Maternal and Child Health Advisory Task Force

Infant, Child and Adolescent Mental Health Work Group

Summary Report

December 2008

Table of Contents

I. **Background** 3

II. **The Mental Health Work Group** 4

III. **A Public Health Approach to Mental Health** 5

IV. **Terminology** 8

V. **Disparities in Mental Health Services** 9

VI. **Recommendations, Strategies and Action Steps** 11

Attachment 1 22

Attachment 2 25

References 31

Summary Report of the

Maternal and Child Health Advisory Task Force

Infant, Child and Adolescent Mental Health Work Group

Background

In late 2006, the MCH Advisory Task Force released the *Monitoring Trends in Maternal and Child Health: Report and Recommendations of the Maternal and Child Health.*[1] This report described trends in the health status of mothers, infants and children in Minnesota and outlined recommendations and strategies in ten priority areas within three population groups. These population groups and priority areas include:

- **Population Group – Perinatal Health: Women of Child Bearing Age, Pregnant Women and Infants**
  Priority Area: Reduce infant mortality
  Priority Area: Reduce preterm and very preterm births
  Priority Area: Promote preconception and interconception health care
- **Population Group – Children and Adolescents**
  Priority Area: Prevent child maltreatment
  Priority Area: Promote the mental health of children and adolescents
  Priority Area: Prevent underage alcohol use
  Priority Area: Prevent teen pregnancy
- **Population Group – Children and Youth with Special Health Care Needs**
  Priority Area: Promote early identification and early intervention for children with special health care needs
  Priority Area: Promote access to health care and related services for children and youth with special health care needs
  Priority Area: Promote comprehensive care and coordination of services for children and youth with special health care needs

In October of 2007, the MCH Advisory Task Force convened a group to direct the next steps in defining the strategies outlined in the *Monitoring Trends* report. Three priority areas (one from each population group) were chosen for 2008. A work group would be convened for each area, bringing together Task Force members and partners with expertise in the priority area.

The priority area identified for further discussion in the Children and Adolescents population group was "Promote the mental health of children and adolescents." This priority area included four recommendations (recommendations 5-8 in the *Monitoring Trends* report):

- Recommendation 5: Promote healthy behaviors by supporting a public health model of mental health promotion.
- Recommendation 6: Collaborate with partners to enhance and coordinate activities targeted at promoting mental health.
- Recommendation 7: Increase access to mental health assessments and services for children and adolescents and their families.
- Recommendation 8: Strengthen capacity and infrastructure within the state to support mental health promotion and wellness.

These four recommendations and associated strategies served as the foundation for the discussions of the Mental Health Work Group.

The Mental Health Work Group

The Maternal and Child Health Advisory Committee convened a work group in July 2008 to begin to add further definition to a public health approach to children's mental health. The work of the Mental Health Work Group began with a series of presentations to the full MCH Advisory Task Force in June 2008. These presentations provided an overview of: 1) a public health approach to mental health; 2) what we know about infant, child, and adolescent mental health in Minnesota; and 3) what is happening to address infant, child, and adolescent mental health in Minnesota. This information will not be presented in this report but is available at: http://www.health.state.mn.us/divs/fh/mchatf/June08Materials.html.

The purpose of the work group was to build on the strategies presented in the *Monitoring Trends* report by identifying action steps that could help strengthen a public health approach to children's mental health in Minnesota. These action steps are included in a later section of this report.

Additionally, the work group spent considerable time discussing several broader issues that had an impact on the discussion and on the system for children's mental health. These issues include:

- What is a public health model for mental health?
- How do we reach a common terminology?
- How do we incorporate cultural differences and health disparities in our action steps?

Because these issues are overarching to all of the action steps discussed by the work group, they are presented as separate sections in this report and not included in the summary of the discussion on each strategy. Efforts were made to fully inform the discussion sharing multiple points of view.

This report attempts to convey the complexity of the issue and express the varied opinions of work group members. It is not intended provide all of the solutions. Instead, it is intended to lay the foundation for more work that needs to be done by public health, mental health providers, social services, education and multiple other community partners at both the state and local level to address this issue. It is hoped that agencies at the state and local level will consider the information in this report as they engage in discussions on mental health and more clearly define services for infant, children and adolescents.

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A Public Health Approach to Mental Health

The need to enhance a public health approach for mental health has been going on for years. Public health has long been involved in efforts to promote mental health and prevent mental illness. In addition, many in the mental health community have worked to promote mental health and prevent mental illness.

A public health approach typically addresses the needs of the entire population, but also focuses on individual, family and community wellness. A public health approach is also grounded in the belief that it is better to promote healthy behaviors and prevent illness, rather than treat illnesses after they occur. A public health approach includes addressing risk and protective factors that affect the mental health of children. These terms will be described more fully in the Terminology section of this report.

This section describes the model for a public health approach to children's mental health used by the work group. It also discusses possible roles for public health in children's mental health.

A Model for the Public Health Approach

Several models are available that attempt to describe a public health approach to mental health. In 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) released a report on promotion and prevention in mental health.[2] This report describes the public health context of children's mental health programs, defines risk and protective factors that affect children's mental health, discusses the costs and benefits of prevention and describes opportunities for implementing evidence-based practices. This report was used as a primary reference for the work group. Staff to the work group also relied heavily on a 2007 report by the Washington State Board of Health[3] on a public health approach to mental health in the development of this report.

Another effort that had a significant impact on the work group was the ongoing development of a new framework for a public health approach to mental health being developed by a team of Georgetown University faculty[4] through the support of SAMHSA. While this framework is still under review by SAMHSA, Georgetown has conducted a number of "listening sessions" and developed materials and a graphic representation of the model. The final result will be a monograph that can be used by leaders across the country. The purpose of the monograph will be:

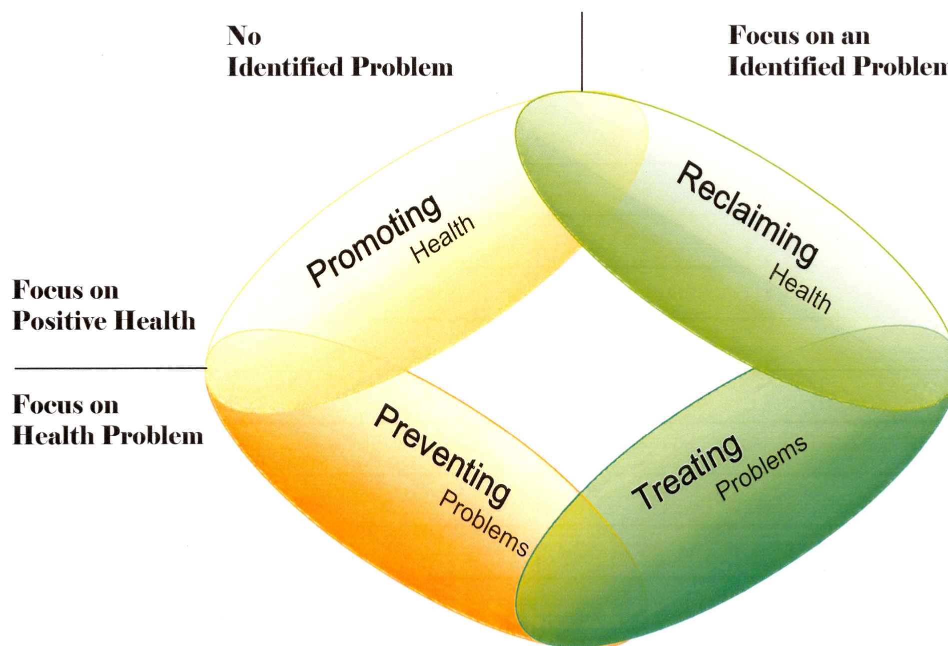
- To present a conceptual framework for a public health approach to mental health grounded in values, principles, and beliefs
- To link the array of environment supports, services and interventions from promotion, prevention, treatment, and maintenance
- To offer common definitions, language and milestones for a public health approach to mental health and promote their use
- To offer examples of promising and effective public health models, strategies and policies that community leaders and policy makers can use to implement a public health approach to mental health.[5]

