Governor's Task Force on Mental Health:
Draft Mental Health Overview 7/20/16

Appendices in Separate Document

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Governor Mark Dayton established the Governor's Task Force on Mental Health in order to advise the Governor and Legislature on improvements to the mental health system in Minnesota.[1] This document provides an overview of the current system that is based on dozens of recent government and industry reports.[2] The document is necessarily incomplete but provides a starting point for discussion and additional presentations to the Task Force.

I.   Primer on Mental Health and Mental Illness

A.   Introduction: Mental Health is Biological, Psychological, and Social

Our conceptions of normal behavior and optimum health grow out of our cultural backgrounds, personal experiences, and the myriad messages we receive from family, friends, education, and the media. These conceptions change historically, shaped by scientific discoveries, commercial interests, and political and cultural relationships. The current scientific understanding of mental health in the United States is based on a medical model that interprets some thoughts, feelings, and behaviors, such as hearing voices or feeling prolonged periods of despair, as symptoms of illness that can be treated by medical professionals with medications and therapies. This model emphasizes the biological and chemical dimensions of mental illness as a brain disease and builds interventions within the medical system.

The medical model acknowledges that mental illness has both biological and social dimensions. Robust research on adverse childhood experiences shows that children who experience traumatic events or protracted dangerous or chaotic living situations are more likely to develop mental illnesses as children or adults if they are not given adequate support to heal from those experiences. "Toxic stress" can create chemical changes in the body and maladaptive patterns of behavior that can contribute to the development of both mental and physical illnesses. Because children from ethnic and cultural minorities are more likely to live in poverty, and children in poverty are more likely to experience adverse events, this research helps explain some of the origin of mental and physical health disparities in Minnesota.

As more research is done on brain chemistry and the genetic factors involved in mental illness, it is becoming clearer that epigenetics, the process by which genetic factors are expressed or ameliorated by other biological and social factors, could also shed more light on our likelihood to develop mental

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[1] See Appendix I for the complete text of the Governor's Executive Order.
[2] See Appendix II for links to recent reports on Minnesota's mental health system.

illnesses and our ability to recover quickly from them.[3] These studies provide new explanations of how mental illness—like other illnesses—involve the intertwined impacts of chemical/biological processes in the brain and social experiences. They may also begin to explain how mental illnesses can be both biologically and socially "inheritable," as seen in the impacts of intergenerational trauma on members of groups that have suffered historical oppression and its negative consequences across generations.

B.　　Definitions of Mental Illness and Emotional Disturbance in Minnesota

Mental health is defined by the World Health Organization as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."[4] Minnesota statute defines **mental illness** as follows:

> *"Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is detailed in a diagnostic codes list published by the commissioner, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.*[5]

For children, mental illness is referred to as "**emotional disturbance**" with a similar definition in Minnesota statute.[6] Both "mental illness" and "emotional disturbance" are generic terms that refer to a range of medical disorders and the symptoms that define them. Some diagnoses include depression, anxiety disorder, schizophrenia, bipolar disorder, post traumatic stress disorder (PTSD), and eating disorders. Clinicians diagnose the conditions based on physical, psychological, and behavioral symptoms, and the American Psychiatric Association maintains a manual of classifications of mental illnesses called the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, or "DSM-5."

"Behavioral health" is a term that commonly refers to both mental health and substance use disorder treatments. Because the Task Force's focus is on mental health, we will use that term in this document. However, many people experience both mental illnesses and substance use disorders, and treatments for the two are most effective when integrated. Services, policies, and funding for the two are often intertwined.

Mental illnesses and emotional disturbances affect every Minnesotan directly or indirectly. Close to half of adults will experience at least one mental illness during their lifetime, and almost everyone has a family member or close friend who has experienced mental illness.[7] Mental illness is associated with other chronic illnesses and can lead to disability. It can compromise a person's ability to go to school or

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[3] "Disorders Share Risk Gene Pathways for Immune, Epigenetic Regulation," (Washington, DC: National Institute for Mental Health Science Update, January 29, 2015). Accessed on 6/10/16 at http://www.nimh.nih.gov/news/science-news/2015/disorders-share-risk-gene-pathways-for-immune-epigenetic-regulation.shtml.

[4] "Mental health: a state of well-being," World Health Organization Website, accessed on 6/3/16 at: http://www.who.int/features/factfiles/mental_health/en/.

[5] Minnesota Statutes, section 245.462, Subd. 20 (a).

[6] Minnesota Statutes, section 245.4871, Subd. 15.

[7] "Mental Illness Surveillance Among Adults in the United States," Center for Disease Control and Prevention website, accessed on 7/12/16 at http://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html.

work and it contributes to absenteeism. It creates financial and personal burdens for the person with the mental illness as well as family members, other earners, and/or taxpayers who help provide or pay for services. Improving the mental health system is a goal that almost everyone supports.

C.   Parity

In general terms, "parity" is the concept that people should have access to mental health services under the same conditions that they have access to other healthcare services. For example, if someone experiences symptoms that indicate they may have cancer, they expect to be able to get immediate appointments for the diagnostic and treatment services they might need. However, in many cases, mental health services aren't available (or covered by insurance) until someone has severe mental illness symptoms—a "fail first" model that is markedly different from the cancer scenario (e.g., "We'll start treating you once your cancer has advanced to Stage IV").

Minnesota was an early proponent of parity, and now both federal and state laws require that insurance benefits for mental health and substance use disorders are equal to coverage for other types of healthcare services. However, studies have concluded that parity laws have not yet had much effect on mental health service utilization in Minnesota.[8] Advocates and some policymakers continue to pursue the concept of parity and look for new ways to implement it. One barrier is stigma, the negative stereotypes about mental illness that are sometimes used to justify discrimination against people with mental illnesses. These stereotypes can influence the way in which policy and funding decisions are prioritized.

D.   Co-Occurring Conditions

Many people who have a mental illness also have other health challenges including substance use disorders; developmental, intellectual, perceptual or motor disabilities; or chronic physical illnesses. This is called having a "co-occurring" condition, and these conditions contribute to the fact that people with schizophrenia, schizoaffective disorder, and bipolar affective disorder in Minnesota die younger than their peers who do not have serious mental illnesses by an average of 24 years.[9] The cause of death that reflects the widest disparity is heart disease (27 years difference), followed by accident (18 years), COPD (15 years), and cancer (15 years). Causes of the disparities include higher rates of smoking, poor weight management, poor nutrition, low physical activity, poor access or utilization of preventive healthcare, poverty, social isolation, effects of anti-psychotic medications, higher rates of substance use disorders, unsafe sexual behavior, and residing in group care facilities and homeless shelters where there is increased exposure to infectious diseases.

People with mental illnesses are more likely than people without mental illnesses to experience substance use disorders and chronic physical illnesses, and about 45% of people seeking substance use disorder treatments have been diagnosed with mental illness as well.[10] According to SAMHSA, the best

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[8] "Insurance for Behavioral Health Care," (Saint Paul: Minnesota Office of the Legislative Auditor, February 12, 2001). Accessed on 6/29/16 at http://www.auditor.leg.state.mn.us/ped/PEDREP/0104all.pdf.

[9] Michael Trangle, Gary Mager, Paul Goering, and R. Christensen, "Minnesota 10 by 10: Reducing Morbidity and Mortality in People with Serious Mental Illnesses," *Minnesota Medicine*, Vol. 93, No. 6, 2010, p. 38-41.

[10] "Treatment for Co-occurring Mental and Substance Use Disorders," SAMHSA website accessed on 7/12/16 at http://www.samhsa.gov/treatment#co-occurring.

treatment for people with co-occurring conditions addresses the multiple conditions simultaneously. This requires integrated treatment and collaboration across disciplines. Some chronic care models have been developed specifically to support people with co-occurring conditions, including the Behavioral Health Home model now being implemented in Minnesota. This model involves certifying providers who can provide integrated and coordinated treatment of mental health, substance use disorders, and chronic physical illnesses. Treatment is also coordinated with long-term services and supports. These certified providers are then able to bill through Medicaid for this enhanced level of service and coordination.

