



**State Advisory Council on Mental Health**  
Subcommittee on Children's Mental Health

*2016*  
**Report to  
Governor and Legislature**



# 651-431-2225

Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntwv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າທ່ານ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງໂທໂປໂທທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la' aan ah ee tarjumaadda qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LBS-001 (3-13)



For accessible formats of this publication or additional equal access to human services, write to [DHS.MH@state.mn.us](mailto:DHS.MH@state.mn.us), call 651-431-2225, or use your preferred relay service. (ADA1 [9-15])

State Advisory Council on Mental Health and Subcommittee on  
Children's Mental Health  
2016 report to the governor and Legislature

For more information, contact:  
Heron Abegaze, Mental Health Program Advisor  
State Advisory Council on Mental Health and  
Subcommittee on Children's Mental Health  
Minnesota Department of Human Services  
PO Box 65981  
St. Paul, MN 55164-0981  
Telephone: 651-431-2249  
E-mail: [Heron.Abegaze@state.mn.us](mailto:Heron.Abegaze@state.mn.us)

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is \$5500.00

Printed with a minimum of 10 percent post-consumer material.  
Please recycle.

# TABLE OF CONTENTS

- Letter from the Chairs..... 1**
- Executive Summary ..... 2**
  - Recommendations Summary ..... 3
- Introduction..... 7**
- Breaking Down Silos and Challenging the Status Quo ..... 8**
  - Individual Placement and Support Services ..... 8
  - Housing Support Services..... 9
  - Intensive Outpatient Programs for Co-Occurring Disorders ..... 9
  - Coordinated System for Children in the Juvenile Justice System..... 10
  - School Linked Mental Health Services ..... 11
  - Dual Diagnosis Treatment for Children with Co-Occurring Disorders..... 12
- Community Supports ..... 13**
  - Bridges Rental Assistance Program..... 14
  - Intensive Outpatient Programs for Pregnant and Postpartum Women ..... 14
  - Evidence-Based Reintegration Processes and Collaboration with School Systems ..... 15
  - Evidence-based Home Visiting Models ..... 15
  - Facilitating Attuned Interactions Training for Home Visitors..... 16
  - Infant Mental Health Consultation and Training for Home Visiting Programs..... 18
  - Family Treatment for Parents with Serious Mental Illness..... 18
  - Minnesota Family Investment Program Child Only Assistance..... 19
  - Resources to Support Local Mental Health Advisory Councils ..... 19
  - Local Mental Health Advisory Council Involvement in the Adult Mental Health Grant Application Process ..... 20
- Workforce and Access..... 21**
  - Cultural and Ethnic Minority Grant Programs..... 21
  - Culturally Informed Mental Health Consultants ..... 23
  - Culturally Specific Mental Health Organizations..... 23
  - Definition for Culturally Specific Agency..... 24
  - Health Equity for Rural Communities..... 25
  - 2-Year Psychiatric Fellowship Pilot Program ..... 25
  - Primary Care and Behavioral Health Fellowship Program..... 26
  - Certified Peer Specialists and Family Peer Specialists..... 28
  - Ancillary Mental Health Treatment Providers..... 28
- Early and Effective Identification of Mental Illness ..... 29**
  - Interpreter Services for Mental Health ..... 30

Evidence-Based Treatment Research for Cultural and Ethnic Communities.....	30
Tele-Mental Health Services.....	31
Positive Behavioral Interventions and Supports.....	32
Multi-Tiered Support of System Model.....	32
Children's Mental Health Screening Tools .....	33
Specialized Level of Care in Children's Residential Treatment Settings .....	34
Interventions to Address Aggressive Behaviors in Children and Youth Under 16 .....	34
<b>Person Centered Care and Promotion of Well-being .....</b>	<b>35</b>
Mental Health First Aid Training for Community Service Providers .....	36
Crisis Intervention Team (CIT) Training for Law Enforcement Officers.....	36
Youth Based Mental Health Peer Supports Program .....	37
Access to Resources and Training for Suicide Prevention .....	38
<b>State Advisory Council on Mental Health Membership List .....</b>	<b>39</b>
<b>Subcommittee on Children's Mental Health Membership List .....</b>	<b>41</b>



# LETTER FROM THE CHAIRS

The Chairs are pleased to deliver the 2016 report of the State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health.

On behalf of the Council and Subcommittee, the Chairs wish to commend the governor and Legislature on the historic investments for mental health services and the improvement of mental health and well-being of Minnesotans in the two years since we presented our last report.

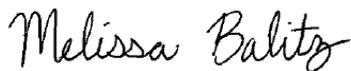
We thank you for taking action and making investments on recommendations from our 2014 report:

- Mental health crisis services and mobile crisis teams
- Txt4Life
- Bridges housing subsidies

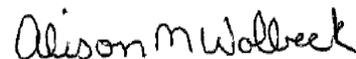
In our 2016 report, the Council and Subcommittee recommendations fall into five key theme areas. These theme areas emphasize the need for mental health services and treatment focused on the whole person in their community, the need to increase the mental health workforce in order to ensure that services are readily available when a person needs them and the need to prevent mental illness and support people experiencing mental health crisis.

We wish to thank the staff from the various state agencies that have supported the Council and Subcommittee in the development of our recommendations. In addition to state agencies, we would like to thank members of the American Indian Mental Health Advisory Council, the American Indian Advisory Council on Chemical Dependency, and the Alcohol and Other Drug Abuse Advisory Council for reviewing and providing feedback on our recommendations during our June 2, 2016 Joint Council and Subcommittee meeting.

We look forward to working with the governor, Legislature and state agencies in taking the steps necessary to implement the recommendations included in this report.



Melissa Balitz  
Chair  
State Advisory Council on Mental Health



Alison Wolbeck  
Vice Chair  
State Advisory Council on Mental Health



Dave Johnson  
Co-Chair  
Subcommittee on Children's Mental Health

# EXECUTIVE SUMMARY

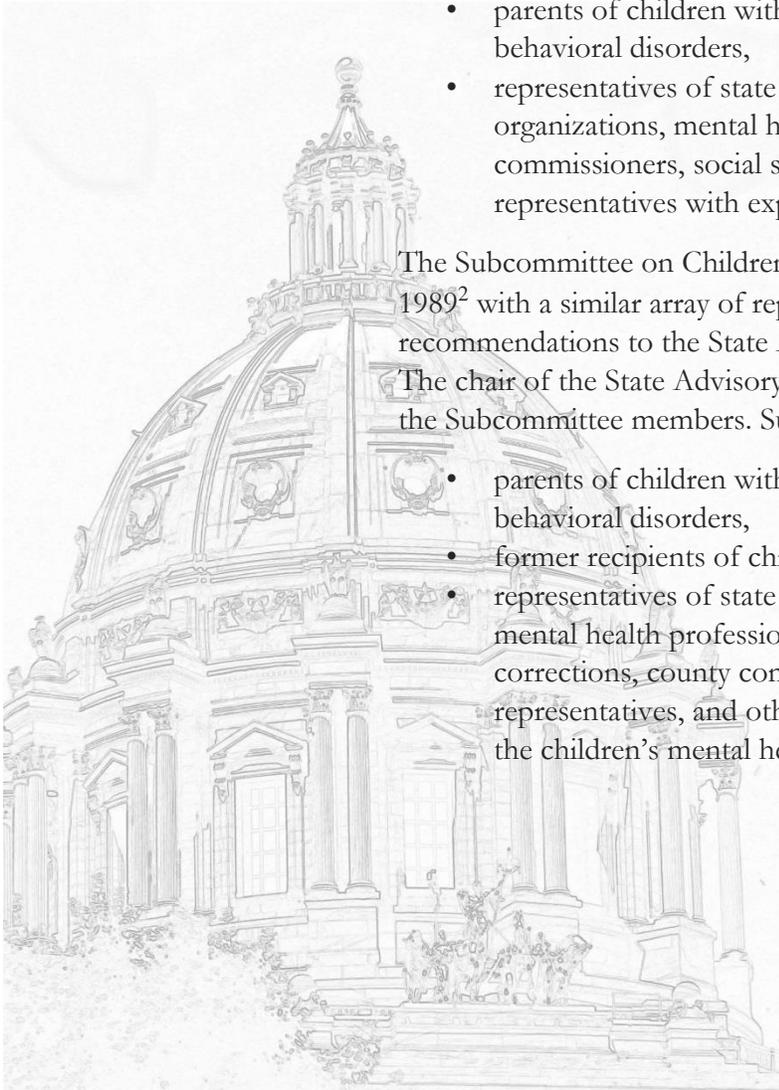
The State Advisory Council on Mental Health was established in 1987.<sup>1</sup> The Council is charged with making recommendations to the governor, Legislature and state departments on mental health policies, programs and services. By including representatives from all groups with an interest in the mental health system, the vision for the Council is to have a body that makes comprehensive recommendations by a consensus. The governor appoints the State Advisory Council members. State Advisory Council members include:

- individuals with lived experience of mental illness,
- family members of individuals with lived experience of mental illness,
- parents of children with a lived experience of emotional and behavioral disorders,
- representatives of state departments and advocacy organizations, mental health professionals, legislators, county commissioners, social service agency directors and other representatives with experience in the mental health system.

The Subcommittee on Children’s Mental Health was established in 1989<sup>2</sup> with a similar array of representatives in order to make recommendations to the State Advisory Council on Mental Health.

The chair of the State Advisory Council on Mental Health appoints the Subcommittee members. Subcommittee members include:

- parents of children with a lived experience of emotional or behavioral disorders,
- former recipients of children’s mental health services, and
- representatives of state departments, advocacy organizations, mental health professionals, legislators, educators, community corrections, county commissioners, social services agency representatives, and others representative with experience in the children’s mental health system.



The 2016 Report to the governor and Legislature provides recommendations from the members of the State Advisory Council on Mental Health and Subcommittee on Children’s Mental Health. The Council and Subcommittee have seven work groups, each work group having contributed to this report.

The State Advisory Council on Mental Health and Subcommittee on Children’s Mental Health recommend that the governor and Legislature focus on the areas discussed in this report to improve the mental health system and continuum of care in Minnesota.