It is anticipated that this monograph will be released in early 2009. It will be an important document in furthering the discussion on a public health approach to children's mental health and will address many of the issues raised by the work group. The MCH Advisory Task Force will need to consider reconvening the work

group after release of the document to consider if it contains information that might affect the action steps outlined in this report.

After review of several models representing "a public health approach to mental health," the work group chose to use the model developed for the Georgetown monograph (Figure 1).

Figure 1[6]



This model most accurately reflects the thinking of the work group and uses terminology that is consistent with the promotion and prevention approach. This model includes four key areas:

- **Promoting Health:** This is a focus on positive mental health with the absence of an identified problem. This area could be related to what is more commonly known as "primary prevention." These activities are universal, there is no specific target population, and the population being served has no specified identified need. This could include activities such as universal home visiting, training for effective parenting (ECFE), school programs (e.g. bullying prevention), and public education about mental health.
- **Preventing Problems:** This is a focus on preventing a specific health issue among a population with no identified health problem. This could be equated with "secondary prevention" Examples of activities might include home visiting for at-risk families, early intervention for infants at high-risk for developmental delays, suicide prevention programs for youth in schools.
- **Reclaiming Health:** This is a focus on positive health among a population with an identified mental health problem. This area could be equated with the more traditional "secondary prevention" by emphasizing recovery and maintenance of mental health, often after treatment. This could include activities that support positive mental health among children with special health needs, special education programs, and intensive parenting programs for mentally ill parents.
- **Treating Problems:** This is a focus on treating a specific mental health problem in a population with an identified mental health problem. This area could be equated with the more traditional "tertiary prevention." Activities may include preventing relapse, promoting long-term care, and rehabilitation.

To further clarify this model, Georgetown University presents a more detailed graphic (see Figure 2) to integrate the various kinds of interventions available and to assure that users see how their current approach can fit into this more comprehensive framework. It also attempts to move existing language that is more familiar to users into the new framework.

Figure 2[7]

Integrating the New Intervention Framework

	No identified health problem		**Focus on an identified health problem**		
Focus on (and Measurement of) Positive Health	Universal **Promoting**	Targeted **Promoting**	Early **Reclaiming** (includes *early identification* and *screening*)	**Reclaiming**	Ongoing **Reclaiming** (includes *Recovery*, job programs, etc.)
Focus on (and Measurement of) Health Problems	Universal **Preventing** (or Primary Preventing)	Targeted **Preventing** (includes Selective and Indicated Preventing)	Early **Treating** (includes Secondary Preventing, Early Identification and screening)	**Treating** (includes Standard Treating, Tertiary Prevention, Preventing worsening of symptoms & co-occurring problems)	Ongoing **Treating** (Continuing Care or Maintenance) Includes Tertiary Preventing, Preventing Relapse, Long-term Care, After-Care, Rehabilitation

This model represents the broad spectrum of mental health interventions, (from promotion to treatment). The work group appreciated the way in which this model distinguishes between promotion and prevention. This distinction is discussed more fully in the Terminology section of this report.

While the model covers the full spectrum of mental health, the focus of the work group was on the "front end" of the continuum and identification of strategies and action steps that promote mental health and prevent mental illness. This is not intended to diminish the need for treatment or support of those with mental illness. These issues were simply outside of the scope of this work group.

The Role of Public Health

A public health approach does not mean that public health agencies (state or local) should lead these efforts. However, public health agencies do have a role to play. Public health agencies are qualified and skilled at bringing together diverse partners to address health issues. They have a long history of working to promote healthy behaviors and prevent illness in areas such as immunizations, tobacco use, cancer, and chronic illnesses. In addition, public health agencies are already involved in mental health promotion activities such as family home visiting, Child and Teen Check-ups (C&TC), chemical health programs, suicide prevention, activities to reduce mental illness stigma, post-partum depression assessments, participation in children's mental health collaboratives, and developmental and social/emotional screening, just to name a few.

There are several other roles for public health agencies in children's mental health promotion and prevention that are based on the fundamentals of public health. These include identifying risk and protective factors, increasing awareness about mental disorders and treatment, working on policy to reduce stigma, assisting with surveillance, and incorporating mental health into maternal and child health and chronic disease prevention efforts.[8]

MDH has implemented a local public health Planning and Performance Measurement Reporting System (PPMRS). As part of this annual performance reporting system, local public health agencies report on program activities at the local level. These performance measures are organized into six areas of public health responsibility. Three of these areas – *Assure an Adequate Local Public Health Infrastructure*, *Promote Healthy Communities and Healthy Behaviors* and *Assure the Quality and Accessibility of Health Services* – contain measures that give an indication of local public health activities to address children's mental health. A sampling of these measures for 2007 is included in Attachment 1.

Terminology

This section of the report is intended to clarify terms that are used consistently throughout this document. Multiple agencies and individuals in multiple communities are involved in promoting the mental health of children. However, this report was developed as a result of a *public health* work group for a public health advisory committee. Therefore the terms are defined from that public health perspective.

Children's Mental Health

For brevity, the term children's mental health should be understood to mean the mental health of infants, children and adolescents. The work group did not specifically identify actions steps to address each of these age groups separately. Children's mental health encompasses the multiple social, emotional and developmental needs of children.

Mental Health and Mental Illness

For purposes of this report, the definitions of mental health and mental illness from the 1999 Surgeon General's Report on Mental Health[9] were used. Just as physical means more than the absence of illness, mental health means more than the absence of mental illness.

In the Surgeon General's Report on Mental Health, mental health is defined as, "a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity."

At the other end of the continuum lies mental illness. The term mental illness is used to refer to all the mental disorders that can be diagnosed. The Surgeon General's Report on Mental Health defines mental illness as, "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning."

Promotion and Prevention

A public health approach *means* a focus on promotion and prevention. For mental health, this means promoting behaviors and activities that enhance overall health and well being and preventing problems "upstream" to assure the best likelihood for success.