E. Continuum of Intensity of Mental Illnesses and Mental Health Services

Mental health and mental illnesses are often arrayed on a continuum of intensity, from complete wellness to severe emotional disturbance (children) and serious and persistent mental illness (adults). Because mental illness is often episodic and many people recover fully from mental health symptoms, individuals' intensity of mental illness can fluctuate over time, but it is useful to have estimates of the populations of people with different levels of mental illness intensity in a given year. The DHS Community Supports Administration estimates that about 20 percent of children experience an emotional disturbance, and about 20 percent of the adult population experiences a mental illness in a given year. This translates to more than 300,000 children and 800,000 adults in Minnesota each year.[11] Many of these people do not seek or receive professional help for their illnesses, and most who do are served in public and private outpatient settings and recover fully within a relatively short period of time.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that 5.4 percent, or 221,000 of adults in Minnesota, have a serious mental illness (SMI), defined as having a diagnosable mental illness that has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.[12] Unlike many other states and SAMHSA, Minnesota statute has defined a subcategory of adults with serious mental illnesses: adults with *serious and persistent mental illnesses* (SPMI). Minnesota has also established a subcategory of emotional disturbances called *severe emotional disturbance*. These categories were created in order to establish eligibility for certain case management services and they are based on repeated use of mental health services. The Community Supports Administration estimates that about 2.6 percent of Minnesota adults have serious and persistent mental illnesses in a given year, and that 9 percent of Minnesota's school-age children and 5 percent of preschool children have a severe emotional disturbance, which is a mental health problem that has become longer-lasting and interferes significantly with the child's functioning at home and school. This totals about 109,000 children from birth to age 21 with serious emotional disturbances.

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[11] "Children's Mental Health: Transforming Services and Supports to Better Meet Children's Needs," (Saint Paul: Minnesota Department of Human Services, DHS-5051-ENG, October 2015). Accessed on 6/28/16 at: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5051-ENG.

[12] Joan Epstein, Peggy Barker, Michael Vorburger, and Christine Murtha, *Serious Mental Illness and Its Co-Occurrence with Substance Use Disorders* (Washington, D.C.: Department of Health and Human Services, SAMHSA Office of Applied Statistics, 2002). Accessed on 10/3/13 at http://www.oas.samhsa.gov/CoD/CoD.htm - ch3.
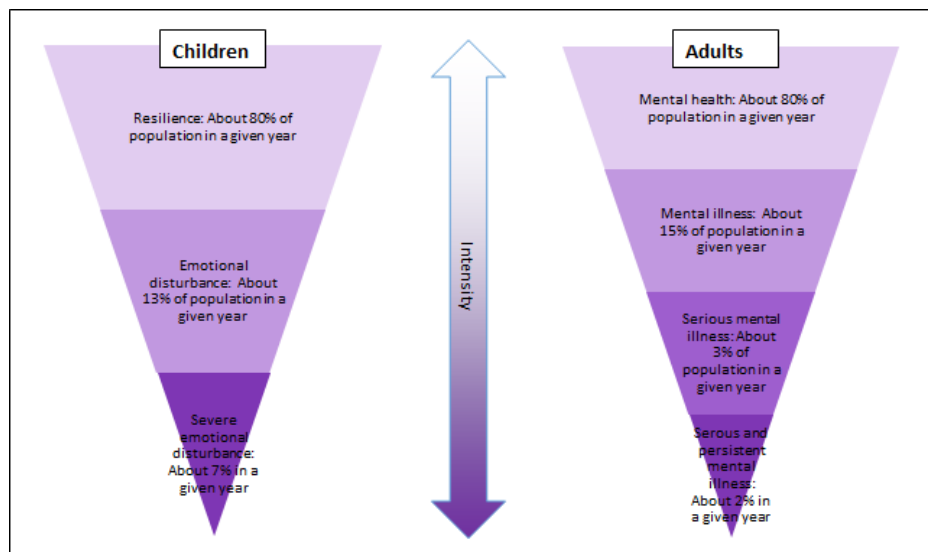
Figure 1: Intensity Continuum of Emotional Disturbance (Children) and Mental Illness (Adults)

Within the categories of adults with serious and persistent mental illness is a much smaller sub-population of adults with co-occurring conditions that complicate their recovery and pose a risk to personal and/or public safety. Co-occurring conditions include: substance use disorders, traumatic brain injuries, developmental disabilities, chronic physical illnesses, aging-related dementias, and symptoms that include aggression, violence, or self-harm. When these conditions cause someone to present a danger to themselves or others, it is sometimes necessary to pursue a temporary restriction of their rights under the Civil Commitment Statute (Chapter 253B of the Minnesota Statutes). This statute lays out the legal process and conditions under which civil commitment might be pursued. Once a person is committed (usually to the Commissioner of Human Services or to a community provider), there are strict rules for treating the person, assessing their progress, and discharging the commitment.

F.   Risk and Protective Factors

Risk and protective factors have been identified to help understand and predict who might develop mental illnesses. **Risk factors** are social, psychological, and biological characteristics or circumstances that can lead to mental illnesses, while **protective factors** are characteristics or circumstances that can help a person avoid mental illnesses. Figure 3 identifies risk and protective factors for mental illness.[13]
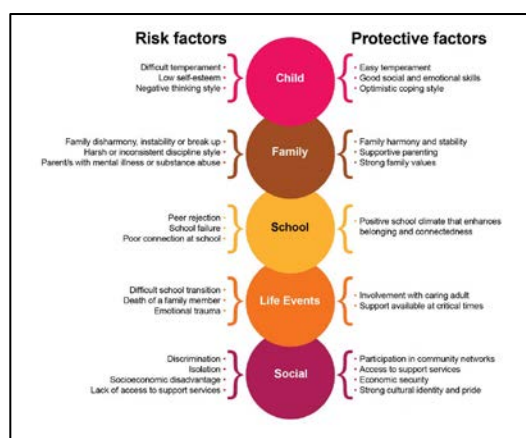

Figure 2: Risk and Protective Factors for Mental Illnesses

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[13] "How Mental Health Difficulties Affect Children," KidsMatter website accessed on 6/7/16 at https://www.kidsmatter.edu.au/families/about-mental-health/should-i-be-concerned/how-mental-health-difficulties-affect-children-0.

G.   The Social Determinants of Health

Figure 3 shows that risk and protective factors are not just personal psychological traits: they also include social determinants of health like whether one lives in a safe neighborhood or has access to nutritious food. In explaining the social determinants of health, the World Health Organization's Commission on the Social Determinants of Health identified three conceptual relationships that help determine health and health inequities:[14]

1. The social, economic and political context into which someone is born plays an important role in that person's socioeconomic position.
2. A person's socioeconomic position (as evidenced by class background, gender identity, race, ethnicity, etc.) shapes the social determinants of health, including: a person's living and working environment; their access to food, transportation, and healthcare; their personal behaviors; their biological predisposition to health and disease; and their psychosocial perspectives.
3. These social determinants of health, mediated by the healthcare system, affect the health of individuals and the unequal health outcomes of populations.
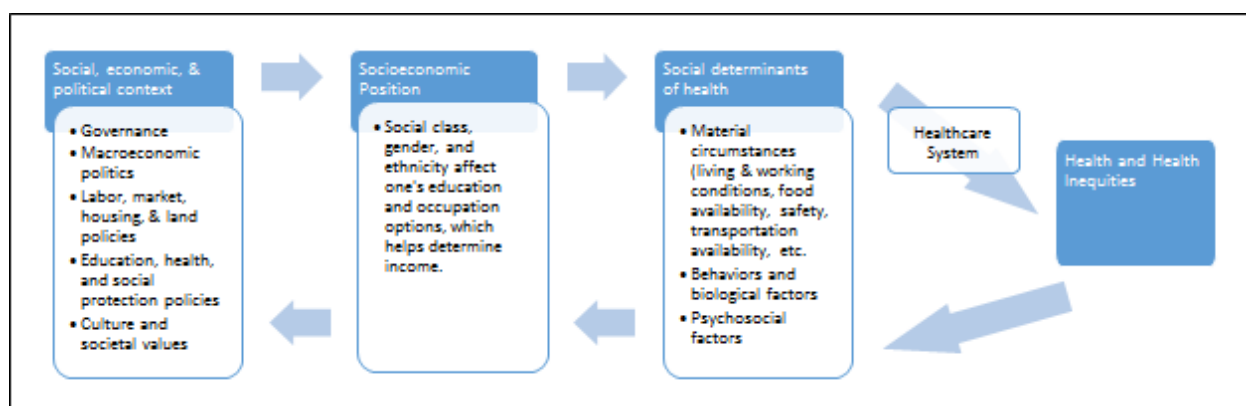
Figure 3: Simplified adaptation of the WHO Commission on the Social Determinants of Health's Conceptual Framework

Figure 3 illustrates those relationships. One benefit of this conceptual model is that it provides a very general map of extremely complex interactions among factors that produce mental health and mental illnesses in individuals. The model draws attention to the larger social and economic forces that affect

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[14] Orielle Solar and Alec Irwin, "A Conceptual Framework for Action on the Social Determinants of Health." Social Determinants of Health Discussion Paper 2, Policy and Practice. (Geneva: World Health Organization, 2010), p. 6. I have simplified the conceptual model by eliminating many of the multi-directional arrows in the original model, so this adaptation loses the original model's recognition that each of these conceptual pieces both influences and is influenced by the other pieces. The adaptation also leaves out the roles of social cohesion and social capital, which are significant concepts in the original model for talking about power relationships and the possibility for authentic participation in systems change.

health and health inequities and helps contextualize our investments in healthcare as just one set of investments that will be needed to improve the mental health of Minnesotans.