The recommendations in this report are organized by the following areas:

- Breaking down silos and challenging the status quo
- Community supports
- Workforce and access
- Early and effective identification of mental illness
- Person centered care and promoting well-being

## **Recommendations Summary**

### **Breaking Down Silos and Challenging the Status Quo**

- Continue and expand funding for Individual Placement and Support Services, which provides evidence-based employment supports for people experiencing mental illness.
- Support efforts to increase availability of housing support services by including it as a Medicaid benefit.
- Expand evidence-based practices that can be used in intensive outpatient programs to improve the treatments available for people experiencing co-occurring mental health disorders and substance use disorders.
- Develop a coordinated system for children involved in the juvenile justice system under one state authority. Ensure the system is accountable for providing for the needs of children involved in the juvenile justice system.
- Increase funding for School Linked Mental Health Services in order meet the high demands for these services. Funding should be allocated towards ongoing evaluation, technical

assistance and evidence-based practices training to providers in schools.

- Expand the capacity and availability of dual diagnosis treatment for children with co-occurring mental and chemical health concerns.

### Community Supports

- Continue funding the Bridges Rental Assistance program. This critical program provides individuals experiencing mental illness, who may otherwise be homeless, housing stability in the form of rental assistances.
- Create a high intensity outpatient treatment program through Medicaid benefit for pregnant and postpartum women experiencing mental illness.
- Develop and require that evidence-based reintegration processes be used for children returning to schools from the juvenile justice system or mental health treatment. Ensure proper collaboration occurs with the child's school system to give the child the best chance to succeed.
- Expand the capacity and increase funding of evidence-based home visiting programs and make it available to all eligible families.
- Provide Facilitating Attuned Interactions (FAN) approach training to home visiting programs. This unique approach supports the mental health and well-being of both the mother and the infant.
- Expand access to infant mental health consultation support, training for evidence-based home visiting programs and other long-term intensive home visiting programs in the state.
- Provide education and training on family-based treatment approaches to address the needs of parents with serious mental illness.
- Expand the availability of childcare assistance for caregivers receiving Minnesota Family Investment Program Child Only Assistance. Receiving childcare assistance will allow caregivers experiencing mental illness to better address their own mental health needs.
- Increase funding and resources available to support local mental health advisory councils. This will allow the State Advisory Council on Mental Health to fulfill its statutory responsibility of coordinating the work of the local mental health councils in the state.



- Revise the questions in the adult mental health grant application to ensure and encourage counties involve their local mental health advisory councils in the grant planning process.

### Workforce and Access

- Increase funding for and expand the availability of the cultural and ethnic minority grant programs. This will increase the number of culturally specific providers and increase access to culturally responsive and specific mental health services.
- Create collaboration between culturally informed mental health consultants and the Department of Human Services (DHS) in order to provide training on cultural proficiency and responsiveness to mental health providers.
- Create collaboration between expert culturally specific providers/organizations and DHS and fund a mentorship program for culturally specific mental health organizations to enhance their proficiency with state program rules and grant requirements.
- Create a statutory definition for “Culturally Specific Agency” to define agencies providing mental health services to culturally specific communities. Additionally, revise statute so that there is one universal definition for culturally specific providers.
- Specifically related to the mental health workforce shortage, we recommend the immediate funding of the following recommendations aimed at providing the mental health system with high quality workforce that is adequately prepared and supported to work in a person centered and coordinated mental health system:
  - Create a 2-year psychiatric fellowship pilot program
  - Create a primary care and behavioral health fellowship program
  - Improve the utilization of Certified Peer Specialists and Family Peer Specialists
  - Study the potential use of ancillary mental health treatment providers
- Make improvements to the grant and contracting processes and create feasible grant and contract requirements for providers in Health Professional Shortage Areas.



### **Early and Effective Identification of Mental Illness**

- Align state statute and ensure availability of adequate interpreter services for mental health.
- Support new research and adaptation of existing evidence-based practices and evidence informed practices to provide treatment and services that are culturally appropriate and responsive to communities of color and underserved communities.
- Create a single tele-health platform for use of mental health services throughout the state. This will increase the availability of mental health service being provided in schools and other settings that use tele-health.
- Expand and better support the use of Positive Behavioral Interventions and Supports in schools.
- Continue to incorporate Multi-Tiered Support Systems model in Minnesota schools and districts along with Positive Behavior Interventions and Supports. In addition, continue to implement access to licensed student support services and specialized instructional support personnel within this model.
- Improve the children’s mental health screening tools, which are used for children involved in the juvenile justice system to better assess if the child has experienced childhood trauma.
- Develop a new specialized level of care to address the needs of children experiencing high emotional dysregulation, who are not having their needs addressed in residential treatment settings.
- Research the needs of treatment available for children and youth under the age of 16, who are presenting with highly aggressive behaviors and emotional dysregulation.

### **Person Centered Care and Promoting Well-being**

- Provide Mental Health First Aid Training for community service providers to promote mental health well-being in all communities.
- Require that all Law Enforcement Officers in Minnesota receive Crisis Intervention Team (CIT) training to better educate law enforcement officers about mental illness and effectively intervening in crisis situations.
- Develop and support youth based mental health peer support programs in schools.
- Increase focus and action on the prevention of suicide in Minnesota.



# INTRODUCTION

Mental health and well-being are important for all people, including individuals who do not have mental illness. The World Health Organization (WHO)<sup>3</sup> defines mental health as:

*"A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community."*

Evidence suggests that mental illness and mental well-being operate on dual continuums, meaning that someone can have positive mental health and a mental illness, which is sometimes referred to as being in recovery, or that someone could have poor mental health but have no diagnosable mental disorder.<sup>4</sup>

There are many factors that shape a person's experience of mental health and mental well-being. According to WHO, "a person's mental health and many common mental disorders are shaped by various social, economic and physical environments operating at different stages of life. Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk."

Given the factors that shape a person's experience of mental health and mental well-being, it is of major importance that action is taken to improve the conditions of everyday life, beginning before birth and progressing into early childhood, older childhood and adolescence, during family building and working ages and through to older age. Action throughout these life stages would provide opportunities for both improving population mental health and for reducing risk of those mental disorders that are associated with social inequalities.

While our 2016 report will primarily focus on addressing the needs of Minnesotans who are experiencing mental illness, we recognize that we must also focus attention on creating policies, systems and environments that will promote mental health and well-being for all Minnesotans, in order to prevent or mitigate the impact of mental illness and support recovery.

Minnesota experiences some of the greatest social inequities in the country. Social and economic conditions such as poverty, mass incarceration, unemployment and poor working conditions, lack of transportation and affordable housing, poor nutrition, unsafe neighborhoods, limited opportunities for social connectedness, child neglect and abuse, historical trauma and racism all contribute to poor mental health and well-being in our state.<sup>5</sup> These foundational issues must be addressed to improve the overall mental health and mental well-being of Minnesotans and to use resources allocated to the state's mental health system more effectively, efficiently and equitably.

# BREAKING DOWN SILOS AND CHALLENGING THE STATUS QUO

We believe, in order to provide more equitable, effective and person centered mental health treatment and support services, the state must work at breaking down silos between different state agencies and systems. Breaking down silos between systems can create a more integrated and holistic approach to the treatment and recovery of mental illness. Additionally, it can lead to sustaining and providing integrated services and supports to individuals living with mental illness and their families. To accomplish this, we propose the following recommendations in various areas including education, judicial and law enforcement, housing, employment and substance use disorder services.

---

*Breaking down silos between systems can create a more integrated and holistic approach to the treatment and recovery of mental illness.*

---

## Individual Placement and Support Services

Individuals who identify as having lived experience of mental illness continue to experience higher unemployment than the general population.<sup>6</sup> Individual Placement and Support Services provides a proven system of employment support for individuals with mental health vocational challenges and are shown to improve employment outcomes for individuals who choose to work. Individual Placement and Support Services is the evidence-based practice of supported employment for people experiencing mental illness, and it is also a cost effective service with demonstrated positive outcomes. While some investments have been made in Individual Placement and Support Services, additional funds are needed to increase the service levels of existing programs and for expansion of Individual Placement and Support Services to make the service more widely available. Without additional funding, it will be difficult to grow or even maintain existing service levels of the current Individual Placement and Support Services programs and it will be impossible to make Individual Placement and Support Services more widely available.

### Recommendations

- We recommend the governor and Legislature continue funding the Individual Placement and Support Services programs that currently exist in Minnesota.
- We recommend the governor and Legislature increase long term and sustainable funding to expand access to Individual

Placement and Support Services to all individuals experiencing mental illness who want to be employed but may experience challenges or barriers to employment.

## Housing Support Services

In state fiscal year 2015, Minnesota Department of Human Services had interactions with over 120,000 people that were experiencing some level of housing instability, homelessness, or living in institutions or segregated settings. People who are faced with situations of housing instability experience high incidences of mental illnesses and various acquired cognitive disorders. Substance abuse and hearing loss are also common, with a large percentage of the group coping with two or more health disorders.<sup>7</sup> These difficulties can directly impact a person or family's ability to maintain their housing or move from segregated settings into the community. Minnesota has the opportunity to plan and implement new Housing Support Services benefits through a proposal to the Centers for Medicare and Medicaid Services. A focused set of Housing Support Services can help a person or family to confront and overcome these barriers, and ultimately we hope this will ensure that people with disabilities or experiencing mental illness can obtain and maintain stable, integrated housing.

---

*...ultimately we hope this will ensure that people with disabilities or experiencing mental illness can obtain and maintain stable, integrated housing.*

---

### Recommendations

- We recommend the governor and Legislature make Housing Support Services available under Medicaid. Services will be available to people with disabilities who want to move into more integrated settings and to people who need assistance maintaining housing in community based settings who receive Medical Assistance (Medicaid).
- We recommend resources be provided to the existing Medicaid and Housing Supports Workgroup to allow ongoing analysis of the state's need for other potential Housing Support Services options for people receiving Medicaid, such as Housing Transition and Tenancy Sustaining Services.
- We recommend providers of Housing Support Services be compensated for the additional costs of shifting to the Medicaid billing system.

## Intensive Outpatient Programs for Co-Occurring Disorders

Currently, the only Intensive Outpatient Program services covered by Medical Assistance (Medicaid) is for Dialectical Behavior Therapy, used for people experiencing mental illness. However, there is a

critical need for additional Intensive Outpatient Program services to be available for people with co-occurring disorders (that is, diagnosable mental health disorders and substance use disorders occurring at the same time for an individual).