SAMHSA defines promotion (of mental health) as "efforts designed to enhance an individual's social competence, self-esteem, and sense of well-being." Prevention (of mental health problems) is defined as "interventions that occur before the onset of a problem, as well as interventions that prevent relapse, disability, and the consequences of severe mental illness or substance abuse."[10]

It is vital to support promotion and prevention activities and programs beyond the individual levels, as described in these definitions. To be successful, mental health promotion and prevention programs must focus not only on the individual, but on the family and community in which that individual lives. This includes creating strong coping skills and social networks and changing societal policies and attitudes regarding mental illness.

The "Whole Child"

Some strategies in this report refer to addressing the needs of the "whole child." This term refers to using a holistic approach when interacting with children and their families. It acknowledges the fact that children live within environments that have an effect on their physical health, emotional and social development, and their mental health. This term also acknowledges that mental health needs of children with special health needs may be overlooked and children with mental health issues may have physical health problems that need special attention. Programs should consider all aspects of the "whole child."

Evidence-Based Programs

The work group discussed the need to support and move Minnesota toward "evidence-based" activities and programs. SAMHSA defines an evidence-based program or practice as "one that has been proven through well-designed research to demonstrate positive outcomes for participants."[11]

When possible, evidence-based activities and programs should be implemented to achieve the recommendation. If evidence-based programs are not available, the work group suggests adapting proven programs to meet the specific needs of the community and undertaking an evaluation to measure success. The work group suggested that, over time, funding should be shifted to support programs that have proven results.

Risk and Protective Factors

There is significant research available on the impact of risk and protective factors on the success of promotion and prevention interventions. A public health approach to mental health emphasizes the identification of risk factors (and working to reduce them) and the identification of protective factors (and working to promote them).

In children, risk factors can include both biological and psychosocial experiences. Biological risk factors may not necessarily mean genetics, but could include injury, infection, poor nutrition, and exposure to toxins (such as lead). Psychosocial experiences that might impact a child's mental health include parental/caregiver discord, a parent/caregiver mental illness, lack of a loving, responsive caregiver relationship, economic hardship, exposure to violence, and poor care giving.[12] These adverse experiences can occur at the individual, family and community (schools, neighborhoods, cities, etc.) levels. In addition, these events can be cumulative over time and have long term ramifications for not only mental health but physical health as well.

On the positive side, protective factors are those events or supports in a child's life that enhance their ability to deal with stress and rebound from adverse events. These protective factors to promote resilience can also occur at the individual, family and community levels. Some examples include:

- At the individual child level: positive temperament, good intellectual functioning, self-confidence, skills for participation/success in school/community, faith, sense of control over life, sense of coherent identity;
- At the family level: close relationship with responsive parent/caregiver, structured and caring parenting, socioeconomic advantages, connections with supportive family networks, smaller family structure, clear standards of behavior, recognition for efforts and accomplishments;
- At the community level: ties to positive adults and organizations, good prenatal care, opportunities to be involved with positive peers, clear standards of behavior, recognition of efforts and accomplishments.[13]

Disparities in Mental Health Services

The work group discussed two broad areas of mental health disparities – disparities among different geographic areas and disparities among racial/ethnic populations. A 2001 supplement to the Surgeon General's Report on Mental Health attempted to analyze the impact of race, culture and ethnicity on mental health.[14] The report indicates that the overall annual prevalence of mental disorders for racial and ethnic minorities is similar to that of whites nationally. Data from the National Survey of Children's Health would support these finding for Minnesota as well. Additionally, studies have shown that the prevalence of mental illness in rural communities is no greater than in urban or suburban areas.[15]

Regardless of the prevalence of mental illness, race, ethnicity and geographic location do appear to impact the ability of a person to receive adequate mental health services. This includes both *access* to services and the *cultural appropriateness* of the services provided.

As part of an annual performance reporting system (the Local Public Health Planning and Performance Measurement Reporting System), local public health agencies report on program activities at the local level. One of these performance measures asks if the local health department has identified gaps in health care services. In 2007, 81% indicated a gap in mental health providers and 76% indicated a gap in mental health services. Additional measures for 2007 can be found in Attachment 1.

Culturally Appropriate Services

A common theme throughout the work group discussion was the need to provide services in a way that is culturally appropriate to the needs of the children and families. The work group strongly supports the need for a culturally competent mental health system that meets the diverse needs of consumers. The work group discussed not only the need to identify and train providers that share a common language or culture with consumers, but also the need to perhaps modify existing evidence-based practices to assure they are effective among diverse cultures.

Rural Services

In early 2005, the Rural Health Advisory Committee (RHAC) released an extensive report on the impact of mental health on Minnesota's rural communities. In that report they identified the following issues:

- Rural primary care providers are seeing an increase in mental/behavioral health issues in their clinics.
- The shortage of rural mental health providers results in long waits for appointments and long travel to obtain specialty care.
- The cost of mental health care and the complexity of the payment system are barriers for patients seeking care.
- The stigma about mental/behavioral health problems is a barrier to care, especially in rural areas.
- Rural primary care practitioners would like more education on managing mental/behavioral health.

To address these issues, the RHAC report identified a number of factors for improving mental health care in the primary care system, including:

- Availability of a trained professional workforce in primary and mental health care.
- Adequate funding so health systems are able to provide needed mental health services.
- Effective state and federal policies that support mental health care.

The recommendations from the RHAC were incorporated into the *Monitoring Trends* report as a strategy to achieve a public health approach to mental health. For purposes of this work group, the Office of Rural Health

and Primary Care provided an update on the status of these recommendations (Attachment 2). The work group fully supports these recommendations.

Recommendations, Strategies and Action Steps

This section of the report is based on the recommendations initially developed as part of the Monitoring Trends report. As noted in the Background section, the *Monitoring Trends* report included recommendations and strategies for three populations groups. The population group, Children and Adolescents, included three priority areas, one of which was to "Promote the mental health of children and adolescents." This priority area included four recommendations (recommendations 5-8 in the *Monitoring Trends* report).

To accomplish its work, the work group used the recommendations and strategies as a starting point. However, they chose to: 1) include actions steps that impact *infants* as well as children and adolescents, and 2) modify the recommendations and strategies from the original report for clarity and to more accurately reflect the purpose of the work group and report. The work group did not remove any strategies; however, strategies were added.

It is noted if the content and purpose of one strategy relates to another (e.g. Related strategy 5.3). If a strategy is so similar to another that it did not generate additional discussion by the work group, which is also noted.

RECOMMENDATION 5: Promote healthy behaviors by supporting a public health model of mental health.

STRATEGY 5.1: Work to assure resources and activities for mental health are balanced for all components of the mental health continuum (promotion, prevention, reclaiming, and treatment). (Related strategy: 8.2)

The *Monitoring Trends* report discussed increasing resource for prevention to create a balance along the mental health/illness continuum from promotion to treatment. This issue led to significant discussion among work group members. The concern was that if efforts are made to achieve a balance between promotion/prevention and treatment at the current funding level, much needed treatment could suffer. Balancing resources within the existing inadequate funding structure puts promotion, prevention and treatment programs at risk.

Because treatment of mental illness is costly, preventing the need for treatment through promotion and prevention programs makes economic sense. While promotion and prevention programs may require an investment "up front," they could have significant cost benefits far into the future. This is especially true for mental health promotion for infants and children. However, it is important to recognize that not all mental illnesses are preventable and hence, treatment will continue to be needed.