H.   Healing: Resilience and Recovery

For children, healing from emotional disturbances is called **resilience:** the process of adapting well in the face of adversity, trauma, or other significant sources of stress. It means processing, healing, and "bouncing back" from difficult experiences.[15] For adults, healing from mental illness is called **recovery** and is defined by SAMHSA as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."[16] SAMHSA delineates four life dimensions that support recovery:[17]

- **Health**—overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem— and, for everyone in recovery, making informed, healthy choices that support physical and emotional well-being
- **Home**—having a stable and safe place to live
- **Purpose**—conducting meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community**—having relationships and social networks that provide support, friendship, love, and hope.

I.   Equity and Disparities in Mental Health Outcomes

Although Minnesotans on average are healthy compared to other states, Minnesota has significant health disparities among populations of color, American Indians, GLBTQ[18] people, veterans, and other groups. These populations have shorter life spans, higher incidence of chronic illnesses including mental illnesses, and generally poorer health. As the face of Minnesota changes and these groups constitute a larger percentage of the state's population, it will become only more crucial that these disparities be eliminated.

A recent needs assessment in conjunction with development of certified community behavioral health clinics described disparities in mental health services and outcomes for American Indians, Asian populations, Hispanic/Latino populations, homeless people, older adults, Somali populations, and

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[15] "The Road to Resilience," American Psychological Association website, accessed on 6/7/16 at http://www.apa.org/helpcenter/road-resilience.aspx.

[16] "SAMHSA Announces a Working Definition of 'Recover' From Mental Disorders and Substance Abuse Disorders," (Washington, CD: SAMHSA News Release). Accessed on December 22, 2013 at http://www.samhsa.gov/newsroom/advisories/1112223420.aspx.

[17] "Recovery and Recovery Support," (Washington, DC: SAMHSA Website. Accessed on 6/3/16 at http://www.samhsa.gov/recovery.

[18] Gay, lesbian, bisexual, transgender, and queer.

veterans.[19] Surveys led researchers to conclude that there is a need for more culturally and linguistically appropriate services. Similar conclusions have been drawn for GLBTQ people and veterans: until people feel that mental health providers understand them and their experiences, they are unlikely to access mental health services and the mental health services they do receive are unlikely to be very helpful.

A recent report by the Minnesota Department of Health explains that disparities—population-based differences in health outcomes—are closely linked with social, economic, and environmental conditions.[20] Moreover, structural racism, intergenerational trauma, and genocide have lasting effects on people and cultures, leading to disparities that are reproduced generation to generation.[21] These points help explain why "equity" and "equality" are not the same concept. Equity involves creating the conditions so that each person and family can maintain mental wellness and/or recover quickly from mental illnesses. It acknowledges that each person may need somewhat different
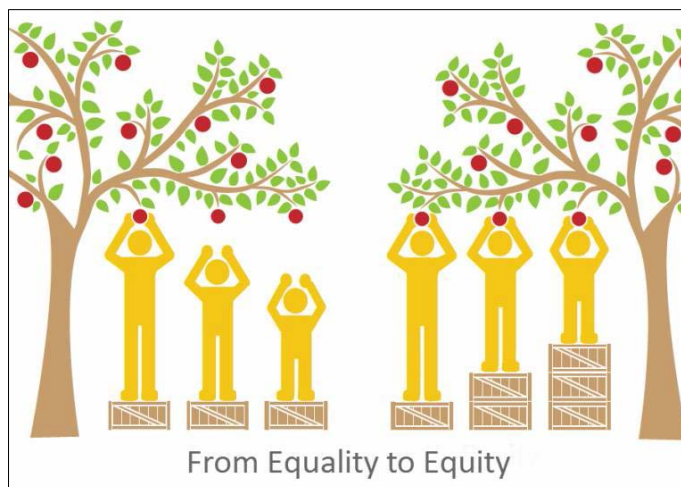

Figure 4: Equality to Equity, copyright by Saskatoon Health Region 2015

levels and types of supports, based on their risk and protective factors. Equality assumes that everyone should have access to the same services, which has a veneer of fairness but actually continues to promote disparities.

According to a World Health Organization report on the social determinants of health, "any serious effort to reduce health inequities will involve changing the distribution of power within society to the benefit of disadvantaged groups."[22] To eliminate mental health disparities, Minnesota will need to

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[19] Trudy Ohnsorg, "Needs Assessment 2016: Excellence in Mental Health Act in Minnesota." (Saint Paul: Cincinnatus, Inc., June 13, 2016), pp. 40-55.

[20] "Advancing Health Equity in Minnesota," Minnesota Department of Health, February 2014, accessed on 6/29/16 at http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf.

[21] "Types of Trauma and Violence," SAMHSA website, accessed on 7/7/16 at: http://www.samhsa.gov/trauma-violence/types; "Behind the Term: Trauma," SAMHSA's National Registry of Evidence-based Programs and Practices, accessed on 7/7/16 at: http://nrepp.samhsa.gov/Docs%5CLiteratures%5CBehind_the_Term_Trauma.pdf, p. 2; "Environmental Scan Summary Report," Native American Center for Excellence report to SAMHSA, November 2008, accessed on 7/7/16 at: http://www.samhsa.gov/sites/default/files/programs_campaigns/tribal_training/nace-environmental-scan-summary.pdf.

[22] Orielle Solar and Alec Irwin, "A Conceptual Framework for Action on the Social Determinants of Health." Social Determinants of Health Discussion Paper 2 (Policy and Practice). (Geneva: World Health Organization, 2010), p. 22.

address the social determinants of health that shape risk and protective factors, and we will also need to change how mental health policy is developed, which could include:

- Creating conversations that explicitly raise the structural, unequal distribution of key social and material goods as a source of health disparities.
- Identifying institutional and cultural racism and homophobia as causes of disparities.
- Promoting policy decision-making processes that include the people likely to be affected by the decisions.
- Making an explicit commitment to reducing disparities as one important goal to be achieved by the Governor's Task Force on Mental Health.

II.   The Mental Health System

A.   Defining the Mental Health System

Chapter II makes it clear that our definition of the Minnesota mental health system cannot be narrowly focused on clinical services, but must comprise a much wider set of formal and informal health and social services that support individuals, families, and communities. We therefore define Minnesota's **mental health system** to include the following:

- **Mental health services providers**: Psychiatrists, psychiatric nurse practitioners, psychologists, and social workers in public and private practice; community mental health centers and outpatient clinics; residential treatment and rehabilitation centers; psychiatric hospitals; and psychiatric units of general hospitals. The vast majority of Minnesotans are served by community-based providers, but a small portion are also served by Direct Care and Treatment, the state-operated mental health services providers. Most people served by Direct Care and Treatment have been civilly committed to the Commissioner of DHS (although community providers also serve people who have been civilly committed).
- **General medical and primary care providers**: Primary care doctors, nurse practitioners, and nurses often provide mental health services as part of their physical medicine practices in private clinics, community health centers, and hospitals.
- **Human and social services providers**: Minnesota has a huge network of social service providers who assist clients with direct mental health services as well as support services including housing, education, employment, food supports, family counseling, etc. Mental health and substance use disorder services are also sometimes provided in schools, community centers, spiritual centers, jails, and prisons.
- **Suppliers**: Providers of mental health services rely on commercial suppliers of clinical and treatment protocols, pharmaceuticals, medical equipment, and supplies, including the extensive research and evaluation networks that underlie those products.
- **Voluntary and community networks**: Minnesota has an especially vibrant network of volunteer- and peer-run organizations that support people with mental illnesses and substance use disorders.
- **Policy makers**: Federal and state agencies and professional boards, counties, and tribes all play a strong role in developing and shaping the mental health provision system by helping to determine

what services are provided and/or funded, by setting the standards under which those services will be provided, by determining the eligibility of individuals for various services, and by overseeing the licensing, certification, and quality management of the various players in the system.