People with co-occurring disorders benefit from an integrated treatment system where there is “no wrong door” to accessing treatment. Minnesota has recently begun to recognize the importance of providing integrated treatment for co-occurring disorders, by creating an optional certification available to previously existing providers. However, there has been no additional funding allocated to provide integrated treatment or to create new appropriate treatments for people experiencing co-occurring disorders.

---

*People with co-occurring disorders benefit from an integrated treatment system where there is “no wrong door” to accessing treatment.*

---

### **Recommendations**

- We recommend that funding and necessary policy changes be made to expand the use of Intensive Outpatient Program services to include the use of multiple effective interventions — Motivational Interviewing, Cognitive Behavior Therapy and Dialectical Behavior Therapy — to treat co-occurring disorders by making these interventions available as Intensive Outpatient Programs under Medical Assistance. To ensure that these Intensive Outpatient Programs are of high quality and meet the needs of people experiencing co-occurring disorders, we recommend that providers wishing to use the additional approaches to treat people experiencing co-occurring disorders be certified as integrated treatment providers.
- We recommend the creation of an enhanced rate and specific Intensive Outpatient Program billing codes for Integrated Treatment for Co-Occurring Disorder Programs for children and adults.

## **Coordinated System for Children in the Juvenile Justice System**

The current criminal justice system in Minnesota was not designed to accommodate the complex emotional and developmental needs of juvenile offenders within the juvenile justice system. The criminal justice system is fragmented in its delivery of services. The system needs to have a consistent and coordinated response that is attentive to the unique needs of each juvenile offender within its care.

### **Recommendation**

- We recommend that a state authority, the Office of Juvenile Justice, be created to oversee and integrate a coordinated

system that addresses the unique needs of children in the juvenile justice system.

- This new centralized authority's responsibilities should include collaborating across state and county agencies to define a specific array of services that must be provided to children in the juvenile justice system in a consistent manner and meets the needs of the child.
- The Office of Juvenile Justice would have authority and provide accountability so that any mental health, chemical health and community support services provided to a child in the juvenile justice system incorporates best practices while taking into account cultural and gender differences and family engagement in a trauma informed manner.
- We believe through the improved coordination, collaboration and increased availability of specialized services, the return on investment would exceed the cost through improved outcomes.

## School Linked Mental Health Services

Since expanding the availability of School-Linked Mental Health Services in Minnesota in 2014, school-linked services have proven to be particularly effective in: reaching children who have never accessed mental health services, early identification of mental health concerns and achieving improved clinical and functional outcomes in young children and K-12 students. Another important outcome of the expansion of School-Linked Mental Health Services is that students of color, who have typically been underserved or have not accessed services in the mental health system, are more likely to be accessing School-Linked Mental Health Services when compared to white students, 58 percent versus 52 percent for white students.

Mental Health Services offered in schools are convenient for both students and their families leading to sustained engagement rather than dropping out of services after only one or two sessions.

Teachers and parents report decreases in the emotional and behavioral problems at school and at home for students served by the grant. Schools with School-Linked Mental Health Services in the Minneapolis Public Schools District have reported decreased school suspensions and increased attendance by students.

Since expanding the availability of this service, the demand for these services continues to substantially increase each year as more students are needing to access these services. While most school districts offer

---

*Mental Health Services offered in schools are convenient for both students and their families leading to sustained engagement rather than dropping out of services after only one or two sessions.*

---

this service through collaboration with a provider receiving grants, they are only available in a few schools in each district. Students attending schools that do not have this service can end up without beneficial services they may really need. Due to the high demand for school-linked services, many school districts have established waiting lists for this service.

### **Recommendations**

- We recommend long-term and sustained funding for School-Linked Mental Health Services in order to increase access in schools currently without these services and, for schools with School-Linked Mental Health Services, increase the availability to reduce or eliminate the need for waiting lists.
- We recommend doubling the base funding level set for State Fiscal Year 2018-2019 for School-Linked Mental Health Services by State Fiscal Year 2020-2021.
- We recommend funding be allocated to DHS to provide resources, oversight and ongoing outcome evaluation of School-Linked Mental Health Services.
- We recommend DHS include technical assistance activities and increase training for providers of school-linked services in evidence-based practices adapted for use in schools in their activities.

## **Dual Diagnosis Treatment for Children with Co-Occurring Disorders**

There is limited capacity within the state to address the needs of children with co-occurring disorders (diagnosable mental health disorders and substance use disorders occurring at the same time). Until we develop programming that address these issues, we cannot expect children experiencing both mental illness and substance use to improve.

### **Recommendations**

- We recommend the development and expansion of the integrated capacity to deliver services to address chemical dependency, mental health and dual diagnosis treatments to children within the juvenile justice system and in the community. This capacity building should include prevention, inpatient and outpatient treatments, aftercare services and providers that provide trauma informed care and services.
- We recommend DHS, the Legislature and the governor support the funding and policy changes that will be necessary to ensure that the capacity building needed to provide

---

*There is limited capacity within the state to address the needs of children with co-occurring disorders...*

---

adequate dual diagnosis treatment for children can be successful. Any dual diagnosis treatment programs developed for children should be outcome focused and accountable for the outcomes.

## COMMUNITY SUPPORTS

We believe, in order to treat and prevent mental illness, proper community supports must be in place for individuals experiencing mental illness to access services with ease. Having community supports is essential to ensuring that people with disabilities and individuals living with mental illnesses are living, learning, working and enjoying life in the most integrated setting, as outlined in Minnesota's Olmstead Plan.<sup>8</sup> The Olmstead Plan will help achieve a better Minnesota for all Minnesotans; it will help people with disabilities have the opportunity, both now and in the future to:

- Live close to their family and friends
- Live more independently
- Engage in productive employment
- Participate in community life

Community supports are also one of the most critical services needed by those living with mental illness who have recently been discharged from a higher level of care. Having community supports is a crucial and key component in being able to properly and successfully discharge someone from a higher level of care to their communities. Additionally, communities should continue to collaborate and work with their Local Mental Health Advisory Council and Mental Health Initiatives to ensure that quality supports are available. In order to accomplish both of these objectives, we propose the following recommendations aimed at increasing community supports and mental health services in Minnesota.

---

*Having community supports is a crucial and key component in being able to properly and successfully discharge someone from a higher level of care to their communities.*

---

## Bridges Rental Assistance Program

Individuals who experience a serious mental illness are over-represented in people who experience homelessness and housing instability.<sup>9</sup> Stable housing in a community setting is the foundation for improving and maintaining health. The existing Bridges Rental Assistance Program provides a housing subsidy for a person to live in a rental unit of their choosing and linkages to mental health services while the person experiencing mental illness is on a waiting list to receive a Section 8 housing voucher. Program priority is given to individuals' exiting institutions and who are experiencing homelessness.

### Recommendation

- We recommend continued funding for Bridges Rental Assistance Program. We emphasize continued funding should provide assistance for individuals transitioning out of Anoka Metro Regional Treatment Center and St. Peter Regional Treatment Center, this is critical to getting people back to their communities.

---

*Pregnant and postpartum women experiencing moderate to severe mental illness are currently at higher risk for developing mental illness and are being underserved in Minnesota.*

---

## Intensive Outpatient Programs for Pregnant and Postpartum Women

Pregnant and postpartum women experiencing moderate to severe mental illness are currently at higher risk for developing mental illness and are being underserved in Minnesota. One in five pregnant and postpartum women have significant mood and anxiety symptoms.

Untreated depression and anxiety during pregnancy and postpartum impacts the whole family. It can lead to poor obstetrical outcomes for the mother, for example: preterm delivery and low birth weight. It can lead to poor mental well-being for the mother including: poor self-care, increased smoking/alcohol/drug use, decreased compliance with prenatal care, self-harm and in some instances, suicide.

Untreated depression and anxiety in new mothers can also impact the infant child, for example the infant can experience attachment difficulties and cognitive, social and emotional developmental delays.

For pregnant and postpartum women experiencing moderate to severe mental illness, there are limited options for intensive treatment that address both maternal mental health and the need to increase the maternal capacity of the mother to support the healthy development of her children. The Hennepin County Medical Center Mother-Baby Day Hospital is the only partial hospital program for pregnant and postpartum women in Minnesota. Outcome data from this program

has shown reduced depression and suicidal thinking, which can prevent the need for inpatient hospitalization.

Currently, there is no intermediate level of care for pregnant and postpartum mothers that falls between a clinic, which provides low intensity treatment and a partial hospitalization program, which provides high intensity treatment. An intensive outpatient program level of care to serve this population could provide significant cost savings. For example, if in one year eight mothers were able to utilize an intensive outpatient program rather than the more costly partial hospitalization program, cost savings could be as high as \$675,584.

### **Recommendations**

- We recommend that funding and necessary policy changes are made to expand Intensive Outpatient Programs services to treat pregnant and postpartum women experiencing moderate to severe mental illness.
- We recommend making this treatment available through Medical Assistance.

## **Evidence-Based Reintegration Processes and Collaboration with School Systems**

There is a lack of continuity for students when they are reintegrating into school following extended time away due to mental health treatment that is away from home, time spent in a correction facility, or an out of home placement. Transitions between healthcare settings, such as hospitals and other treatment settings, as well as correctional facilities, require timely and effective planning. In order to provide effective transition planning, collaboration between where the child will be leaving from and the school the child is returning to are critical. Reintegration Framework is an evidence based model that can help schools, discharge planners and mental health professionals facilitate coordinated and successful transitions for children.

### **Recommendation**

- We recommend the creation of and required use of evidence-based collaborative reintegration models for all children transitions back to school from mental health treatment and correctional facilities. This will allow children the greatest chance at success when returning to school settings.

## **Evidence-based Home Visiting Models**

Children and families in communities experiencing economic, social and environmental disadvantages are disproportionately affected by stressors such as poverty and adverse experiences in early childhood.

---

*Reintegration Framework is an evidence based model that can help schools, discharge planners and mental health professionals facilitate coordinated and successful transitions for children.*

---

---

*Evidence-based home visiting models have been implemented in some communities in Minnesota but at this time only serves a small portion of eligible families.*

---

These stressors can lead to adverse physical and mental health outcomes later in life. Evidence-based home visiting programs have been shown to improve the health and well-being of the families who participate in home visiting models.