There was agreement that there is not enough funding devoted to promotion and prevention, but achieving a balance with existing funding would be difficult. To achieve balance, funding will need to increase for promotion, prevention and treatment, thereby not having a negative impact anywhere on the mental health continuum.

One way to begin to balance promotion and prevention activities with reclaiming and treatment activities is to assure that activities that are being funded are evidence based and have performance measures in place to track their success (see Strategy 5.2). One of the challenges with trying to balance resources by supporting evidence-based activities is that currently there is not a coordinated, systematic way to track the outcomes of

children's mental health programs and services. The magnitude of programs and funding streams has led to a complex and disjointed system of prevention and promotion activities. The work group expressed concern that if there is no systematic documentation of the programs being offered and their outcomes, should state agencies continue to fund programs without information regarding their successes?

Action Steps

1. Continue to support efforts to increase children's mental health funding – specifically funding that promotes mental health and prevents mental illness.

STRATEGY 5.2: Support evidence-based promotion and prevention programs that serve and promote the health of the whole child.

While acknowledging that programs in the state seem to be moving in the direction of addressing the needs of the *whole child* through evidence-based programs, there is currently no clear understanding of which programs are working. Minnesota lacks a comprehensive system for identification, tracking and assessment of mental health promotion and prevention services. The Minnesota Departments of Health, Education, and Human Services all provide (through multiple funding streams) funding for mental health promotion and prevention services. However, there is not a comprehensive inventory of these programs, nor is there adequate evaluation or outcome data on many of these programs.

The three state agencies represented on the work group provided a brief overview of a sample of the program monitoring activities that support children's mental health:

- In 2003, the Minnesota Department of Education developed a report on the funding available to local school districts and maintained a comprehensive inventory of programs funded with state and federal dollars. Due to cuts in funding and staff, the agency was unable to maintain this inventory. Additionally, each school district has the flexibility to choose their own programs, making it difficult to implement a statewide performance measurement system for school-based programs.
- The Minnesota Department of Human Services provides funding for children's mental health collaboratives. While each collaborative is required to report on their activities, again there is no statewide documentation of outcomes. Every collaborative is allowed to identify the target population and goals that best serve their respective community. This prohibits development of consistent performance measures statewide.
- The Minnesota Department of Health asks local public health departments to report on a number of performance measures. Some of these measures relate to infant, child and adolescent mental health (Attachment 1). While these measures allow local public health to report on activities, they are not a measure of program success.

This is not to say the individual programs at the local level do not have measures in place to evaluate program success. This only indicates that there is currently no *systematic statewide* way to gather and consolidate this information. No state agency currently has the resources or staff capacity to conduct a comprehensive environmental scan of programs that affect the mental health of infants, children and adolescents.

Action Steps

1. Define and then document existing evidence-based mental health promotion and prevention programs.
2. Increase the use of practices in mental health prevention and promotion programs that are evidence-based, evaluated and proven.
3. Increase expectations on outcomes within funded programs. Federal funding is increasing requirements for outcomes and agencies will need adapt to these changing expectations

4. Promote the development (or appropriate adaptations) of evidence-based programs where they do not currently exist (promising practices, cultural adaptations).

STRATEGY 5.3: Support programs that increase mental health protective factors and decrease risk factors with special consideration to target populations at higher risk of future mental health problems. (Related strategy: 6.2)

This strategy was revised significantly from the original report. The work group chose to focus on the impact of risk and protective factors on a child's future mental health. Risk and protective factors and their impact on the mental health of children are discussed more fully in the Terminology section.

The group discussed that activities may need to be tailored to more specifically address the needs of children at greatest risk for future mental health problems. This should not be limited to promotion and prevention activities, but should address adapting programs across the entire spectrum of mental health services and across all age groups.

Work should be done to identify strategies that work best with specific at-risk populations. This may include adapting evidence-based practices to meet the needs of specific populations. Much of this work will need to take place at the community level where the needs of at-risk populations are better known.

Action Steps

1. Adapt programs to meet the specific needs of at risk populations, including children with special health needs, population of color, American Indians, and children living in poverty.
2. Work with communities to adapt evidence-based practices to more appropriately meet the needs of specific at-risk populations and continue to evaluate the outcomes of those adapted programs.

STRATEGY 5.4: Support efforts that reduce the stigma of mental health problems.

As noted in the previous strategy, children benefit from strong community support and social networks. These social networks need to increase across all age groups and among all at-risk populations. One avenue to enhance this support for children is to reduce the social stigma still associated with mental illness.

Methods to change this stigma may vary among communities. Each community (and population within that community) holds different values and norms. What works with one community or racial/ethnic group may not work for another. Effort to reduce stigma should provide ways to promote mental health of children and families and also encourage families to seek help. Schools could serve as an important location for working with students and caregivers on reducing stigma in school-aged children and adolescents.

Typically mental health promotion messages may be more easily accepted because they target large segments of the community. For example, universal family home visiting by local public health departments does not categorize families into an at-risk group and may be more readily accepted by the community.

Action Steps

1. Work with communities and as a state to decrease stigma and increase understanding of mental illness and its impact on society. Adapt these messages so they are appropriate to different communities and applicable to special populations within the community.
2. Increase community understanding of the availability of mental health services and resources and the benefits of participation in programs in an attempt to reduce fear and reluctance within the target community of receiving services.

3. Statewide standards should be developed for use in the school setting for educating students on mental illness (e.g. what is mental health, what is mental illness, where do I go for help, etc.).

STRATEGY 5.5: Promote understanding of the relationship between the mental health needs of parents/caregivers and their ability to parent successfully. (Related strategy: 7.3)

The mental health needs of parents/caregivers can significantly impact the mental health of their children. As noted in the discussion on risk and protective factors, the mental health of children can be positively or negatively influenced by the health of the caregivers and the family system. Parents/caregivers need access to mental health services to assure they are able to be successful in raising mentally healthy children.

Activities to assess the mental health of parents/caregivers, including screening for maternal depression and maternal drug use, have been on the rise. At the community level, public health, social services, education and primary care providers work together to better address both the mental health and public health issues of parenting. Some examples of activities include:

- Public health family home visitors assess the mental health of mothers/caregivers/families both prenatally and post partum.
- Many primary care providers are screening for maternal depression following delivery and during routine prenatal care.
- Mental health workers are working with public health and primary care to address the mental health needs of parents/caregivers.
- Communities are coming together to increase the number of parenting programs for those diagnosed with a mental illness.
- Communities are working together to better integrate all of these programs into a comprehensive set of services for children and families.

Action Steps

1. Continue to provide education for public health, mental health, education and primary care providers on screening parents/caregivers for mental health problems.
2. Increase mental health support to caregivers and enhance the quality of parenting available to the child.
3. Support the evidence-based screening tools that look at the mental health needs of the whole family.
4. Work with primary care clinics to identify needs and information about the services available to parents/caregivers at risk for mental illness.
5. Develop and share post-screening protocols for working with parents/caregivers at risk for mental illness.

STRATEGY 5.6: Support the Local Public Health Association recommendations regarding a public health approach to mental health.