- **Insurers/health plans**: Mental health services are provided under a number of different insurance and provision arrangements. Insurers and health plans play a significant role in determining members' access to mental health services.
- **General population, people with mental illnesses, and advocates**: Virtually every Minnesotan is a part of the mental health system as a recipient of public health messages about mental health, as a family member or friend of someone receiving mental health services, or as a recipient of mental health services.

Another way to illustrate the reach and complexity of the mental health system is to show all the related service systems it touches. These include primary care, education, law enforcement, courts, transportation, social services, income supports, and employment.

B.　　Six Functions of the Mental Health System

The mental health system comprises six basic functions: system assessment, health promotion, illness prevention, early intervention, treatment, and recovery/resilience.[23]
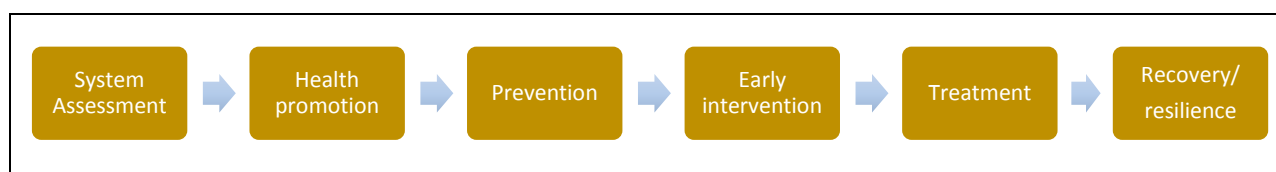

Figure 5: Six Functions of the Mental Health System

1.　　System Assessment

System assessment involves the ongoing measurement and tracking of subpopulation health and the impacts of service delivery in order to drive system improvement. An example is the State Quality Reporting and Measurement (SQRM) measure for depression, which includes a uniform definition, measures, and process for submitting data so that the incidence and impacts of depression can be tracked and analyzed. With agreed-upon measures, we can test and evaluate care models to determine which models have the most positive outcomes in relation to their costs (the DIAMOND model is an example).[24] Because the mental health system includes such a variety of public and private organizations overseen by multiple layers of government, it is difficult to develop shared approaches like

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[23] These functions are based on the conceptual framework outlined in "Improving Mental Health and Well-Being: A Vision for Minnesota's Public Health System," Mental Health Workgroup, State Community Health Services Advisory Committee. (Saint Paul: Minnesota Department of Health, October 2013), p. 13. They also reflect the continuum of care presented by SAMHSA in "Prevention of Substance Abuse and Mental Illness," SAMHSA website, accessed on 7/8/16 at http://www.samhsa.gov/prevention.

[24] The DIAMOND model is a collaborative care management model for primary care providers that has been shown to improve outcomes in the treatment of depression. See the Institute for Clinical Services Improvement website at https://www.icsi.org/_asset/7b699o/COMPASS-QandA.pdf.

this in order to create an integrated picture of the mental health of Minnesotans. Assessing population and subpopulation health is crucial to understanding what services work best for particular populations and to make good decisions about how and where resources should be deployed. Right now the assessment function is spread across governmental agencies, foundations, research organizations, provider organizations, employers, and insurers.

2. Mental Health Promotion

Given the stigma that surrounds mental illness, an important function of the mental health system is to help Minnesotans define mental health and understand its importance, and recognize the many factors that contribute to mental health. To optimize mental health and resilience, mental health promotion addresses the risk factors that can increase vulnerability to mental illness and promotes the protective factors that support mental health and resilience.

3. Prevention

Prevention of mental illnesses is a key public health priority because of the high human and financial costs of mental illness.[25] The human costs can include damage to family and social connections, loss of livelihood, psychological and physical suffering, and even death. The financial cost is also significant, with the mental disorders costing the United States an estimated $201 billion in 2013. [26] This amount puts treatments for mental illnesses (in both community-based and institutional settings) at the top of the list of national spending on medical conditions (ahead of heart conditions, trauma, and cancer).

Prevention of mental illnesses can begin before children are born. Supporting parents to get good nutrition and prenatal care, abstain from the use of substances, and live in safe, healthy environments gives their babies a good start toward mental health. Once babies are born, all of these factors become even more important so that parents can bond with their infants and provide the responsive interactions that babies need to develop cognitively and socially. As children get older, good nutrition, safety, stable housing, compelling education, and reliable relationships with both peers and adults help them develop resiliency and protective factors to avoid mental illness. All of these efforts exist in balance with our knowledge that poverty, racism, and other factors can make it almost impossible for some parents to provide the safe, nurturing childhoods they want for their children, and that some susceptibility to mental illnesses is genetic and outside our control.

Prevention can support adults who may be at risk for mental illnesses as well. Prevention activities can include supports for the social determinants of health (nutrition, safe housing and neighborhoods, transportation, education, employment, etc.). For people who have experienced chronic mental illnesses, prevention can include any supports or activities that help the person maintain stability in the community (see "Resilience and Recovery," below). These efforts can prevent relapse and assist the person's ongoing recovery journey.

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[25] "Prevention of Mental Disorders: Effective Interventions and Policy Implications," (Geneva: World Health Organization), 2004, p. 15.

[26] Charles Roehrig, "Mental Disorders Top the List of the Most Costly Conditions in the United States: $201 Billion," Health Affairs, Vol. 35, No. 6, June 2016, p. 1.

4.   Early Intervention

Early intervention usually refers to finding mental health concerns at the earliest age they appear (in children) or to finding the earliest emerging stages of mental illness, regardless of age. Mental health problems can show up early in childhood and become progressively worse if not treated. Early detection requires an understanding of developmental stages and protective and risk factors, such as quality of attachment with the primary caregiver, parental depression, family substance use, or trauma, any of which can affect a child's social and emotional development. When a child is struggling, it is important to create support around the child and family and—if warranted—to screen the child for possible emotional disturbances.

Early intervention is just as important for adults. The National Alliance for Mental Illness (NAMI) reports that the average person waits 8-10 years from the first onset of mental illness symptoms to seek help. Building individual willingness to seek help and communicating the fact that recovery is possible can help shorten that delay. An individual's likelihood of seeking or accepting help may be hindered by social and cultural factors. Teens or young adults experiencing psychotic episodes may decline to seek help for fear of being ostracized. Men struggling with anxiety may feel pressure from the stereotype that they should not have difficulty with emotions, for example, or women struggling with post-partum depression may worry that they are not living up to a maternal ideal. Addressing these barriers will make more people feel safe in seeking care. Identifying mental illnesses and intervening early can then reduce the need for more intensive types of treatment and decreasing costs overall for health care, education and social services. The recent funding for intervention in First Episode Psychosis is an example of a proven early intervention strategy.

5.   Treatment

Nearly all of the mental health treatment services in Minnesota are provided by private (as opposed to public government-operated) providers: community mental health centers, hospitals, clinic networks, private providers, mental health professionals, and nonprofit organizations. Some counties and tribes also provide direct treatment to people with mental illnesses (through county-run clinics, for example, or county hospitals), and the state serves a small percentage of people through its Direct Care and Treatment division. The treatment services available in Minnesota are also predominantly community-based, with some institutional services. Community-based treatment services include clinical services, rehabilitation services, and crisis services. Residential and inpatient services provide an intensive level of treatment and rehabilitation, and acute care is provided in specialized psychiatric hospitals, the psychiatric units of community hospitals, and sometimes in general medical units of community hospitals. People with serious and persistent mental illnesses or severe emotional disturbances can qualify for case management and care coordination services that help them gain access to the treatment services they need.

6.   Resilience and Recovery

A resilience and recovery-based mental health system does not stop when a person ends treatment. Recovery supports are a crucial element in the system because they allow the person to continue their recovery journey once treatment ends, or while treatment continues in community settings. Recovery services can include: outpatient treatment, peer support and counseling, housing assistance, education

and employment services, respite services, and family supports. For individuals with severe emotional disturbances or serious mental illnesses, recovery services can also include case management, care coordination, assertive community treatment, and illness management and recovery.