Evidence-based home visiting models have been implemented in some communities in Minnesota but at this time only serves a small portion of eligible families.<sup>10</sup> Minnesota needs to increase capacity and funding to serve all eligible families in order to better address the mental well-being of the families who participate in evidence-based home visiting models.

#### **Recommendations**

- We recommend increasing the capacity and funding in Minnesota so all eligible families have the opportunity to participate in an evidence-based home visiting model.
- We recommend that funding should cover the costs for providing family visiting and training and implementation costs for specific evidence-based models including culturally specific models, and infrastructure support from both the state and community level needed to support expansion of the service.

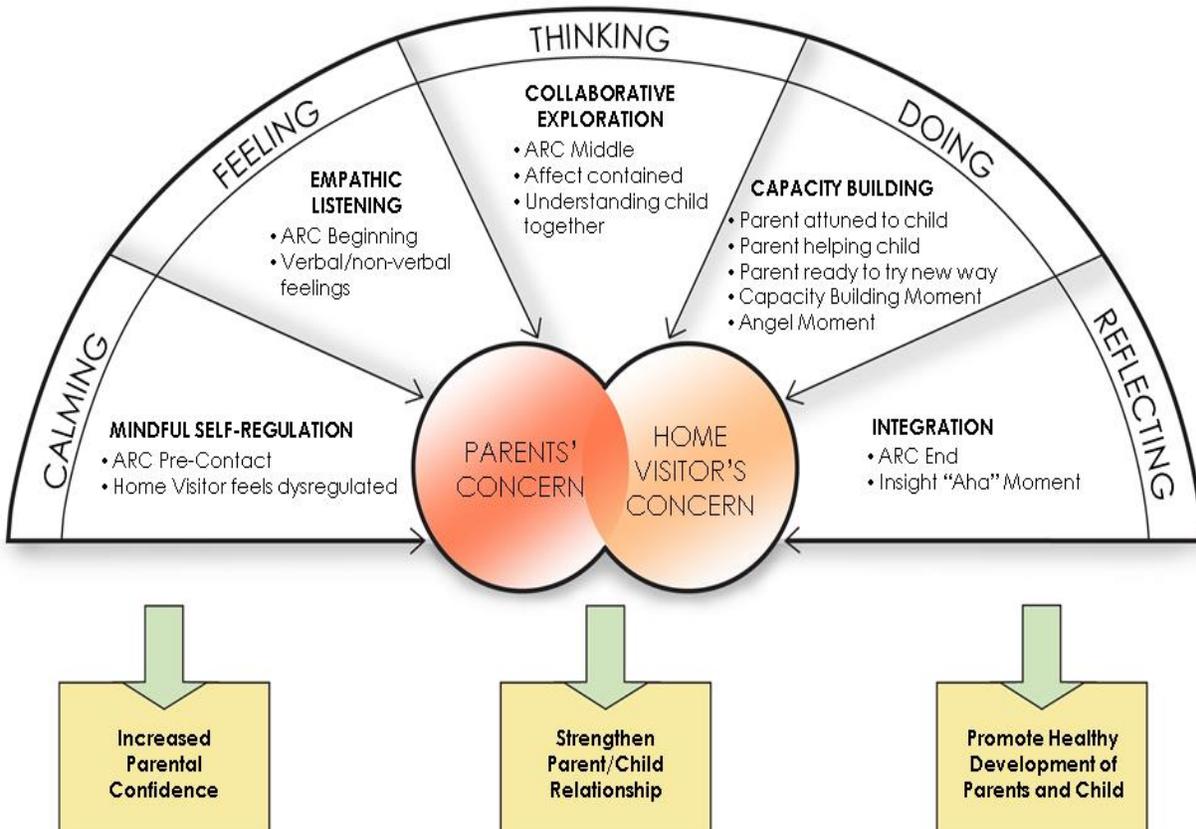
## **Facilitating Attuned Interactions Training for Home Visitors**

Home visiting providers in Minnesota interact with families with multiple types of concerns and stressors including mental health. Home visiting providers often indicate they have not received a framework to be able to support families with an approach that supports the mental health of the mother and infant. The Fussy Baby Network has provided a unique approach to working with families called Facilitating Attuned Interactions (FAN).<sup>11</sup> This approach has been utilized to support home visiting providers in several states by providing a structure to support the relationship and mental health of an infant and the infant's primary caregiver.

The goals of FAN are to increase parent confidence, strengthen the parent-infant relationship and promote healthy development of parents and infants.

# Home Visitor's FAN<sup>®</sup>

Facilitating Attuned Interactions



©Gilkerson, 2010, rev 2015  
Erikson Institute Fussy Baby Network

## Recommendations

- We recommend the development of a train-the-trainer model for the FAN approach in Minnesota.
- We recommend funding of approximately \$70,000 to cover the cost of consultation from the developer of the approach, support of the train-the-trainer program, training materials and training two people in the FAN framework (who would then train others in the state).
- When developing the train the trainer model, we recommend partnerships be made with the providers serving families with infants, include home visiting providers and the use of a Minnesota-based training system, in order to support ongoing implementation and sustainability of the program.

## Infant Mental Health Consultation and Training for Home Visiting Programs

Many home visiting programs serve families with mental health concerns. The capacity and access to infant mental health consultation support services is challenging in Minnesota, especially for home visiting programs. There is a need in Minnesota for additional training and increased availability of infant mental health consultation for providers of home visiting programs and this is causing the state to inadequately provide for the mental health needs of infants within the state.

### Recommendation

- We recommend \$225,000 of funding be allocated to provide the following:
  - Infant mental health consultation support and training for evidence-based home visiting programs and other long-term intensive home visiting programs by supporting local agencies to contract for infant mental health consultation.
  - Training for evidence-based home visiting programs and other long-term intensive home visiting programs on infant mental health and reflective practice. The training should focus on ensuring the programs have an understanding and basic knowledge of infant mental health, reflective practices and relationship-based work for home visiting supervisors and staff providing intensive, evidence-based home visiting services.

---

*It is essential that Minnesota have a mental health system that can be responsive to the generational impact mental illness can have on families.*

---

## Family Treatment for Parents with Serious Mental Illness

Parents with serious mental illness often have difficulty understanding their children's needs separate from their own, don't have the skills to provide sensitive care to their children and do not have the support system required to sustain the parenting skills they may develop. For example, when a parent experiences a severe mental illness, their young developing child may experience stressors. There needs to be more thoughtful consideration of the needs of the parent, the child and the relationship that exists between the parent and the child. Promoting awareness of the parenting needs of parents diagnosed with serious mental illness and ensuring the availability of evidenced based family treatments for parents with serious mental illness and their young children is necessary. It is essential that Minnesota have a mental health system that can be

responsive to the generational impact mental illness can have on families.

### **Recommendations**

- We recommend efforts to begin training mental health providers in parenting interventions, including training for adult psychotherapists to be able to provide multigenerational family psychotherapy.
- We recommend that DHS work to understand the parenting supports and needs of parents who are experiencing severe mental illness and their children and to educate providers of additional types of mental health services on the overall needs of parents experiencing a serious mental illness.

## **Minnesota Family Investment Program Child Only Assistance**

Parents receiving Supplemental Security Income and Minnesota Family Investment Program Child Only cash assistance experiencing mental illness often are not eligible for childcare assistance. The lack of access to childcare often affects parents' ability to attend their appointments, treatment and to get respite. When a parent or caregiver is experiencing a mental illness, many times the parent or caregiver can struggle to meet the child's social-emotional needs. Childcare can give the child access to an environment that can support their social-emotional needs, while their parent or caregiver can focus on their own mental health needs.

### **Recommendation**

- We recommend the Minnesota Family Investment Program be expanded to allow child-only cases, in which the child's primary caregiver has a diagnosis of a mental illness eligibility to up to 20 hours of childcare per week for children ages 6 and under, when recommended by the treating mental health professional.

## **Resources to Support Local Mental Health Advisory Councils**

The Adult and Children's Mental Health Acts of 1987 and 1989 <sup>12</sup> requires counties to establish Local Mental Health Advisory Councils. Local Mental Health Advisory Councils offer individuals with a lived experience of mental illness, parents, families and providers the opportunity to make a difference in their community's mental health system.<sup>13</sup>

---

*Childcare can give the child access to an environment that can support their social-emotional needs, while their parent or caregiver can focus on their own mental health needs.*

---

Minnesota Statute 245.697<sup>14</sup> states that one of the roles of the State Advisory Council on Mental Health is to coordinate the work of local children's and adult mental health advisory councils and subcommittees. The State Advisory Council on Mental Health does not have the resources, both financial and in manpower, available to appropriately fulfill this responsibility.

In previous years, DHS has funded an organization to work with local mental health advisory councils, however that effort was not coordinated with the State Advisory Council on Mental Health and the deliverables of those contracts were not adequate to assist with this duty.

Currently, DHS has not contracted with an organization to provide training, coordination, or technical assistance to Local Mental Health Advisory Councils or counties looking to establish mental health advisory councils.

#### **Recommendations**

- We recommend DHS creates a request for proposal in consultation with the State Advisory Council on Mental Health, for organizations who wish to coordinate and support local mental health advisory councils across the state. Additionally, DHS should coordinate with the State Advisory Council on Mental Health in reviewing the submitted proposals before contracting with an organization.
- We recommend DHS secures adequate funding with the required deliverables to assure effective coordination and support to all local mental health advisory councils.

---

*Local Mental Health Advisory Councils should be playing an important advisory role to counties.*

---

### **Local Mental Health Advisory Council Involvement in the Adult Mental Health Grant Application Process**

Local Mental Health Advisory Councils should be playing an important advisory role to counties. The main purpose of their existence is to give county leaders an opportunity to hear recommendation about their local mental health systems. Despite legislation requiring counties to have local mental health advisory councils addressing both the adult and children's mental health systems, there are some counties that have not established local mental health advisory councils to serve their communities.

DHS requires counties to report on their unmet needs in the adult mental health grant application, completed annually. However, the adult mental health grant application does not include an adequate

level of inquiry into how their Local Mental Health Advisory Councils participate and communicate with counties.