The Minnesota Local Public Health Association (LPHA) continues to promote a public health approach to mental health as part of its legislative platform. This issue has been on the legislative platform for the last two years. For the upcoming legislative session, LPHA will be refocusing their platform to strengthen the prevention and promotion aspects of mental health. The platform will focus on mental “wellness” with a stronger public health approach.

Action Steps

1. Continue to support the LPHA position on a public health approach to mental health.
2. Upon request, provide information to LPHA for use with policy makers.
3. Provide research data on the role/impact of public health in mental health promotion.

RECOMMENDATION 6: Collaborate with partners to enhance and coordinate activities targeted at promoting mental health and preventing mental illness.

STRATEGY 6.1: Sustain and support public health's role in mobilizing partnerships to promote mental health. (Related strategy: 6.4)

The work group emphasized the need to support the public health role in mobilizing partnerships at both the state and local level. Public health agencies are skilled at bringing together diverse partners to address health issues. This does not mean that public health agencies (state or local) should always lead these efforts. However, public health agencies do have a role to play.

At the state level, the Departments of Health, Education and Human Services work together on numerous programs and activities related to the promotion of children's mental health – MECCSS, C&TC, Part C, Head Start, to name a few. These agencies also participate on multiple statewide advisory committees to address children's mental health, early intervention, early education, etc.

Local public health has always played a significant role in working with community partners to address public health needs. Local public health departments are often able to serve as a neutral partner to convene groups to address complex issues. Local groups are better able to support activities tailored to cultural needs of their respective community.

In the 2007 LPH-PPMRS, 100% of local public health departments reported that they participate in collaborative efforts to improve community health. While not specific to mental health, this does indicate that local public health undertakes efforts to mobilize community partnerships. In the examples provided by local public health, most participate in a mental health or early intervention collaborative at the local level (see Attachment 1).

The work group noted that the decrease in child care resources at the local level has led to an increased use of family, friends and neighbors to care for their children. This will be an additional challenge for local public health and community partners as they work with this less formal network of child care providers to assure they have the information they need to support the healthy mental development of children.

Action Steps

1. Continue coordination of activities at the state and local level to identify and solve mental health needs of infants, children and adolescents.
2. Increase efforts to include informal networks of child care providers in mental health promotion and prevention activities.

STRATEGY 6.2: Collaborate and build capacity across all systems to serve moderate risk families for whom services might have the greatest prevention impact. (Related strategy: 5.3)

The work group discussed the impact of moderate risk exposure and continuing stress on the mental health of children. As noted in the information on risk and protective factors, these stressors can be cumulative and have long term consequences on the mental and physical health of children. The work group also discussed the CDC Adverse Childhood Events (ACE) study which showed the relationship between multiple categories of childhood trauma (ACEs), and poor health and behavioral outcomes later in life.[16]

The focus of the work group discussion was on the difficulty in identifying moderate risk families. High risk families are more readily identifiable through obvious risk factors and may be afforded greater access to

services. The services needed by high risk families should not be diminished. However, dealing with chronic, moderate risks factors within a non-supportive environment or an environment devoid of protective factors can lead to compounded effects on the mental and physical health of children. For example, the current economic downturn poses a moderate risk for many families, as well as a high risk for those families who lose jobs, housing, and have inadequate resources for food and basic necessities.

Work will be needed to assist providers in the identification of families at moderate risk and increase their understanding of the impact of these risk factors on children. Moderate risk families will need access to services that can strengthen their capacity to decrease risk factors and increase protective factors.

Action Steps

1. Continue to work with primary care providers to increase understanding of the impact of moderate risk and ongoing stressors on families and the implications for prevention of mental health problems.
2. Encourage primary care providers to assess children/families on moderate risk and ongoing stressors and use that as a "jumping off" point for services.
3. Increase awareness in schools of moderate risk and adverse events on children.
4. Work with communities to build the number of protective factors available to families with moderate risk.

STRATEGY 6.3: Partner with the Minnesota Department of Human Services to support and promote increased training and utilization of the Diagnostic Criteria (DC) 0-3 codes and crosswalk for diagnosis, treatment and reimbursement of services for children with mental health needs.

DC: 0-3R training prepares mental health clinicians to diagnose the mental health and developmental difficulties of infancy and early childhood. In 2007, DHS and MDH (MCSHN) offered a series of trainings on DC: 0-3. The training was designed for mental health professionals working within the infant-family field who have experience with diagnostic procedures using DSM-IV or ICD-9/10 criteria. The session included how and why DC: 0-3R was developed, the underlying philosophy and approach, principles of effective mental health and developmental assessment of infants and toddlers, the five axes and the major diagnostic categories in DC: 0-3R, and use of decision trees and crosswalks to DSM-IV-TR or ICD 9/10. Multiple trainings were offered at both the introductory and diagnostic level.

There has been no state-sponsored training since late 2007. However, some communities have paid for and hosted their own DC: 0-3 trainings. DHS recently received funding for six additional trainings. Planning is underway to determine the location of these trainings.

Action Steps

1. Continue to provide and promote DC: 0-3 training.
2. Develop a mechanism to support those trained in DC: 0-3 to enhance their implementation skills.
3. Increase the number of self-insured providers participating in DC: 0-3 trainings.

STRATEGY 6.4: Ensure representation of public health in early childhood mental health activities at the state and local level. (Related strategy: 6.1)

There are multiple committees and collaborative groups at the state and local level working to address early intervention, early education, and early mental health services for children. At the state level, several interagency committees work to address the complex array of services available. These include (but are not limited to) the Governor's Interagency Coordinating Council, Children's Mental Health Advisory Committee, State Advisory Council on Early Education and Care, Minnesota Early Childhood Comprehensive Screening

Systems Leadership Team, and Family Home Visiting Steering Committee. Each of these committees has representatives of public health (MDH and/or local public health).

At the local level, public health departments actively participate in numerous community partnerships and collaboratives to support early intervention and children's mental health (see Attachment1). In 2007, 100% of local public health departments reported that they participated in some type of collaborative activity to improve the health of their communities. Attachment 1 provides examples of collaborative activities related to children's mental health.

Action Steps

1. Both local and state public health agencies should continue their active participation and leadership in activities that support children's mental health.

STRATEGY 6.5: Facilitate collaboration among state agencies, counties, community organizations, and health plans to expand early childhood pre-school centers/services to serve young children with identified social-emotional needs.

Due to the increase in informal childcare networks (families, friends and neighbors), it is difficult to find a consistent way to provide education to child care providers. This is not a formally recognized system at the national level. These informal networks often provide childcare for racially and ethnically diverse populations.

In Minnesota, efforts are being made to expand child development training for this group. At both the state and local level, organizations are attempting to increase education of child care providers and all child serving agencies on the need to provide developmentally appropriate activities for children.

One initiative underway in parts of the metro area and two greater Minnesota communities is Parent Aware (www.parentawareratings.org/). Parent Aware voluntarily evaluates and rates child care centers, preschools and home sites. Participating providers can receive a one- to four-star rating to let caregivers know how well they prepare children for school. The ratings are based on many factors, including staff experience and qualifications, family education, adult-child interactions and the progress of children in the program.