C.   Mental Health System Treatment and Support Services Providers

The assessment, health promotion, and prevention functions of the mental health system comprise a fairly small percentage of overall effort in Minnesota. Early intervention, treatment, and recovery services comprise most of the mental health services in Minnesota, and these are provided by a range of organizations. It is especially important to remember the role of primary care in mental health services provision: primary care doctors are often the first to be consulted about a mental health issue and many people are treated only within the primary care system and do not seek out providers who specialize in mental health. The provider system includes:

- Community mental health centers
- Counties (provided directly or purchased from contracted provider organizations)
- Public and private hospitals and clinics
- Public and private residential service providers
- Public and private outpatient service providers, including individual providers
- School districts
- Jails and prisons
- Tribal authorities or Indian Health Clinics (to members)
- Federal and state-operated providers: Veterans' Administration and the Direct Care and Treatment (DCT) division of DHS. DCT includes community-based residential and vocational services, psychiatric hospitals, chemical dependency treatment centers, intensive residential treatment services, the Minnesota Security Hospital and the Minnesota Sex Offender Program.

More information about Minnesota's mental health service providers will be presented at the second meeting of the Governor's Task Force on Mental Health.

D.   Governance of the Mental Health System

About two-thirds of Minnesotans receive their health care through a non-governmental insurance plan.[27] There are federal and state laws that govern these plans but the plans have wide latitude in determining what particular insurance products they offer and what services are included in each.
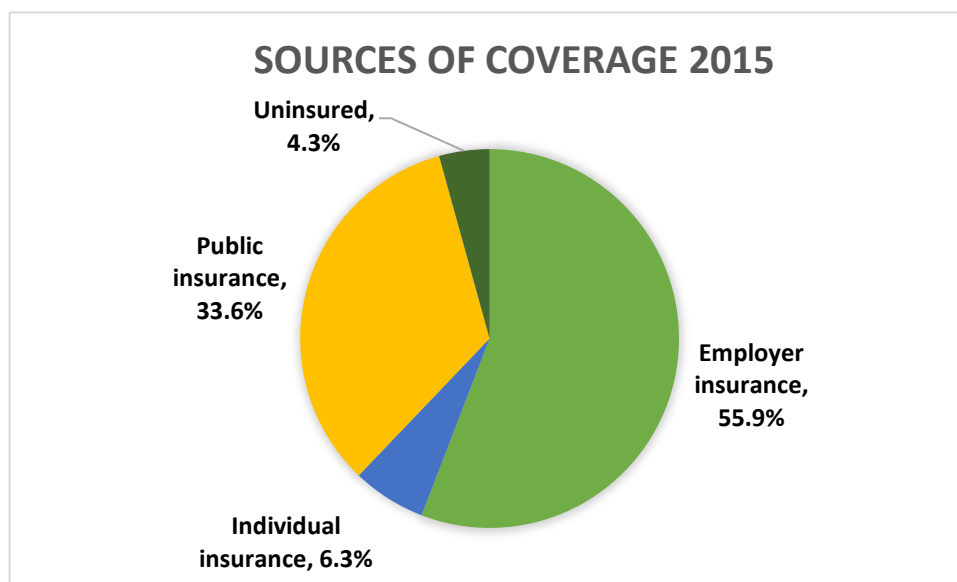

Figure 6: Sources of Health Insurance Coverage, 2015

It is also true that most people receive mental health services through their primary care clinics or in the emergency departments of hospitals.[28] Oversight of primary care and hospitals is provided by a complex combination of federal and state agencies and accreditation and licensing bodies that is outside the scope of this review, but it might make sense for the Task Force to have a presentation on the governance of healthcare in general before focusing specifically on the oversight of mental health services. Minnesota is striving to improve integration across physical health and mental health service provision. The rest of this section focuses on mental health services oversight.

At the federal level, SAMHSA coordinates policy around mental health and substance use disorders. They operate a variety of public mental health programs, issue grants, provide information and technical assistance, and work with other federal agencies on mental health issues. The Centers for Medicare and Medicaid Services (CMS) also plays a large role in mental health service provision because it controls policy for Medicaid and Medicare spending and service definitions. This policy directly affects the approximately 30% of Minnesotans who are insured through Medicaid and Medicare.

The Minnesota Legislature plays a huge role in shaping Minnesota's mental health system and the services it offers as it implements laws and guidelines set at the federal level. State statute lays out the definitions of mental health and mental illnesses, assigns responsibility for oversight of the system, sets

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[27] "Health Insurance Coverages in Minnesota: Results from the 2015 Minnesota Health Access Survey," Minnesota Department of Health website, February 29, 2016, accessed 7/12/16 at http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2015brief.pdf

[28] Sara Klein and Martha Hostetter, "Integrating Behavioral Health and Primary Care," Commonwealth Fund website accessed on 7/12/16 at http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus#/#3.

the rules for licensing and regulating providers, and establishes services and eligibility requirements. The Legislature has established Minnesota's health and social services as "state supervised, county administered" programs. The state, counties, and tribes partner with providers and payers to deliver mental health services.

1.   State Mental Health Authority

State law and federal regulations give the Department of Human Services (DHS) the role of "state mental health authority," which has the following responsibilities:

- Defining and disseminating statewide policy for mental health service delivery and administration, and monitoring compliance with established policy
- Coordinating development of statewide and local mental health system plans, including statewide goals and objectives
- Developing and profiling programs of technical assistance to local administrative agencies
- Developing new programs of service, and new or reorganized methods of service delivery based on best practices
- Monitoring and evaluating the performance of local service delivery systems, typically with the county or region as the unit of analysis
- Developing and disseminating standards for service programs, service delivery, and administration
- Allocating funds to local systems and demonstrating the accountability of these systems to the Minnesota Legislature and to federal funding sources

The mission and framework for the mental health service delivery system are articulated within the Comprehensive Mental Health Acts for Adults and Children. Originally passed into law by the State Legislature in 1987 (adult) and 1989 (children) respectively, the Acts define an array of publicly-funded mental health services to be implemented in each county, emphasizing community-based services. The target populations were people with intense mental health needs: people in crisis, adults with serious and persistent mental illness, and children with serious emotional disturbance. Over the years, the Acts have gone through many changes, including the addition of some prevention and early intervention services.

2.   Local Mental Health Authorities

The Mental Health Acts establish counties (and some tribes) as local mental health authorities. Each county or tribal board is responsible for system planning, implementing, and coordinating programs of service delivery among local providers, coordinating client care through case management, allocating state and local funds, and reporting data and information requested by the state mental health authority. They contract with local providers to deliver mental health services that are funded with federal, state, and local tax dollars and some contract with managed care organizations for the provision of mental health services. They are required to consider public input as part of their administrative responsibilities. Statute has also established regional bodies, called Adult Mental Health Initiatives (for adult services) and Children's Mental Health and Family Services Collaboratives (for children's services), that allow counties to work together and with other stakeholders to improve their community-based

service systems (see Appendix III for a list). The Initiatives are funded by state grants, and significant portions of the funds are spent on contracting with local providers for crisis services and paying the counties' share of mental health targeted case management, a Medicaid service.

The Children's Mental Health and Family Services Collaboratives are groups of counties, tribes, school districts, local mental health entities, juvenile corrections, parents, public health, schools, Head Start, and other community-based organizations that partner to provide integrated and coordinated services to support children and families. There are currently 90 Children's Mental Health and Family Services Collaboratives in Minnesota. The Collaboratives are primarily funded by claiming federal funding via the Local Collaborative Time Study.

3. Other Policymaking Bodies in Minnesota's Mental Health System

The state and local mental health authorities collaborate with many state agencies on health care policy, including the Departments of Health, Corrections, Transportation and professional health boards including the Board of Psychology, the Board of Psychiatry, and the Board of Nursing.

E. Access to Mental Health Services

One goal of Minnesota's mental health system is to provide a continuum of services so that people can get the services they need in the right place and at the right time. "Continuum" refers to a range of services that fulfills all of the six functions described above and that addresses mental illnesses at all levels of intensity and acuity.

Access to mental health services is probably the biggest issue facing Minnesota's mental health system. With almost 96% of Minnesotans covered by health insurance, the policies governing insurance carriers probably have the biggest impact on what services are available to a person seeking mental health treatment. More than half of Minnesotans are insured through their employers and about a third are insured by public health insurance programs.[29] Having health insurance is not a guarantee that someone will have access to mental health services, however. There are hundreds of policies, business practices, situational factors like geographic location or age, and personal decisions that help determine access to services.