### Recommendations

- We recommend DHS add the following question to the Mental Health Grant Application: “Identify how Local Mental Health Advisory Councils were involved in developing, implementing and evaluating this grant plan. Describe how Local Mental Health Advisory Councils provided input or comment on the grant plan.”
- We recommend DHS coordinate with the Local Advisory Council Workgroup of the State Advisory Council on Mental Health to implement this and similar questions into future mental health grant applications. It is essential DHS continuously collaborates with the State Advisory Council on Mental Health in order for the council to fulfill its duty to coordinate the work of local children's and adult mental health advisory councils.

## WORKFORCE AND ACCESS

There is a shortage of mental health services and service providers in the state. According to the January 2015 report [Gearing Up for Action: Mental Health Workforce Plan for Minnesota](#),<sup>15</sup> Minnesotans’ need for mental health care has been increasing and as a result there is an increased need for mental health services and qualified mental health professionals. Additionally, there is an even greater shortage of mental health services providers and professionals from diverse cultural backgrounds and rural communities.

While we stress the importance of all the recommendations in this report, we acknowledge that it is unlikely that all recommendations can be fully implemented without reducing the workforce shortage across the continuum of mental health services. The ability for people to access mental health services in Minnesota is tied directly to Minnesota having a trained and available workforce to provide those services.

### Cultural and Ethnic Minority Grant Programs

To ensure the workforce of mental health professionals are well rounded and that the workforce includes professionals from both diverse cultural backgrounds and rural communities, two grant

---

*...there is an even greater shortage of mental health services providers and professionals from diverse cultural backgrounds and rural communities.*

---

programs have been created for this purpose since 2007. These grants, the Cultural and Ethnic Minority Grant Program and the Cultural and Ethnic Minority Infrastructure Grant Program, expand the workforce of licensed mental health professionals and practitioners from diverse cultural and ethnic backgrounds and rural communities by supporting professionals in obtaining clinical supervision, preparing and supporting them to become licensed as mental health professional in Minnesota. These grants provide important foundational strategies in bridging the critical gap in access to mental health services and addressing the mental health workforce shortage in diverse and rural communities.

---

*...the Cultural and Ethnic Minority Grant Program and the Cultural and Ethnic Minority Infrastructure Grant Program, expand the workforce of licensed mental health professionals and practitioners from diverse cultural and ethnic backgrounds and rural communities...*

---

The Cultural and Ethnic Minority Grant Program is a \$566,000 grant program with ongoing state and federal funding. Currently, DHS has awarded \$2.3 million dollars through state fiscal year 2017-2018 to six grantees using the \$566,000 ongoing funds and \$1,734,000 from one-time federal block grant funds.

The purpose of the Cultural and Ethnic Minority Infrastructure Grant Program is to increase access to mental health services provided by mental health professionals who are proficient to provide culturally responsive and specific services to children, youth and families from diverse communities. The Cultural and Ethnic Minority Infrastructure Grant Program is a \$650,000 grant program with ongoing state and federal funding. Currently, DHS is in the process of awarding \$730,000 dollars through state fiscal year 2017-2018 to 13 grantees using the \$650,000 ongoing funds and the \$80,000 from one-time federal block grant funds.

These grant programs are necessary to reduce the workforce shortage, increase the number of culturally specific providers and the availability of mental health services that are culturally responsive and specific. Therefore, both the Cultural and Ethnic Minority Grant Programs need sustainable and ongoing funding that is dedicated to expanding the program throughout the state.

### **Recommendations**

- We recommend expanding the availability of the Cultural and Ethnic Minority Grant Program by increasing funding for this grant program to \$3,150,000 each biennium, while ensuring these funds are made available in an ongoing and sustainable manner.
- We recommend expanding the availability of the Cultural and Ethnic Minority Infrastructure Grant Program by increasing funding for this grant program also to \$3,150,000 each

biennium while ensuring these funds are made available in an ongoing and sustainable manner.

- We recommend DHS ensures grants awarded through both programs focus on increasing access to mental health services that are culturally responsive and specific to adults, children, youth and families from underserved cultural and ethnic communities.

## **Culturally Informed Mental Health Consultants**

Culturally informed mental health consultants, who are recognized by specific cultural groups as having knowledge of that particular culture's definition of health and mental health, are necessary in the state's mental health and health workforce. These consultants are necessary so they can assist DHS, local county boards and mental health providers in assessing and providing culturally appropriate mental health services for children and adults from specific cultural, linguistic or racial heritage and their families.

### **Recommendations**

- We recommend DHS contracts with culturally informed mental health professional consultants to provide cultural training to mental health service providers on how to interact with and provide services to individuals and families from culturally specific communities.
- We recommend the trainings focus on providing culturally appropriate and responsive services with cultural sensitivity, so that individuals and families from culturally specific communities are more understood and supported by their service providers.
- We recommend funds be allocated to cover the costs of hiring culturally informed consultants to provide training to mental health providers.

---

*There is a growing need in the state for culturally specific services that are responsive to the communities they are serving.*

---

## **Culturally Specific Mental Health Organizations**

There is a growing need in the state for culturally specific services that are responsive to the communities they are serving. The culturally specific organizations that already exist face numerous barriers with many of the current program rules and grant requirements DHS and other state agencies have implemented. Due to this, culturally specific organizations that are providing services have a hard time becoming proficient in the state's grant and rule requirements.

---

*There is no universal statutory definition across the Children's or Adult Mental Health Act related to the requirements or provisioning of grant funding for services intended to serve people from diverse communities.*

---

### **Recommendation**

- We recommend DHS fund a program, in collaboration with culturally specific mental health providers and organizations, which mentors other culturally specific mental health organizations. This will enhance culturally specific mental health organizations' proficiency with state program rules and grant requirements.

### **Definition for Culturally Specific Agency**

Currently, there is no universal statutory definition across the Children's or Adult Mental Health Acts related to the requirements or provisioning of grant funding for services intended to serve people from diverse communities. Additionally, DHS does not provide any universal guidance on which providers should be considered providers serving diverse communities. For example, some of the current state requirements or definitions related to serving people from diverse communities are as follows:

- The Children's Mental Health Grants are authorized to assist in the provision of "mental health services for people from cultural and ethnic minorities."<sup>16</sup>
- To qualify for start-up funds for a Local Children's Mental Health Collaborative, the collaborative must include "culturally specific organizations."<sup>17</sup>
- An Integrated Local Service System requires that mental health services be "culturally appropriate."<sup>18</sup> The Excellence in Mental Health Demonstration Project requires certification that clinicians are "culturally and linguistically trained to serve the needs of the clinic's patient population."<sup>19</sup>
- Criteria for the Quality of Services require that services provided by providers be based on the served individual's "cultural and ethnic needs."<sup>20</sup>

### **Recommendations**

- We recommend relevant statutes related to the provisioning of grant appropriations be amended to refer to one standard definition for "culturally specific agency" as agencies providing mental health services to culturally specific communities.
- We recommend a "culturally specific agency" be defined as: programs or subprograms designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background; governed with significant input from individuals of that background; and that employ

individuals to provide individual or group therapy, at least 50 percent of whom are of that background.

## Health Equity for Rural Communities

Agencies and clinics in Health Professional Shortage Areas often struggle to obtain grant and contracting opportunities available from state agencies such as DHS. Grant and contracting opportunities through the state have minimum requirements that agencies and clinics need to meet. These requirements are not always attainable for agencies and clinics that are in Health Professional Shortage Areas due to the lack of healthcare providers. Health Professional Shortage Areas are defined by a score, used by the National Health Service Corps, to determine federal loan repayment program eligibility. Many DHS contracts and grant funding opportunities currently have one minimum requirement that are the same for all geographic regions of the state, regardless of the availability of health care professionals within certain regions of Minnesota.

### Recommendations

- We recommend state agencies, including DHS, adapt contract and grant funding opportunity requirements to meet the health equity needs of rural communities by taking into account percent of populations served.
- When creating contract and grant funding requirements, we recommend DHS create sliding scale minimum requirements that are acceptable and achievable for those seeking funds from Health Professional Shortage Areas. We recommend that this sliding scale be based on the Health Professional Shortage Area scores, which are 1-25.

## 2-Year Psychiatric Fellowship Pilot Program

In psychiatry, there is a rapidly growing crisis related to the retirement of psychiatrists. A 2012 Minnesota Department of Health survey showed that 50 percent of Minnesota's psychiatrists were 55 or older and too few new psychiatrists are entering the workforce. Existing training does not prepare providers best positioned to pick up the unmet need, such as physicians assistants and nurse practitioners, to hit the ground running. Depending on their experience and training programs, there is great variability in how ready they are to practice when entering the mental health workforce.

HealthPartners and Regions Hospital created a fellowship program that has been successful in training physicians' assistants and nurse

---

*A 2012 Minnesota Department of Health survey showed that 50 percent of Minnesota's psychiatrists were 55 or older and too few new psychiatrists are entering the workforce.*

---

practitioners to practice in the mental health workforce and pick up where there is an unmet need. The methods used in the HealthPartners and Regions Hospital fellowship program could be replicated in other hospitals with a similar set of available resources. The HealthPartners and Regions Hospital fellowship program has graduated 15 such fellows from 2008-2015 and 10 are practicing in Minnesota.

### Recommendations

- We recommend funding for a 2-year Psychiatric Fellowship pilot project to provide fellowships to three fellows every 6 months for 2 years. For the program to stay solvent and provide all the proper resources and supervision, the fellowship program would require \$45,000 per fellow for a total of \$540,000 for the 2-year pilot.
- We recommend that there be an expectation that any fellows graduating from the fellowship pilot commit to practicing in Minnesota for two years after graduating, to help meet the unmet needs throughout Minnesota, including rural areas.
- We recommend during the fellowship pilot, that testing of graduation rates and retention rates be completed. In addition, make recommendations on if the fellowship program length can be shortened successfully from the current one year to six months.