In addition, efforts are underway to increase the availability of mental health consultants to serve as a resource to child-serving organizations, including child care providers. Use of mental health consultants will expand the availability of expertise on children's mental health.

Action Steps

1. Increase training/education of child care providers to assure they have information specific to the age and cultural, social, and developmental needs of the children they serve.
2. At the local level, continue and increase collaboration with child care providers to assure access to developmentally, age, and culturally appropriate information.
3. Increase the use of mental health consultation to expand expertise on the social-emotional needs of young children.

RECOMMENDATION 7: Increase access to mental health assessments and services for children and adolescents and their families.

STRATEGY 7.1: Work with partners to increase access to services for children who are found through screening to have a need for further assessment.

The screening process is a means to find and identify children who may need further health, social-emotional, or developmental assessment, to promote healthy development, and to connect families with resources. Multiple organizations at the local level are involved in the screening process.

Many local communities have a comprehensive system to assure screening of children; however, many still struggle with assuring the referral of children in need of further assessment to the *appropriate* services, particularly those children who do not qualify for special services. As previously noted, there is no comprehensive directory of available services. Nor is there a directory of the types or levels of services available. Many communities are trying to develop this list of resources at the local level to assure appropriate referral such as further assessment or evaluation.

To address this issue, the work group recommends that a group of stakeholders be convened to identify available resources related to social-emotional and behavioral needs of children to develop guidance on appropriate referrals. Due to the complexity of the current system, the group acknowledged that this could be a major undertaking and may not be realistic at a state level and would perhaps need to be undertaken at the local level.

Action Steps

1. Convene a group of stakeholders (at the state or local level) to further explore the feasibility of:
    - Identifying available resources for the further assessment of children identified through screening.
    - Developing guidance on appropriate referrals based on the issues identified during screening.

STRATEGY 7.2 Document unmet service delivery needs for children who are identified through screening. (Related strategy 8.6)

As noted above, the current erratic system for reporting screening and follow-up activities makes it difficult to identify gaps in service delivery needs. Due to the lack of a systematic reporting system, it is difficult to identify evidence of demand for services that are not being met.

There has been an increase in the use of developmental and social-emotional screening. Infants and children identified through screening are monitored. However, there is no coordinated system in place for screening adolescents. Basic mental health screening of adolescents mainly occurs in the primary care setting, but adolescents infrequently use the primary care system. This has led to a gap in the capacity to comprehensively monitor or evaluate adolescents' mental health needs.

The work group also noted that children with an identified special *physical health* need are less likely to be screened for *other* developmental (i.e., behavioral/social/emotional) needs. Work should be done with providers working with children with special health needs to assure they are comprehensively assessed for all developmental, social and emotional needs.

The work group discussed the need to provide additional support and education of school nurses and increase support of school-based health services in high schools. This increase could lead to the expansion of the number of school-aged children being screened for mental health problems.

Action Steps

1. Develop a system for documenting the unmet needs of children identified through screening.
2. Develop a strategy to systematically screen school-aged children.
3. Include school-aged children in a comprehensive documentation system.
4. Provide support and education of school nurses on the mental health needs of school-aged children.

5. Work with primary care providers to increase the mental health screening of adolescents and children with special health needs.

STRATEGY 7.3 Work with partners to increase access to services for caregivers' mental health needs. (Related strategy: 5.5)

The work group discussed the impact of caregivers' mental health (including substance abuse) on the mental health of children. As noted earlier, race, ethnicity and geographic location impact the ability of a person to receive adequate mental health promotion, prevention and treatment services.

Action Steps

1. Explore options to increase the availability of mental health providers, including bilingual/bicultural mental health providers. This could include:
    - Increased training of mental health providers.
    - Increased training of bilingual/bicultural providers.
    - Increased awareness of mental health provider training programs, including recruitment in areas that are more diverse (e.g. community colleges, tribal universities).
2. Further explore and expand the use of "telehealth" resources to increase access to mental health services.
3. Increase the awareness of primary care providers about the mental health needs of caregivers.
4. Explore the option of a "community health worker" type mental health provider to bridge families who have poorer utilization and access to services.

STRATEGY 7.4: Continue to work towards implementation of the Rural Health Advisory Committee (RHAC) recommendations on access in the RHAC Report on Mental Health and Primary Care of January 2005. (Related strategy: 7.4)

In early 2005, the Rural Health Advisory Committee (RHAC) released an extensive report on the impact of mental health on Minnesota's rural communities. The report identified a number of factors for improving mental health care in the primary care system, including:

- Availability of a trained professional workforce in primary and mental health care.
- Adequate funding so health systems are able to provide needed mental health services.
- Effective state and federal policies that support mental health care.

For purposes of this work group, the Office of Rural Health and Primary Care provided an update on the status of these recommendations (Attachment 2). The work group fully supports these recommendations.

Action Steps

1. Continue to support the activities of the Rural Health Advisory Committee to address recommendations outlined in the RHAC report.

RECOMMENDATION 8: Strengthen capacity and infrastructure within the state to support mental health promotion and wellness.

STRATEGY 8.1: Strengthen the state level infrastructure to support a public health approach to children's mental health.

The work group discussed the need to strengthen the attention devoted to mental health (children's mental health in particular) at the Minnesota Department of Health. Given budget constraints and changes in federal and state funding, the MDH only recently filled a part time position to support mental health activities. The

work group recommends that MDH assure the appropriate level of staffing to adequately support children's mental health promotion and prevention activities.

Action Steps

1. Assure a full-time staff position at the MDH with a focused on children's mental health promotion and mental illness prevention.

STRATEGY 8.2: Advocate for the investment of additional resources for promotion and prevention as a cost-saving measure that could reduce the need for expensive treatment interventions. (Related strategy: 5.1)

As discussed in Strategy 5.1, the group supports the investment in prevention as a cost-saving measure. However, there was concern that any increase must occur while maintaining a balance between prevention and treatment.

There are significant unmet needs in both mental health prevention and treatment resources. The group did acknowledge that additional investments in mental health promotion and prevention would lead to the development of healthy and successful families that would ultimately result in a cost-savings to society. The group also noted that not all mental illnesses can be prevented and therefore prevention may lead to only a partial reduction in the need for treatment services.

Action Steps

1. Continue to advocate for mental health promotion and prevention resources while maintaining a balance with mental health reclaiming and treatment resources.

STRATEGY 8.3: Continue to work towards implementation of the RHAC recommendations regarding health professional education to build capacity – especially as they relate to the unique social-emotional development of children. (Related strategy: 7.4)

No additional discussion by the work group. See Strategy 7.4.

Action Steps

1. See action steps identified in Strategy 7.4.

STRATEGY 8.4: Encourage and support use of the screening tools for social-emotional and behavioral development of young children as recommended by the Minnesota Interagency Developmental Screening Task Force (Minnesota Departments of Health, Education, and Human Services).

The Minnesota Interagency Developmental Screening Task Force supports the use of screening tools for social-emotional development. They did not, however, agree on one recommended tool given that multiple tools assess components of behavioral health in children.