Government at the federal, state, and local levels create policies that shape the institutional infrastructure of health care. Within that structure, insurers make decisions about the types of services they will cover and under what conditions. Minnesota's independent and networked providers—both for-profit and nonprofit—then try to stay in business while those providing mental health services to their customers or clients. Most providers develop multiple streams of revenue to support their operations, and many, especially those who serve public-pay clients, operate very close to the line. The 2015 closure of the Riverwood Mental Health Center in central Minnesota, for example, illustrates how

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[29] "Early Impacts of the Affordable Care Act on Health Insurance Coverage in Minnesota," (Minneapolis: State Health Access Data Assistance Center, University of Minnesota, June 2014), p. 6.

complex the operation of a community mental health center can be and how many different factors are involved in the daily business operations.[30]

There are workforce shortages in Minnesota, so another challenging dimension of providers' business decisions involves their strategies for competing for employees. Mental health services providers often struggle to sustain the required professional staffing (for example, psychiatry, but employees at all levels are in short supply) to maintain their licensing or certification.[31] Minnesota has established a workforce development plan for the mental health workforce, but many of its activities remain unfunded.[32] When groups of stakeholders convene to talk about barriers to the improvement of the state's mental health system, workforce challenges are consistently one of the top three concerns mentioned.

Our policy infrastructure and the myriad business decisions of providers—though understandable and well-motivated—add up to a very unfortunate situation: every geographic area of the state, including the metro, has a shortage of some mental health services, and some geographic areas lack all but the most basic services. This forces residents to forego care or to travel long distances to receive services. The state and counties can attempt to "sweeten the pot" by raising rates, handing out grants, or creating other incentives, but the barriers to operation can be so complicated and multifarious that these incentives are not enough. State-operated services can fill some of the gap, but they are a relatively small segment of the overall provider system and they are also struggling to operate within their financial constraints.

In addition to all of the above factors that help determine access to services, there are individual and personal factors that affect access. The nature of one's insurance is key, but factors like what county one lives in, access to transportation, ability to cover co-pays and deductibles, accessibility and cultural responsiveness of services, and ability to negotiate the confusing healthcare and social service system are other factors. There is also the question of personal or family motivation that drives someone to seek out mental health treatment. Stigma, the negative stereotypes about mental illness, can keep people from admitting that they need help and/or deciding to seek that help.[33] What's worse, many medical professionals also carry some of these stereotypes and are reluctant to ask their patients about mental health symptoms. NAMI estimates that the average person experiences mental health symptoms for 8-10 years before seeking treatment.

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[30] "The Riverwood Centers Closure: A Systems Analysis," Chemical and Mental Health Services Administration, Minnesota Department of Human Services, June 30, 2014, accessed on 6/15/16 at https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6976-ENG.

[31] "Minnesota's Psychiatrist Workforce, 2012," (Saint Paul: Minnesota Department of Health, Office of Rural Health and Primary Care, 2012), p. 1.

[32] "Gearing up for Action: Mental Health Workforce Plan for Minnesota," (Saint Paul: HealthForce Minnesota and MnSCU, January 2015;

[33] Laura Greenstein, "9 Ways To Fight Mental Health Stigma," National Alliance for Mental Illness, accessed at https://www.nami.org/Blogs/NAMI-Blog/October-2015/9-Ways-to-Fight-Mental-Health-Stigma on 6/20/16.

F.   Advisory and Advocacy Organizations

Minnesota statute has established strong community input on the design and delivery of the mental health system through several advisory councils:

- American Indian Mental Health Advisory Council: The Council was created by legislative action to advise and assist the Mental Health Division to formulate policies and procedures relating to American Indian mental health services and programs and to make recommendations regarding approval of grants. The Council includes 15 American Indian individuals representing each of the seven Chippewa reservations and four Sioux reservations, and four individuals representing the urban American Indian population of Duluth, St. Paul and Minneapolis. Reservation representatives are selected for appointment by the governing body of each reservation.
- State Advisory Council on Mental Health: This 30-member Council advises the Governor, Legislature and state agencies about policy, programs and services affecting people with mental illness. The Council meets monthly and is required to submit a biennial report to the Governor and Legislature. The Governor appoints members to the Council.
- The Subcommittee on Children's Mental Health: The Children's Subcommittee provides recommendations to the State Advisory Council on Mental Health on policies, laws, regulations, and services relating to children's mental health. Members are appointed by the chair of the State Advisory Council, and the Subcommittee contributes to the State Advisory Council's biennial report to the Governor and Legislature. Meetings are held once a month.
- Local Mental Health Advisory Councils (LACs): Each county establishes a Local Mental Health Advisory Council, made up of local residents including people with lived experience of mental illness, to work with the county to develop the mental health service system in that county.
- Local Coordinating Councils (LCCs): For children's mental health services, county boards must establish an LCC to help implement local mental health responsibilities and evaluate local needs.

Advocates for people with mental illnesses also play an important role by providing education about mental illness to the general public and informing policymakers about mental health issues and particular needs within the mental health system. They serve as a voice for individuals and families served by the public mental health system and partner with DHS, counties, tribes, and other stakeholders to improve the mental health system.

III.   Funding the Mental Health System

Minnesota has a complex system for funding mental health services from a variety of sources.

A.   Sources of Funding for Mental Health Services

Minnesotans pay for mental health services through the following sources:

- Private health insurance, which is funded by employers and individuals' premiums, copays, and deductibles

- Public health insurance (Medical Assistance, MinnesotaCare), which is funded primarily by federal and state funds, but with some county contributions for certain mental health services (e.g., mental health targeted case management)
- State and federal grants (including grants to the Adult Mental Health Initiatives and the Children and Family Collaboratives, and to other mental health providers)
- County levy dollars
- Out-of-pocket spending by individuals
- Charity care by providers
- State appropriations to state-operated mental health services

Most mental health treatment is paid through health insurance, with only about 4.3% of Minnesotans currently uninsured. Because most Minnesotans have private insurance (through an employer or self-paid), the largest source of funding for mental health services in Minnesota is private companies and individuals. However, public insurance—Medicaid, Medical Assistance, and Minnesota Care—is also a huge payer for mental health treatment services, funded by state and federal tax dollars, with some county funds. Federal and state grants supplement these funds to support health promotion and prevention and target particular populations, and county funds pick up the costs of services for people who are not eligible for public insurance and for other local services. Federal and state funding for publicly-funded mental health services are shown in the following table.

Source	Description
Medical Assistance (Minnesota's Medicaid Program)	A fund composed of federal, state, and local shares that pays for medical services for low-income and disabled people, including many mental health services.
MinnesotaCare	State health insurance for low income families and children not eligible for Medical Assistance.
Prepaid Health Plans	Federal and state Medicaid and MinnesotaCare managed care organizations. Funds are pre-paid on a capitation basis for eligible populations.
Community Mental Health Funds	State allocations and grants for community support services, community residential treatment, early identification and intervention, enhanced housing support, crisis services, and services to people who lack stable housing.
Community Mental Health Services Block Grant	A federal grant to the state that funds: - some mental health services for American Indians - demonstrations for services targeted for racial/cultural communities - some crisis response services - some awareness and prevention services - child screening services (state grant)
Regional Treatment Center Fund	A state fund for the state-operated Anoka Metro Regional Treatment Center and Community Based Behavioral Hospitals, which is supplemented by a county match.
Group Residential Housing Fund	A state fund to cover the room and board costs for adult residential treatment

Source	Description
Family Preservation Fund	State funds to support permanency planning for children, some of whom have emotional disturbances.
Community Social Services Fund	State block grants to counties for social services, including some mental health services. Counties provide a match.
Title XX	A federal block grant to the state for social services, including some mental health services, which the state passes on to counties.
Title IVB and I-VE	Federal grants for children's social services, with some services for people receiving mental health services.

Table 1: Federal and State Funding for Public Mental Health Services

B.   Mental Health Services Funding for Minnesota American Indian Tribes

The financing of mental health services for American Indians in Minnesota is somewhat different from that of other Minnesotans. American Indians can access mental health services through state, county, and tribal governments and through American Indian Health Boards. All Minnesota tribes provide at least some health services for their members. Health services provided by tribes are financed via:

- Private insurance
- Medicare
- Medicaid
- Tribes' own funds
- Federal Indian Health Service (HIS) funds
- Veterans Administration (many American Indians are veterans and many are eligible for VA health benefits)

Because unemployment is high on and near most Minnesota reservations, employer-sponsored health insurance is not an option for many tribal members. Indian Health Service funds are appropriated annually by Congress; they are estimated to cover less than half of the level of need, and are especially inadequate in the IHS region that includes Minnesota. Tribes themselves may fund health care services at various levels, depending in part on the tribe's wealth. Medicaid has become a larger source of health services funding for Minnesota tribes in recent years, and some tribal governments are working with DHS to build their capacity to provide Medicaid-funded services.

Twenty-five percent of Minnesota's mental health federal block grant funding is designated for mental health services for American Indian communities. Adults with serious and persistent mental illness or children with severe emotional disturbance are the two highest priority groups targeted for services. The federal block grant funds nine reservations and three urban American Indian mental health projects. These federal block grants are distributed through a request-for-proposal process.