---

*...primary care is where people go requesting help.*

---

## Primary Care and Behavioral Health Fellowship Program

According to the United States Department of Health and Human Services, over 50 percent of individuals with diagnosable mental health problems are not receiving care, in Minnesota it is no different. This shortage of available care is in part due to a scarcity of mental health services, especially in primary care settings where many individuals present for help. Notably, twice as many individuals who died by suicide were seen in primary care than seen in specialty psychiatric care.<sup>21</sup>

Furthermore, 45 percent of those who died by suicide had seen a primary care provider within the last month of their death. At the same time primary care is where people go requesting help. Primary care providers are reporting they do not have the skills, nor the time, to provide behavioral health care.<sup>22</sup> Additionally, there is a lack of skilled primary care behavioral health specialists, traditionally, health psychologists, to address this need.

While Minnesota continues to increase efforts to train mid-level therapists, such as Licensed Independent Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Marriage and Family Therapists to fill the need, mid-level training has been focused on more foundational aspects of diagnosis and treatment of mental illness while the more advanced skill of practicing integrated primary care behavioral health has not been achieved. This is a skill set taught more in psychology doctoral coursework, internship, and postdoctoral fellowship training but not in the training of mid-level therapists.

To address the needs of the people seeking help in primary care settings, we need to better prepare mid-level therapists to address the complexities of working in a primary care setting. These therapists will be faced with treating the psychological aspects of co-occurring health and addiction conditions alongside mental illness, chronic disease and other health concerns such as pain and adjustment to health concerns. Expertise in consultation, panel management, brief and targeted interventions for mental and physical health, and working as part of a medical team are skill sets that we believe need to be developed for mid-level therapist. However, we also believe that psychology doctoral programs should not be the only place where someone can learn these skill sets.

Borrowing from psychology, we believe a fellowship training program, leading to certification, will provide mid-level therapists a parallel opportunity to achieve a similar skill set. Ideally, the fellowship training program would target mid-level therapists from diverse backgrounds or those seeking to work in rural settings to align with where we see the greatest workforce needs.

### **Recommendation**

- We recommend the creation and funding of a Primary Care and Behavioral Health Fellowship Program, using chosen grantees to provide the fellowship training and programing. The fellowship program would cost approximately \$270,000 per year and graduate 12 mid-level therapists with additional competency in primary care behavioral health. This would cover the costs of infrastructure to deliver didactics, supervision, observation, consultation, travel time of the instructor to the primary care sites and other costs. During the time the fellows are in the fellowship program, the fellows would be practicing and their salary would be paid for by their employer.

---

*To address the needs of the people seeking help in primary care settings, we need to better prepare mid-level therapists to address the complexities of working in a primary care setting.*

---

## Certified Peer Specialists and Family Peer Specialists

Certified Peer Specialists and Certified Family Peer Specialists are individuals with lived experience who are trained and certified by DHS in the delivery of peer services to people with a mental illness and their families.<sup>23</sup> The Center for Medicare and Medicaid Services recognizes peer support providers as a distinct provider type for the delivery of support services and considers it an evidence-based mental health model of care. However, in Minnesota, certified peer specialists are being employed by providers at a significantly lower rate than the rate that peer support specialists are becoming certificated, with a current employment rate of newly certified peer support specialists of about 30 to 40 percent.

### Recommendations

- We recommend that Certified Peer Specialist and Family Peer Specialists be recognized to work in various areas of the service provision across the continuum and services provided by peer specialist are Medicaid reimbursable service.
- We recommend continued efforts to recruit additional certified peer specialists, with particular focus on communities of color, American Indian/Native American communities, immigrant communities and other culturally specific and underserved groups that lack access to mental health care from providers with a similar cultural background.
- We recommend improving peer specialists' success in the workforce, by providing supports such as: a single Certified Peer Specialist and Family Peer Specialist professional organization and trainings that focus on person centered approaches for agencies employing Certified Peer Specialists and Certified Family Specialists.

---

*...there is a shortage of mental health treatment providers from diverse cultural backgrounds in school settings within rural communities.*

---

## Ancillary Mental Health Treatment Providers

There is a shortage of mental health providers, in rural communities, that can provide services that are a part of individuals' treatment plans. Specifically, there is a shortage of mental health treatment providers from diverse cultural backgrounds in school settings within rural communities. Opportunities need to be expanded for individuals wishing to provide culturally responsive mental health treatment for children from Kindergarten to 12 grade that are in public schools, in Head Start, in early childhood education programs and families and adult experiencing serious mental illnesses.

## Recommendations

- We recommend that a study be done to determine the need for and the feasibility of expanding the types of mental health treatments covered by Medical Assistance (Medicaid) to include music therapy and art therapy.
- We recommend that in coordination with the results of the study, the following actions be taken:
  - The creation of a health licensing board to oversee music therapists. In addition, establish a volunteer Music Therapist Advisory Council to advise the Department of Human Services' Commissioner regarding standards for licensure of art therapists, review applications and make recommendations on granting or denying licensure.
  - The creation of a health licensing board to oversee art therapists. In addition, establish a volunteer Art Therapist Advisory Council to advise the Department of Human Services' Commissioner regarding standards for licensure of art therapists, review applications and make recommendations on granting or denying licensure.

## EARLY AND EFFECTIVE IDENTIFICATION OF MENTAL ILLNESS

We believe, in order to decrease and prevent serious and persistent mental illnesses and serious mental illnesses, we need to focus on early and effective identification of mental illness in children, youth, adults, families, undeserved and disparate communities, and communities of color. Waiting until it is disabling for the person experiencing mental illness before we begin treatment is not an effective, efficient and equitable way to use the resources and funds allocated to the mental health system.

Intentional and equitable investments need to be made in the areas of early intervention and early identification of mental illness. To do this, person centered and culturally responsive mental health services that meet the needs of the individual experiencing early signs of mental illness are needed. Additionally, services and resources that

---

*...person centered and culturally responsive mental health services that meet the needs of the individual experiencing early signs of mental illness are needed.*

---

support family members are essential in the early and effective identification of mental illness.

## Interpreter Services for Mental Health

On July 18, 2016, the Nondiscrimination in Health Programs and Activities Rule<sup>24</sup> became effective in the United States. The Nondiscrimination in Health Programs and Activities Rule implements Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs administered by U.S. Department of Health and Human Services and entities established under Title I of the Affordable Care Act. The rule requires reasonable steps be taken to provide meaningful access to each individual with Limited English Proficiency pursuant to Title VI for interpreter services and an Office of Civil Rights compliant effective written language access plan.

This new rule has created a need in Minnesota for more access to third party reimbursement funding for medically necessary interpreter services in both public programs and private insurance markets in order to avoid discriminatory impacts in the delivery of culturally and linguistically appropriate mental health services. This provision applies on the first day of the first plan year (in the individual market, policy year) beginning on or after January 1, 2017.

### Recommendations

- We recommend the state of Minnesota enact legislation in conformity with the Office of Civil Rights, U.S. Department of Health and Human Services, Nondiscrimination in Health Programs and Activities Final Rule. The rule establishes requirements for meaningful access to interpreting services for individuals with limited English proficiency in compliance with the provisions of the Americans with Disabilities Act. This includes an emphasis on the critical need for interpreters for mental health services and trauma informed care.
- We recommend the state ensure federal conformity in statute to support and direct state agencies in providing for Nondiscrimination in Health Programs and accompanying it with funds for training and interpreter services.

## Evidence-Based Treatment Research for Cultural and Ethnic Communities

Currently, we lack mental health providers from cultural and ethnic backgrounds and communities of color who have the training necessary to work on developing culturally appropriate evidence-

---

*...a need in Minnesota for more access to third party reimbursement funding for medically necessary interpreter services...*

---

based treatments for targeted and specific communities. It is becoming an expectation to implement evidenced based practices and best practices with cultural and ethnic communities and communities of color. However, it is a necessity for the evidence-based practice to be culturally appropriate in order to be effective in the respective cultural and ethnic communities and communities of color. To do this, there needs to be dedicated resources, research and funding put into developing culturally specific evidenced-based practices and evidence informed practices. To be effective and appropriate, this research needs to be conducted within the communities served by professionals who are within the culturally specific community. This research will advance mental health treatment and services that are culturally responsive and specific, it will also assist in bridging the gap in mental health disparities.

### **Recommendations**

- We recommend funding and technical support be provided to research adaptations of evidence-based treatments and evidence informed practices. This will ensure that the limited pool of professionals that provide culturally specific services and are providers from specific cultural and ethnic backgrounds adapt evidence-based treatments and evidence informed practices.
- We recommend training be provided to targeted cultural and ethnic communities and communities of color on evidence-based treatments and evidence informed practices.

## **Tele-Mental Health Services**

There is a lack of timely access to mental health services in many communities and schools in greater Minnesota. Mental health services across different systems (i.e. schools, counties, etc.) exist in silos, which has caused difficulty in accessing adequate services for individuals and families. A single tele-mental health platform such as Vidyo, a product already in use in many areas, needs to be made more available. Establishing one tele-mental health platform will improve immediate mental health services and access to communities and schools without developing the same complications we are seeing with the expansion of other fragmented technological systems. In addition, by implementing one tele-mental health platform throughout the state maximum flexibility, provider engagement and lower cost are expected to occur.

### **Recommendations**

- We recommend the development of infrastructure and tools for quick access to clinical mental health services via Internet

---

*There is a lack of timely access to mental health services in many communities and schools in greater Minnesota.*

---

Telepresence, also known as Tele-Mental Health, between Minnesota communities, schools and contracted providers. Culture, age and developmental appropriateness needs to be taken to consideration when expanding and providing these services.

- We recommend the development of a single tele-mental health platform to use across the state. The Vidyio software is already being used to provide tele mental health services in the state and it should be implemented across systems such as schools and other settings where people receive mental health services. Additionally, this should be made available under one state contract for purchasing.

---

*Schools and districts in Minnesota are moving toward the development of a continuum of prevention to intervention services...*

---

## **Positive Behavioral Interventions and Supports**

Positive Behavioral Interventions and Supports provides an evidence-based practice that sets to improve school climate and to create ways to address all students' needs using a multi-tiered framework. This supports the ability to respond quickly and appropriately to behavioral and mental health concerns within school settings. Positive Behavioral Interventions and Supports have not been implemented statewide due to insufficient funding, despite the ongoing demands for the service. Currently, Positive Behavioral Interventions and Supports are working well within the 300 plus schools it has been implemented in.<sup>25</sup>

### **Recommendations**

- We recommend increasing funding for Positive Behavioral Interventions and Supports to sustain existing Positive Behavioral Intervention Supports cohort schools.
- We recommend increasing the base funding to implement Positive Behavior Intervention Supports in 40 new schools every year.