Action Steps

1. Continue to increase the use of social-emotional screening tools with young children.
2. Encourage the Minnesota Interagency Developmental Screening Task Force or other committees to continue to address how to increase screening at the middle school and adolescent ages.

STRATEGY 8.5: Document unmet service delivery needs for children who are identified through screening. (Related strategy: 7.2)

No additional discussion by the work group. See Strategy 7.2.

Action Steps

1. See action steps identified in Strategy 7.2.

STRATEGY 8.6: Collect and analyze data from the Ages & Stages Questionnaires: Social – Emotional (ASQ-SE) on both a statewide and regional level, paying specific attention to referral and follow-up activities. (Related strategy 7.2)

Data from the ASQ-SE are being collected in a variety of ways through a variety of agencies. There is currently no one central repository for the submission or analysis of these data. Additionally, there are currently no resources available to create a more central data collection and analysis system for these data.

The work group discussed that a possible proxy measurement system is the data collected for the Follow-Along Program (FAP). The FAP has data available, in multiple configurations (local public health, tribal government, regional, and statewide) on children participating in FAP and the results of their ASQ and ASQ-SE pass/fail domains. In addition, referral and follow-up activity is available on FAP participants.

Action Steps

1. Where possible, local agencies should use local data from ASQ-SE screenings to monitor trends in infant and child mental health.

STRATEGY 8.7: Support and promote increased training and utilization of the DC 0-3 codes and crosswalk for diagnosis, treatment and reimbursement of services for children with mental health needs.

No additional discussion by the work group. See Strategy 6.3.

Action Steps

1. See action steps identified in Strategy 6.3.

ATTACHMENT 1

Local Public Health PPMRS
Summary of 2007 Mental Health Related Activities

Assure an Adequate Local Public Health Infrastructure

100% of local health department participated in collaborative/partnership efforts to improve community health and address public health issues. Examples include (mental health-related examples only):

- Local early identification collaboration
- Local child abuse prevention collaboration
- Children's Mental Health Collaborative
- Community mental health collaborative
- Home visiting collaborative
- Success by 6 Impact team
- Family Services collaborative
- Prenatal Early Childhood Coalition
- Child and Teen Check-up Regional Partnership
- Interagency Service Committee
- Early Childhood Initiative
- Early Intervention Committee
- Chemical Health Initiative
- Hispanic Health network
- Systems of Care collaborative
- Healthy Communities Collaborative
- Nurse-Family Partnership
- Follow Along Steering Committee
- Twin Cities Healthy Start
- Adolescent County Collaborative
- Children's Cabinet/Collaborative
- Preplacement Screening Team
- FASD Connection
- Daycare Association

Promote Healthy Communities and Healthy Behaviors (This area or responsibility includes reports on 31 topic areas.)

Infant, Child, and Adolescent Growth and Development

69 of 75 (92%)	LHDs provide programs (activities with designated staff and/or budget)
5 of 75 (7%)	LHDs provide promotion/educational activities
1 of 75 (1%)	LHDs provide no activities/services

Program examples include:
- Family home visiting
- Follow-along
- Parenting programs
- Developmental, social/emotional screening

- Child & Teen Check-Up
- Early intervention services
- Teen pregnancy/parenting support
- CSHN education/support
- Adolescent health programs
- Prenatal education

Mental Health (including suicide)

22 of 75 (29%)	LHDs provide programs (activities with designated staff and/or budget)
24 of 75 (32%)	LHDs provide promotion/educational activities
29 of 75 (39%)	LHDs provide no activities/services

Program examples include:

- Community activities/education to reduce stigma
- Suicide prevention assessment in city/county jails
- Post-partum depression assessment during family home visiting (prenatal and postpartum)
- Mental health status assessment during home health care service visits
- Mental health status assessment during contacts (family planning, WIC, pregnancy testing, etc.)
- Participation in children's mental health collaborative/initiatives
- Convening of early childhood professionals to discuss children's mental health
- "Mapping" of local mental health resources
- Mental Telehealth consultation
- Psychological first aid training
- QI projects on delivery of children's mental health services
- Bullying prevention projects
- Developmental, social/emotional screening
- Co-location of PHNs in schools

Assure the Quality and Accessibility of Health Services

- Local health departments *identified* and *worked to address* gaps in health care services or access to health care.

Gap	Identified	Addressed
Dental services	92%	81%
Transportation	88%	53%
Lack of insurance	85%	73%
Dental providers	83%	73%
Primary care providers	83%	7%
Mental health providers	81%	40%
Mental health services	76%	34%

- Describe progress and/or results the public health department has made to address gaps in and barriers to health care services in the community. (Mental health-related examples only)
  - Increased children's mental health service with the addition of a CMH specialist in local mental health initiative.
  - A community group of medical providers, public health, social services, Head Start and others are meeting to address children's access to mental health services.
  - Developing program with human services to provide a clinical nurse specialist and a psychiatrist for mental health population.

- A coordinated care model to increase early identification, assessment and treatment of children with mental health problems. This model establishes a consultation relationship between primary care providers and child-adolescent psychiatrists, thereby addressing the severely limited access to child-adolescent psychiatric services.
- The region was successful in hiring a psychiatrist to work across the region.
- The public health department participates in a collaborative process called the THIRVE Initiative that is funded by the Southern Minnesota Initiative Foundation to address gaps in children's mental health services.
- Using mental health screening tool at C&TC to identify those needing further services.
- Assisted Family Services in increasing the hours that a Psychiatric Nurse Practitioner is available to residents.
- Member of the Northwest Council of Collaborative. This organization has been successful in receiving millions of dollars in grants to meet the mental health needs of clients in our rural community, which is lacking in mental health providers.
- Public health is planning with social services and mental health center to bring more direct services into county rather than having to go out of the county to obtain.

- Indicate the programs or services the local health department provided and/or contracted for to fill a health service gap or to coordinate/link people to services.
  - C&TC outreach (95%)
  - Family home visiting (91%)
  - Following along program (91%)
  - Early intervention service coordination for CSHN (83%)
  - C&TC clinics (55%)

ATTACHMENT 2

Mental Health and Primary Care in Rural Minnesota Report – Recommendations Update (9/08)