IV.   Trends in Minnesota's Mental Health System

This section identifies several trends that are shaping the mental health system in Minnesota.

A.   Deinstitutionalization in Minnesota

Minnesota has been in a process of deinstitutionalization of mental health care for at least 60 years. The first state hospital for mentally ill people opened in St. Peter, MN, in 1866, with similar institutions opening in the following decades.[34] These institutions were following the social reform movement of their time, which assumed that providing asylum—removing people from the community and serving them in peaceful, rural settings—would protect people with mental illnesses from exploitation and protect society from people with mental illnesses. The expectation for many residents was that they would live and work at the asylums for years or for the rest of their lives, although a significant portion actually returned to their communities in relatively short periods of time.[35] Minnesota built eleven state hospitals, and by 1955, the system reached a peak size of 11,500 people with mental illnesses.[36]

By the late 1950s, however, serious questions were being raised about the quality of care in state hospitals. Social reformers called for the closing of these facilities because they believed that people could be better treated in more integrated community settings. New psychotropic drugs were expected to make it possible for institutional residents to return to their communities and lead integrated, productive lives. Driven by social and political movements to protect the rights and dignity of people with mental illnesses and by the promise of psychotropic drugs that provided new treatment options, President Kennedy signed the Community Mental Health Act of 1963, which promoted deinstitutionalization by funding community mental health centers aimed at delivering care for people with mental illnesses in integrated community settings. The population of Minnesota's state hospitals shrank rapidly through the latter half of the 20th century in response to this policy.

As the state hospitals closed, their funding was shifted to community-based residential and outpatient services. By the late 1960s, community mental health centers were diverting some people from the state hospitals and providing follow-up care for others. After the implementation of Medicare and Medicaid (called Medical Assistance in Minnesota) in the 1970s, community hospitals began increasing their psychiatric capacity to serve people whose care was reimbursable.[37] The state also began to shift some of its state-operated services to community-based models, including treatment for substance use disorders (the Community Addiction Recovery Enterprise—C.A.R.E.) and residential facilities for people with developmental disabilities (Minnesota State Operated Community Services—MSOCS).

Deinstitutionalization brought a new payment model to mental health services. Unlike the regional treatment centers, which relied on appropriated dollars to fund care, most community providers billed for their services. As the medical model of mental health care become stronger, private and public

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[34] *Deinstitutionalization of Mentally Ill People* (Saint Paul: Office of the Legislative Auditor, State of Minnesota, February 1986), 1.

[35] G.N. Grob, "Mental Health Policy in America: Myths and Realities," Health Affairs, Vol. 11, No. 3, 1992, p. 11+.

[36] *Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill* (Saint Paul: Office of the Legislative Auditor, State of Minnesota, February 1981). The number provided is somewhat difficult to interpret, but it appears that this figure includes only people with mental illness, not the rapidly increasing number of people with developmental disabilities who were being served in state hospitals.
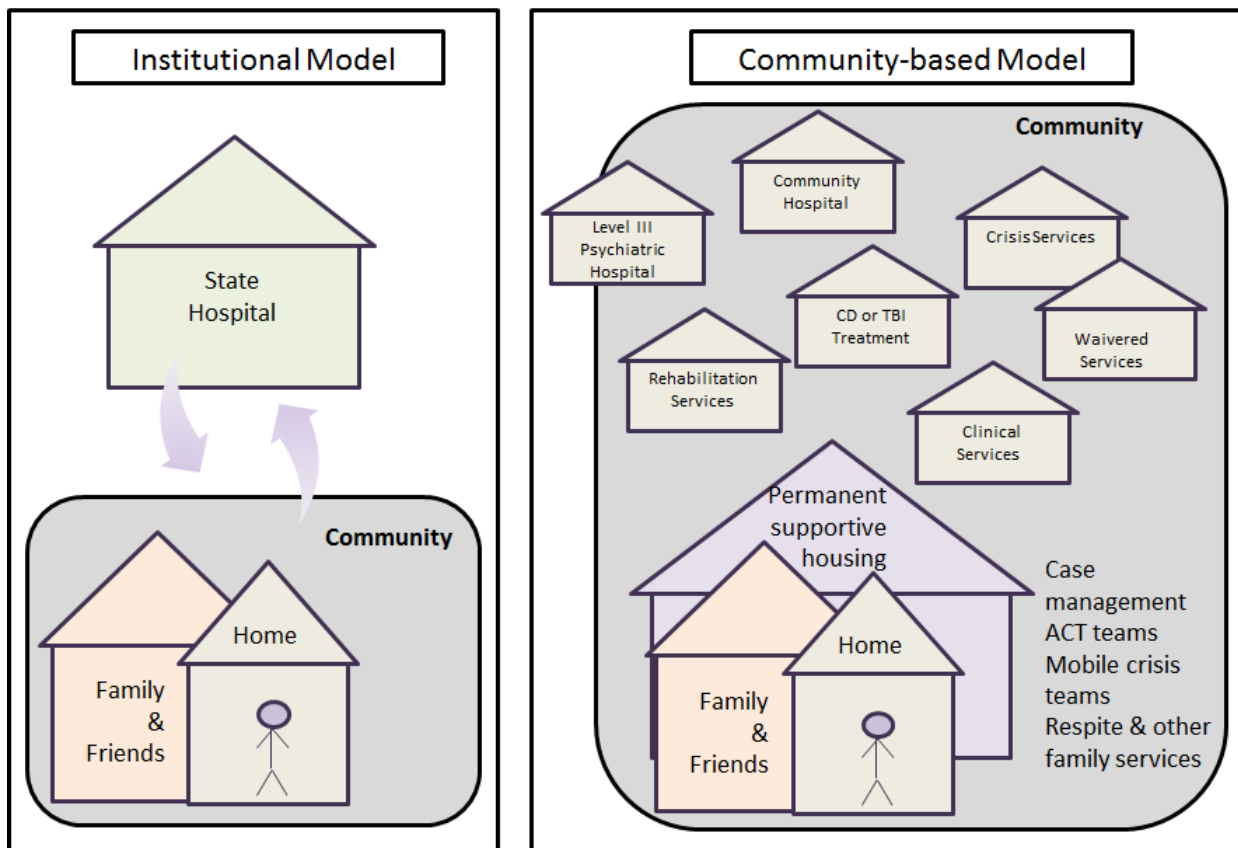
[37] Ibid., p. 8.

health insurance became key payers of mental health services. Minnesota looked for help from the federal government to cover the costs of mental health care for low-income and disabled people. The list of services reimbursable under Medicare and Medical Assistance became a key determinant of what services were available to low-income Minnesotans and the role of the federal government in shaping Minnesota's mental health service system increased.

B.   Continued Growth of Community-Based Services

Deinstitutionalization brought gradual growth in community-based services. This system-level change resulted in changes in how individuals gain access to care. Instead of leaving the community and receiving care at a state hospital, clients now move among providers and levels of care—some in the community and some far away. Most stakeholders, including clients themselves, say that this change has been positive because a much wider range of services is available and is provided in a more recovery-based environment. Receiving services in the community is also much more supportive of resilience and recovery than is treatment in a state hospital far from one's home community.

However, the change has significantly increased the complexity of the mental health service system. This can make it more difficult to get access to care and adds a new requirement to coordinate among various providers and funders.

Publicly-funded Mental Health Care

Institutional Model

State Hospital

Community

Home

Family & Friends

Community-based Model

Community

Community Hospital

Level III Psychiatric Hospital

Crisis Services

CD or TBI Treatment

Rehabilitation Services

Waivered Services

Clinical Services

Permanent supportive housing

Home

Family & Friends

Case management
ACT teams
Mobile crisis teams
Respite & other family services

	Key Characteristics of Institutional Model:	Key Characteristics of Community-Based Model:
Services Available	Design and delivery of services is controlled by state/institution.	Design and delivery of services is influenced by range of entities.
Location of Care	Person leaves family and community to access whatever care in the institution.	Person pursues services within home and community.
Community Integration	Assumes that separating people with mental illnesses from society is good for them and for society.	Assumes that integrating people with mental illnesses within society is good for them and for society.
Geographic Dispersion of Services	A range of general and specialized services is available in one location.	Ideally, a range of services is available locally. In fact, the range of services available varies from region to region. Expertise is often scattered and/or far away.
Care Coordination	Coordination of services occurs within the single institution.	Significant coordination of services among providers and levels of care is needed.
Funding Model	Funding goes directly to institution, which then provides the needed services. Access depends upon overall levels of appropriated funding.	Funding is controlled by many entities, primarily insurers. Access depends on employment or qualifying for public programs.

