2016
Sherri Mortensen Brown State Program Administrator Principal, Health Care Policy Minnesota Department of Commerce	Rep. of state agency regulating private insurance (Commerce Department)
Renelle Nelson Minneapolis	Rep. of an advocacy group for children with emotional disturbances (PACER Center) Term expires: January 2015
Terry Ocana Madison	Rep. of parents of who have children with emotional disturbances Term expires: January 2016
Jane Olive Mantorville	Rep. of county commissioners (*Dodge County*) Term expires: January 2015
Charles Olson Fergus Falls	Rep. of present or former consumers of adolescent mental health services Term expires: January 2015
Richard Oni St. Paul	Rep. of persons knowledgeable about the needs of children with emotional disturbances of minority races and cultures Term expires: January 2015
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John Soghigian Ely	Rep. of parents of who have children with emotional disturbances Term expires: January 2015
Madeline Starke Woodbury	Rep. of present or former consumers of adolescent mental health services Term expires: January 2016
Rep. John Ward Brainerd	Rep. of state legislators Term expires: January 2016
Robyn Widley Supervisor, Interagency Services Unit, Special Education Policy Division	Rep. of the Minnesota Department of Education
Vacant	Rep. of parents of who have children with emotional disturbances Term expires: January 2016

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