## **Multi-Tiered Support of System Model**

Schools and districts are moving towards the development of a continuum of prevention to intervention services for students based on a Multi-Tiered System of Supports. The Multi-Tiered System of Supports model is a framework that provides schools with an integrated system of high-quality, standards-based instruction and interventions that are matched to students' academic, social emotional and behavioral needs.<sup>26</sup> The framework focuses on needs of individual students, early intervention, problem solving and prevention.<sup>27</sup> Students are provided with access to licensed student

support services or specialized instructional support personnel,<sup>28</sup> such as licensed school counselors, licensed school psychologists, licensed school nurses, licensed school social workers and licensed chemical health counselors, using a multidisciplinary team staffing structure. The Minnesota Department of Education has been collaborating with schools and districts in closing achievement gaps through the effective implementation of Multi-tiered Systems of Supports strategies. Multi-tiered Systems of Support should be used along with Positive Behavioral Interventions and Supports.

### **Recommendation**

- We recommend the Multi-Tiered Support of System model continues to be implemented in schools and school districts throughout the state.

## **Children’s Mental Health Screening Tools**

The Children’s Mental Health screening instruments are limited in their ability to address concerns regarding childhood trauma. Currently, two tools are used in Minnesota in the juvenile justice system: the Massachusetts Youth Screening Instrument second version (MAYSI-2) and the Problem Oriented Screening Instrument for Teenagers (POSIT)<sup>29</sup>, which are inadequate in assessing childhood trauma.

### **Recommendations**

- We recommend DHS, in collaboration with other agencies and stakeholders, review and assess the current Children’s Mental Health screening tools. Review and assessment should focus on the tools’ ability to screen for trauma indicators. Additionally, review and assess other available tools used for screening or addressing childhood trauma and make recommendations regarding changes to better address childhood trauma in children in the juvenile justice system.
- We recommend DHS, in collaboration with other agencies and stakeholders, develop and implement a revised trauma tool that is validated, focuses on culture and gender and is easy to administer and score.



## Specialized Level of Care in Children's Residential Treatment Settings

When children and youth that are in the juvenile system are court ordered to residential treatment subsequent to criminal charges, our existing levels of residential placement cannot adequately address the needs of individuals who struggle with aggressive behaviors and emotional dysregulation. Due to this service gap, these children and youth are often removed from less restrictive residential levels of service and end up in juvenile correctional facilities. Juvenile correctional facilities are inappropriate settings for these children, as more often than not, these children have lengthy histories of serious trauma and mental and chemical health concerns.

---

*...there is a lack of adequate services necessary to address the developmental and mental health needs of the children, youth and their families.*

---

### Recommendation

- We recommend that a specialized level of treatment, outside of a correctional setting, be developed. This level of care should address the safety needs of the children, community and the staff that care for them. In addition to focusing on the treatment of aggressive behaviors and emotional dysregulation, this level of care should be informed by current best practice in the treatment of children & young adults that are in the juvenile justice system.

## Interventions to Address Aggressive Behaviors in Children and Youth Under 16

Mental health providers in Minnesota are reporting a dramatic increase in children and youth identified with aggressive behaviors and emotional dysregulation. These behaviors demonstrate a safety risk to the youth and community that often lead to the child's involvement in the juvenile justice system. Due to the inadequacies within our mental health system, these children and youth are being placed in more restrictive level of care that may be away from their families and that do not meet their developmental needs. These settings may, in fact, exacerbate their mental health symptoms instead of helping children improve their levels of functioning.

Often times, the reason that children who display aggressive behaviors and emotional dysregulation are ending up in the levels of care that cannot meet their needs developmentally, is due to the lack of adequate services available in community settings to address the behaviors the child is exhibiting. Additionally, there is a lack of adequate services necessary to address the developmental and mental health needs of the children, youth and their families.

## Recommendations

- We recommend the state study and produce a report regarding the dramatic increase in aggressive behaviors and emotional dysregulation in children and youth under the age of 16.
- We recommend the report include evidence-based recommendations and models that address the unique needs of these children and youth. Once the study and recommendations have been made, provide funding for and implement the recommendations in a timely manner so that services to address the children's needs can be created and the number of children being placed inappropriately in more complex and costly residential services can begin to decrease.

# PERSON CENTERED CARE AND PROMOTION OF WELL-BEING

We believe, to effectively promote well-being, prevent mental illness and suicide in our state there must be additional accessible supports and trainings implemented on the community level to support individuals living with mental illness. Accessible and culturally appropriate and responsive supports need to be available to families, parents, guardians and to community members. To do this, the state needs to focus more efforts on and allocate funding towards effective and equitable prevention strategies and programs that promote the mental well-being of children, youth, adults and families. Additionally, it is essential that all communities, especially communities of color and underserved communities, have access to resources that support and enhance their mental well-being.

The Council and Subcommittee have chosen to place our recommendation on suicide prevention at the end of our report, not because of the lack of importance about the issue but instead to signify the great importance of it.

In 2015, a record high number of Minnesotans died by suicide, at 13.1 people per 100,000 residence of the state.<sup>30</sup> In 2015, death by suicide became the second leading cause of death of Minnesota teenagers. Between 2014 and 2015, there was a 6 percent increase in the number deaths by suicide in Minnesota. With the record high number of deaths from this cause, the state should take immediate action to this public health crisis. As a state, focused efforts must be

---

*In 2015, a record high number of Minnesotans died by suicide...*

---

to prevent seeing more Minnesotans' lives end by suicide, deaths that could have been and should be prevented.

## **Mental Health First Aid Training for Community Service Providers**

People providing Community Services, such as paramedics, Emergency Medical Technicians (EMTs), community service officers, day care providers, community health workers and others, lack training in mental health. As a result, those providing community services are not able to respond to basic mental health needs of the community. The National Council for Behavioral Health<sup>31</sup> recommends Mental Health First Aid as a public education program, although other training programs also exist. These programs assist individuals across the community to understand mental illnesses, support timely intervention and save lives.

### **Recommendations**

- We recommend that all Community Service Providers, such as paramedics, EMTs, community service officers, day care providers, community health workers and others should receive basic mental health training, such as Mental Health First Aid, so they can identify signs and symptoms of mental illness.
- We recommend basic mental health training include cultural proficiency and responsiveness, to ensure awareness about cultural influence on behaviors.

## **Crisis Intervention Team (CIT) Training for Law Enforcement Officers**

The challenges and dangers associated with encounters between law enforcement officers and people who live with mental illness has become an increasingly visible concern over the last decade. Law enforcement officers have, in fact, become first-responders to mental health crisis in many communities. These interactions have unfortunately lead too often to significant negative outcomes involving harm to both citizens and law enforcement officers. These include emotional distress for individuals and families, inappropriate or inadequate treatment of those with mental illness, bodily harm and even death. Studies have shown that development of effective policies, procedures and law enforcement officer training can “decrease incidents of use of force, reduce costs, lower recidivism and support access to needed services to support the improved quality of life of those experiencing mental illness or emotional disorders.”<sup>32</sup>

---

*The challenges and dangers associated with encounters between law enforcement officers and people who live with mental illness has become an increasingly visible issue over the last decade.*

---

For law enforcement officers, Crisis Intervention Team Training is considered the “gold standard” in the field for preparing law enforcement officers to properly handle situations involving people with mental health concerns. It is highly recommended as the ideal for training by various groups on the state and federal level. The full training in Crisis Intervention Training curriculum<sup>33</sup> includes 40 hours of programming participation.

### **Recommendations**

- We recommend, for current law enforcement officers, an initial 8 hours of CIT training should be required within the next year. Within 5 years, all active officers should complete the full 40 hours of training.
- We recommend the Minnesota Board of Peace Officer Standards and Training (POST) require a full 40 hours of CIT training for all new law enforcement officers seeking certification. This training should also be part of law enforcement training programs and/or in preparation for work in the law enforcement field available in Minnesota.
- We recommend local law enforcement agencies be required to collaborate, coordinate and partner with local mental health crisis teams in order to meet the needs of their community’s residents experiencing mental health concerns. This cooperation could lead to ongoing training and development specific to the needs of each region, as well as promote coordination between law enforcement and local social service/mental health resources.

## **Youth Based Mental Health Peer Supports Program**

Currently, there are insufficient peer supports in mental health programming within schools. Funding for youth led, school and community based, programs aimed at raising mental health awareness, peer to peer support as well as reducing stigma surrounding mental illness are limited in the state. There is a lack of adequate funding since these programs are student driven and prevention focused. A sustainable funding process has not been created for programs such as these.

### **Recommendations**

- We recommend that a process be created that allows funding for youth based mental health programs that are led by youth and co-facilitated by adult advisors, peer supports and education to school-aged youth and families.

---

*...there are insufficient peer supports in mental health programming within schools.*

---

- We recommend the state define requirements of these types of programs and include measurable outcomes focused on reducing the stigma of mental illness.

## **Access to Resources and Training for Suicide Prevention**

All Minnesotans need to have access to the regional coordinators that provide information on suicide prevention, [txt4Life](#)<sup>34</sup>, regional mobile crisis teams and anti-bullying efforts. These services are important in coordinating with other local mental health services. Increased access to resources and training related to suicide prevention, txt4Life, mobile crisis teams and anti-bullying efforts needs to occur through a coordinated process between DHS, the Department of Health and the Department of Education. The current funding for txt4Life covers the 24/7 response center staff and seven Regional Coordinators.

### **Recommendations**

- We recommend the state take immediate focused actions to address this growing public health crisis and work towards preventing suicide.
- We recommend funding for an additional 15-20 regional coordinators to cover the remaining population residing in the 48 Minnesota counties who currently do not have access to txt4Life services and resources for suicide prevention.
- We recommend additional funding to oversee the additional regional coordinators, using a health education model.