Figure 7: Comparison of Institutional and Community-Based Care

C.　　Increasingly Challenging Patient Flow Issues

One of the defining characteristics of a community-based model of care is that the individual receiving care has to move around to access services because the services are not all provided in one place. From the individual perspective, this is described as "getting the right services at the right time and place," and it can be extremely challenging to gain access to these services. An individual must be able to identify the appropriate services, qualify for funding for those services, and receive and manage a variety of services (as each service provides support for different aspects of an individual's recovery needs). From the system perspective, this requires smooth and efficient client flow through the system.

People with complex mental health illnesses and co-occurring conditions, especially symptoms that include aggression or violence, face significant barriers as they try to access the level of care and supports that they need. They make journeys through the service system over and over, cycling from hospital to residential placement to home to hospital. They are often "stuck" in levels of care that don't meet their needs while they wait for admission to an appropriate treatment or rehabilitation service. This ties up beds that are needed by others who *do* meet the criteria for that level of care. Those people then wait in inappropriate settings (jails, emergency rooms, and community hospital units) for beds to become available, often for days or weeks.

D.　　Sharing of the State Safety Net Role

In the 1950s, state hospitals were considered "safety net" institutions because they served anyone with serious mental illnesses (or intellectual disabilities), regardless of their ability to pay. Even into the 1980s and 1990s, counties counted on the state hospitals to accept clients whom private providers declined to serve. However, deinstitutionalization has meant that the state's safety net role has become increasingly shared with other public and private providers. Today, safety net providers care for: people who are uninsured or underinsured so that their services are at least partially paid for by public payers; people who are committed to the Commissioner of DHS; and/or people whose health challenges are so complex that, even with insurance, community-based providers cannot serve them. As deinstitutionalization progressed, safety net providers have come to include:

- Direct Care and Treatment (the provider arm of DHS)
- Community hospitals
- Community health programs and clinics (including dental)
- Community mental health and substance use disorder programs
- Public health agencies
- Providers of mental health and substance use disorder services in jails and prisons
- Foster care and nursing homes

The fact that the safety net role is now being filled by a variety of public and private providers has led to significant conflict over who has responsibility for serving people whom community providers decline to serve. State-operated facilities no longer have the capacity to be the "go-to" provider of last resort, even for people committed to the Commissioner of DHS, and some people wait for services in

inappropriate settings because there is no provider available to meet their needs. There is significant frustration across the mental health system about this situation.

Direct Care and Treatment has recently clarified its role as serving people who are committed to the Commissioner of DHS and who are not being served by private providers. In addition to the capacity issues discussed above, recent reports have also raised questions about the civil commitment process and the need for improvements to the process.[38]

E. Incarceration of People with Mental Illnesses

The question of how to best serve people with mental illnesses who are in the criminal justice system has received significant attention in Minnesota in recent years. Federal and state law require that jails and prisons provide health care services to inmates, yet most jails and prisons do not have the staffing, expertise, physical plant, or funding to provide adequate mental health services. Moreover, some people are incarcerated primarily as a result of their mental health symptoms rather than their criminality, even with our system of civil commitments for mental illnesses and chemical dependency. The inadequacy of crisis services in some locations, the fact that not enough police officers receive training on responding to people in mental health crises, and the dearth of secure mental health services means that people with mental illnesses are often unnecessarily jailed. This can lead to further mental health complications for the individual involved and significant challenges for law enforcement. This is a complex problem with social, legal, financial, and medical dimensions.

F. Person-Centered Care and Minnesota's Olmstead Plan

The Americans with Disabilities Act (ADA) defines certain mental health conditions as disabilities, thus giving protections to some people with mental illnesses who are served in the health care system.[39] The courts have interpreted the ADA to mean that people with qualifying mental health conditions have the right to live integrated lives in the community settings of their choice. Minnesota's Olmstead Plan lays out strategies for assuring that Minnesotans with disabilities can live self-directed lives and that services and service planning are "person-centered." According to the Plan,

> *"Person-centered planning is an organized process of discovery and action meant to improve a person's quality of life. Person-centered plans must identify what is important to a person (e.g., rituals, routines, relationships, life choices, status and control in areas that are meaningful to the person and lead to satisfaction, opportunity, comfort, and fulfillment) and what is important for the person (e.g., health, safety, compliance with laws and general social norms). What is*

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[38] Office of the Legislative Auditor, "Evaluation Report: State-Operated Human Services," February 2013, pp. 73-90; "Plan for the Anoka Metro Regional Treatment Center," op. cit., pp. 53-54.

[39] The ADA includes people with behavioral health conditions who meet one of these three criteria: "1) a physical or mental impairment that substantially limits one or more major life activities of the individual; 2) a record of such an impairment; or 3) being regarded as having such an impairment." *Americans With Disabilities Act of 1990*, Title 42, Chapter 126, Section 12102. Accessed on October 18, 2013 at http://www.ada.gov/pubs/adastatute08.htm#12102

important for the person must be addressed in the context of his or her life, goals and recovery. This means that people have the right and opportunity to be respected; share ordinary places in their communities; experience valued roles; be free from prejudice and stigmatization; experience social, physical, emotional and spiritual well-being; develop or maintain skills and abilities; be employed and have occupational and financial stability; gain self-acceptance; develop effective coping strategies; develop and maintain relationships; make choices about their daily lives; and achieve their personal goals. It also means that these critical aspects cannot be ignored or put aside in a quest to support health and safety or responsible use of public resources."[40]

The Minnesota Olmstead Plan is a comprehensive list of strategies and actions across the entire state to assure that people with disabilities can live integrated lives in the communities of their choice. It is bringing significant change in service provision for people with serious mental illnesses and people with mild mental illnesses and co-occurring conditions like intellectual or physical disabilities.

G.   Integration of Services

Minnesota's mental health system offers a wide range of services and supports, but they are often a confusing array of overlapping or disjointed services that leave people with mental illnesses and their families confused and frustrated. Mental health services are most effective when they are integrated with all of the other health care and social services that the person is receiving. Many types of integration are being pursued in Minnesota. Perhaps most basic is the function of case managers and care coordinators, professionals who help people understand what services are available and gain access to the services people need. Another type of integration is the integration of mental healthcare, substance use disorder treatment, and primary care services, most notably through the Minnesota 10 by 10 program, the COMPASS care management model, and through Behavioral Health Homes. Further integration across primary care, mental healthcare, substance use disorder treatment, and related social services is being pursued through managed care organizations, Accountable Communities for Health, and Certified Community Behavioral Health Clinics. Integration among levels of care (say from inpatient treatment to community mental health services) is being addressed in programs like the RARE program that is attempting to reduce inpatient readmissions through better discharge planning and through regional collaborations among providers.[41] Integration across sectors, including collaborations among courts, law enforcement, social services, schools, and healthcare, is also being pursued to make sure that people don't fall through the cracks between institutional silos. All of these integrative efforts are aimed at assisting the "whole person" to pursue resilience and recovery while controlling costs.

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[40] Putting the Promise of Olmstead into Practice: Minnesota's Olmstead Plan (Saint Paul: State of Minnesota, June 1, 2016 revisions), p. 35.

[41] "RARE: Reducing Avoidable Readmissions Effectively," website developed by the Institute for Clinical Systems Improvement, the Minnesota Hospital Association, and Stratis Health, accessed on 6/28/16 at http://www.rarereadmissions.org/.

H.   Shift from Episodic to Chronic Care Management Models

Supported by changes brought by the Affordable Care Act, health care is moving from an episodic model of care to chronic care models. Episodic medical care is aimed at a particular instance of illness and curing that illness. Chronic care management models are focused on long-term illnesses like diabetes and lupus and provide service coordination, social supports, and treatment to help the person live successfully with their condition. For the small percentage of people who have chronic mental illnesses, the chronic care model can help the person maintain wellness, react effectively in the face of relapse, and manage symptoms in order to live a satisfying life. Minnesota is experimenting with several chronic care management models, including the development of Behavioral Health Homes, Certified Community Behavioral Health Clinics, and accountable care organizations like Hennepin Health.

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Appendices are provided in separate document.

Appendix I: Governor's Executive Order

Appendix II: Links to Mental Health Reports

Appendix III: Adult Mental Health Initiative Regions and Children's Collaborative
Regions

Appendix IV: Acronyms in the Mental Health System