# STATE ADVISORY COUNCIL ON MENTAL HEALTH MEMBERSHIP LIST

**Melissa Balitz**

*Chair*

Hastings, MN

Representative of Family Members

**Claire Courtney**

Representative of the State Vocational Services Agency

**Joseph DeBoer**

St. Paul, MN

Representative of Consumers of Mental Health Services

**Michele Fournier**

Andover, MN

Representative of Mental Health Providers

**Jode Freyholtz-London**

Verndale, MN

Representative of Consumers of Mental Health Services

**Rozenia Fuller**

Minneapolis, MN

Representative of Consumers of Mental Health Services

**Steve Hansberry**

Mora, MN

Representative of Family Members of an Adult with a Mental Illness

**Stephanie Hogenson**

Minneapolis, MN

Representative of Family Members

**Steve Huot**

Representative of the Department of Corrections

**Mary Kjolsing**

Willmar, MN

Representative of Parents

**Amoke Kubat**

Minneapolis, MN

Representative of Family Members

**Dave Lee**

Cloquet, MN

Representative of County Social Services Directors

**Anna Lynn**

Representative of the Minnesota Department of Health

**Carrie Marsh**

Representative of the Minnesota Housing Finance Agency

**Jodi Martin**

Annandale, MN

Representative of Parents

**Ken Moorman**

Baudette, MN

Representative of County Commissioners (Rural)

**Shannah Mulvihill**

St. Paul, MN

Representative of Mental Health Advocacy Organization- Representative of Mental Health Minnesota: The Voice of Recovery

**Danielle Norby (Lien)**

Park Rapids, MN

Representative of Professional Social Workers

**Emmanuel Oppong**

St. Cloud, MN  
Representative of Professional Clinical  
Counselors

**Stephen Palmer**

St. Paul, MN  
Representative of Marriage and Family  
Therapy Practitioners

**Tarloh Quiwonkpa**

Maplewood, MN  
Representative of Registered Nurses

**Patricia Siebert**

Representative of Minnesota Disability Law  
Center

**Allison Stolz**

Minnetonka, MN  
Representative of Family Physicians

**Michael Trangle**

Minnetonka, MN  
Representative of Psychiatrists

**Ken Ujifusa**

Minnetonka, MN  
Representative of Psychologists

**Claire Wilson**

*Ex-Officio Member*  
Assistant Commissioner  
Community Supports Administration  
Department of Human Services

**Alison Wolbeck**

*Vice Chair*  
Moorhead, MN  
Representative of Consumers of Mental  
Health Services

**John Yanish**

Stillwater, MN  
Representative of Mental Health Advocacy  
Organizations- National Alliance on Mental  
Illness (NAMI-MN)

**Shelley White**

State Advisory Council Staff  
Mental Health Program Consultant  
Mental Health Division  
Department of Human Services  
PO Box 64981  
St. Paul, MN 55164-0981

**Heron Abegaze**

State Advisory Council Staff  
Mental Health Program Advisor  
Mental Health Division  
Department of Human Services  
PO Box 64981  
St. Paul, MN 55164-0981

# SUBCOMMITTEE ON CHILDREN'S MENTAL HEALTH MEMBERSHIP LIST

**Jennifer Coolidge**

Red Wing, MN  
Representative of Department of Corrections

**Thomas Delaney**

Representative of the Department of Education

**Maggie Diebel**

Representative of the Minnesota Department of Health

**Sarah Fuerst**

Woodbury, MN  
Representative of Providers of Mental Health Services to Pre-Adolescent Children

**BraVada Garrett-Akinsanya**

Golden Valley, MN  
Representative of People Experienced in Working with Children with Emotional Disorders who have Committed Statute Offenses

**Linda Hansen**

Representative of Local Corrections Department

**Cari Juarez**

St. Paul, MN  
Representative of Mental Health Advocacy Organizations- National Alliance on Mental Illness (NAMI-MN)

**Dave Johnson**

*Co-Chair*  
Bemidji, MN  
Representative of People Experienced with working with Children with Emotional Disorders from Minority Communities

**Margaret (Peggy) Larkin**

Brooklyn Park, MN  
Representative of Parents of Children with Emotional Disorders

**Donna Lekander**

Cloquet, MN  
Representative of Parents of Children with Emotional Disorders

**Jeffrey Lind**

Bemidji, MN  
Representative of County Social Services Agency

**Sherri Mortensen Brown**

St. Paul, MN  
Representative of Department of Commerce

**Renelle Nelson**

Minneapolis, MN  
Representative of an Advocacy Group for Children with Emotional Disorders- PACER

**Richard Oni**

St. Paul, MN  
Representative of People Knowledgeable about the needs of Children with Emotional Disorders of Minority Races and Cultures

**Cynthia Slowiak**

Minneapolis, MN  
Representatives of County Social Services Agency

**Sai Thao**

St. Paul, MN  
Representative of Parents of Child with Emotional Disorders from Minority Communities

**Jennifer Thomas**

Maple Grove, MN  
Representative of Parents with Children with  
Emotional Disorders

**Amelia Versland**

Representative of Hospital Based Providers of  
Mental Health Services to Pre-Adolescent  
Children

**Bill Wyss**

Representative of the Department of Human  
Services

**Shelley White**

Children's Subcommittee Staff  
Mental Health Program Consultant  
Mental Health Division  
Department of Human Services  
PO Box 64981  
St. Paul, MN 55164-0981

**Heron Abegaze**

Children's Subcommittee Staff  
Mental Health Program Advisor  
Mental Health Division  
Department of Human Services  
PO Box 64981  
St. Paul, MN 55164-0981

# REFERENCES

---

- <sup>1</sup> Minnesota Statute 245.697 <https://www.revisor.leg.state.mn.us/statutes/?id=245.697>
- <sup>2</sup> Minnesota Statute 245.697 Subd. 2a <https://www.revisor.leg.state.mn.us/statutes/?id=245.697>
- <sup>3</sup> The World Health Organization website <http://www.who.int/en/>
- <sup>4</sup> Miles, J. Espiritu, R.C., Horen, N., Sebian, J., & Waetzig, E. (2010). A Public Health Approach to Children's Mental Health: A Conceptual Framework. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
- <sup>5</sup> Compton, M. & Shim, R. (2015). The Social Determinants of Health. Washington D.C., American Psychiatric Publishing.
- <sup>6</sup> 2014 IPS Legislative report. <http://mn.gov/deed/about/what-we-do/agency-results/mandated/index.jsp>
- <sup>7</sup> Medicaid and Housing-Related Activities and Services: A Minnesota Model, Prepared by: The Medicaid and Housing Supports Workgroup, An Interagency Collaboration of The Minnesota Department of Human Services and Minnesota Housing
- <sup>8</sup> Minnesota Olmstead Plan online at [http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc\\_home](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=opc_home)
- <sup>9</sup> 57% of homeless adults report serious mental health concerns. Wilder Statewide Survey of Homelessness 2015. Available online at: <http://mnhomeless.org/minnesota-homeless-study/homelessness-in-minnesota.php#1-3457-g>
- <sup>10</sup> Minnesota Family Home Visiting Program Report to the Legislature, April 2016 <http://www.health.state.mn.us/divs/cfh/program/fhv/content/document/pdf/legrept.pdf>
- <sup>11</sup> Fussy Baby Network Website <http://www.erikson.edu/fussybaby/national-network/>
- <sup>12</sup> Minnesota Statute 245.466 Subd.5. and Minnesota Statute 245.4875 Subd.5
- <sup>13</sup> Local Mental Health Advisory Councils Webpage [mn.gov/dhs/lac](http://mn.gov/dhs/lac)
- <sup>14</sup> Minnesota Statute 245.697 <https://www.revisor.mn.gov/statutes/?id=245.697>
- <sup>15</sup> Gearing Up for Action: Mental Health Workforce Plan for Minnesota Report to the Minnesota Legislator January 2015 <http://www.healthforceminnesota.org/wp-content/uploads/2014/09/Gearing-Up-for-Action-Plan-FINAL.web.pdf>
- <sup>16</sup> Minnesota Statutes 245.4889

- 
- <sup>17</sup> Minnesota Statutes 245.493
- <sup>18</sup> Minnesota Statutes 245.4931
- <sup>19</sup> Minnesota Statutes 245.735
- <sup>20</sup> Minnesota Statutes 245.467
- <sup>21</sup> Luoma, J.B., Martin, C.E. & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry*, 159(6).
- <sup>22</sup> Robinson, P. J., & Reiter, J. T. (2007). Behavioral Consultation and Primary Care: A Guide to Integrating Services. Springer.
- <sup>23</sup> 2016 Use of Certified Peer Specialist Legislative Report  
<https://www.leg.state.mn.us/docs/2016/mandated/160089.pdf>
- <sup>24</sup> The Office for Civil Rights (OCR), US Department of Health and Human Services (HHS), published the Nondiscrimination in Health Programs and Activities Final Rule (81 FR 31376) implementing Section 1557 of the Affordable Care Act (ACA) in the Federal Register on Wednesday, May 18, 2016.
- <sup>25</sup> Positive Behavioral Interventions and Supports Webpage  
<http://education.state.mn.us/MDE/dse/sped/pbis/>
- <sup>26</sup> 2015 Minnesota English Language Arts Standards and Multi-Tiered System of Supports Implementation Survey Report, September 2015, Minnesota Department of Education
- <sup>27</sup> Positive Behavioral Interventions and Supports Webpage, Multitier System of Support Chart  
<http://education.state.mn.us/MDE/dse/sped/pbis/>
- <sup>28</sup> National Alliance of Specialized Instructional Support Personnel <http://www.nasisp.org/>
- <sup>29</sup> Children's Mental Health Screening. Minnesota Department of Human Services  
[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_149102](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_149102)
- <sup>30</sup> Minnesota Department of Health Press Release, Increase in adult suicides shows need to connect Minnesotans to hope and help, September 7, 2016
- <sup>31</sup> Nation Council for Behavioral Health Website
- <sup>32</sup> Preliminary Report Officer Interactions with Mental Health Issues: A Policy Study, Police Conduct Oversight Commission, May 2016  
<http://www.ci.minneapolis.mn.us/www/groups/public/@civilrights/documents/webcontent/wcmsp-174908.pdf>
- <sup>33</sup> Crisis Intervention Team Center: A Resource for CIT Programs Across the Nation  
<http://cit.memphis.edu/curriculum.php?id=0>
- <sup>34</sup> tXt4Life website <http://txt4life.org/>