A) Health Professional Education Recommendations in this section are targeted at academic health programs that train medical students, nurses, mental health professionals and other health professionals who care for patients with mental/behavioral health concerns. These recommendations also apply to health professional organizations and associations responsible for continuing education of their constituents. *Comments provided by Ray Christensen, UM-Duluth Medical School faculty and original workgroup member.	
A-1. Enhance and promote mental/behavioral health education and training for all health profession students training in primary practice.	○ The awareness has been raised and clinical education is addressing it more, but not formalized. Residencies utilize psychologists, but have for some time in family medicine.*
A-2. Enhance mental/behavioral health training for those in family medicine residencies. It is critical that family medicine physicians, in particular those planning to practice in rural areas, have an understanding of the interaction between physical and mental health and disease, and are adequately prepared to diagnose, treat and/or refer patients with mental or behavioral conditions. The UMN and Mayo Medical Schools should seek out practicing rural and family medicine physicians who successfully collaborate with mental health practitioners (either on-site or via telehealth) and develop education and residency programs that highlight the experience of these teams.	○ We do not know whether there is an increase or changes in the education. Awareness is provided in the basic science education and most of the educating occurs in clinical training. It is a part of family medicine residency training as well as pediatrics and internal medicine.*
A-3. Promote and develop rural site experiences for primary care and mental health practitioners that emphasize collaborative practice within the primary care setting. As a starting point, curriculum developers should tap into lessons learned through the experience of the University of Minnesota Rural Health School, which was recently absorbed into the Minnesota Area Health Education Center (AHEC) program. The overall goal of the Rural Health School was to prepare rural health care providers to practice in interdisciplinary teams. In addition, curriculum/site developers should explore potential on-site training experiences with the successful collaborative teams identified in recommendation A-2.	○ 2008 Rural Health Conference breakout session: New Models of Care: Interprofessional Practice and Education Teams (PDF: 160KB/25pgs) ○ MN Academy of Family Physicians and other CME recognize this need and provide didactic materials for attendees. No knowledge of an increase and cannot speak to the local CME offerings at clinics and hospitals.*
A-4. Develop and support rural site experiences for those in psychiatric residency programs. Curriculum/site developers should think creatively about potential on-site residency opportunities, including community mental health centers, state Regional Treatment Centers, correctional facilities and programs, larger regional hospitals and clinics in rural areas of the state (e.g., Marshall, Bemidji, Willmar, Mankato), as well as sites served by the successful teams identified in recommendation A-1.	○ 2008 Rural Health Conference breakout session: Design, Implementation and Progress of a Post-Doctoral Residency in Rural Psychology (Detroit Lakes) ○ Not aware of any progress on this initiative. A problem is lack of central direction from the state or similar body. This is a state wide problem and I am not sure we have good local solutions. Does the dept of health need a high visibility position to address this need?*
A-5. Develop and support mental health related continuing education for rural primary care providers through accessible means such as distance learning (including Web applications), regional conferences and traveling programs. Traveling programs should consider modeling their approach after the Comprehensive Advanced Life Support (CALS) course. CALS is structured to maximize the intensity and volume of material presented, while minimizing the amount of time providers need to take away from	○ 2008 Rural Health Conference breakout session: CALS: Emergency Team Training for Rural Health Care Providers (PDF: 1MB/63pgs)

their practice or facility. Continuing education opportunities should be developed collaboratively with the Minnesota Department of Human Services. Existing trainings for mental health professionals could be expanded and adapted to include primary care providers.	
A-6. Include mental/behavioral health content in conferences and other continuing education opportunities for primary care physicians, nurses, nurse practitioners, physicians' assistants and nursing assistants, as well as nontraditional audiences such as pharmacists, dentists, school nurses and counselors and law enforcement personnel.	○ 2007 Rural Health conference breakout session: Mobile Mental Health Support for Rural Older Adults ○ Difficult to measure except by pulling the offerings for the past five years and counting hours.*
B) Health Systems Health systems include a variety of entities including health care provider systems and networks, hospitals, clinics and payer systems.	
B-1. Promote and support demonstration projects and models of collaborative care between mental health providers and primary care providers. Successful examples include co-location of services, integration of services within the primary care clinic system, and the "shared care" model. Work group members' experience and the relevant literature point to collaborative models of care as one of the most effective and efficient means of integrating mental health and primary care services to better meet the needs of patients.	○ The Center for Rural Mental Health Studies (CRMHS) at the University of Minnesota Medical School Duluth is integrating mental health into primary care settings for underserved rural populations. CRMHS partners with the Family Medicine clinics in Bigfork, Cook, Ely, Littlefork, Mora and Paynesville, Minnesota communities to provide telemental health consultative services: www.med.umn.edu/duluth/about/CRMHS/home.html ○ St. Elizabeth's Medical Center brought a together multidisciplinary team to undergo onsite, computer-based, specialized training as a group in recognizing and caring for patients and residents with dementia and Alzheimer's disease. St. Elizabeth's sponsors community Alzheimer's prevention programs, shares Alzheimer's and dementia information with local primary care clinics and community, and sponsors a local caregiver expert team available to when hospital staff need additional knowledge, resources and assistance.
B-2. Develop a common set of mental health benefits. Support the work being done through the Minnesota Mental Health Action Group (MMHAG) to develop a basic set of mental health benefits common to all health plans. With the development of this common benefit set, people who change insurance could be assured of continuity of coverage levels for mental and behavioral health services, and providers would benefit from administrative consistency across plans. Even with a common benefit set, it is important to bear in mind that rural Minnesotans are more likely to be uninsured or under-insured than their urban counterparts. Therefore, efforts to promote coverage/service options for rural Minnesotans who lack or have inadequate mental health coverage should continue.	○ 2005 MMHAG Road Map for Mental Health System Reform in Minnesota: www.citizensleague.org/mentalhealth/index.html ○ Based on MMHAG recommendations, the Governor proposed a Mental Health Initiative in 2007, calling for $44.8 million in new investments over the coming biennium and $38 million per year thereafter. The proposed investments were to finance the addition of a comprehensive mental health benefit to the state's publicly funded health care programs (GA, MNCare, PMAP) and fund preferred integrated networks (PINs) demonstrating integration of mental and physical health services for adults and children within prepaid health plans and coordination of health care with social services. More detail at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_056871
B-3. **Advocate for funding streams** that promote collaborative and integrated mental health and primary care models. Funding should support reimbursement for consultations between the primary care provider and the mental health provider, as well as care management, care coordination and other collaborative models such as co-location. In addition, the work group identified several existing coding and funding mechanisms that create	*Specific update not available on this recommendation.*

barriers to collaborative care. These mechanisms should be catalogued & brought to the attention of funders & policymakers.	
B-4. Promote and expand telehealth collaborations to strengthen delivery of mental health services in remote and underserved areas. Many rural health care providers have begun to use telehealth technology for a number of purposes, including teleradiology, teledermatology, telepharmacy and home health monitoring. In some cases, telemental health applications could be developed using existing equipment. Equipment does not need to be costly; simple telephone technology can often be used effectively. Although reimbursement is often assumed to be a barrier to providing telemental health services, Medicare does cover teleconsultations by psychiatrists, clinical nurse specialists, clinical social workers and clinical psychologists for beneficiaries living in rural health professional shortage areas. State efforts to expand this coverage to the Medical Assistance program should be supported.	○ 2006 Rural Health Conference breakout session: Telemental Health for Minnesotans - Harvey Caldwell, (PowerPoint 86MB) New Connections: Minnesota Association of Community Mental Health Programs, Inc *and* Telehomecare: Pursuing, Planning and Prospering - Joyce Doughty, (PowerPoint 64KB)Good Samaritan Home Health Care ○ UMD is working on this, but financing is a problem.*
B-5. Improve delivery of mental health crisis services at small rural hospital emergency rooms through quality improvement projects that address mental health bed capacity, appropriate patient transfer and continuing education for emergency room personnel. Provider networks, Stratis Health (Minnesota's Medicare quality improvement organization), the Minnesota Hospital Association, and other health care organizations and associations should incorporate this goal into their quality improvement plans. The Minnesota Department of Health's Office of Rural Health and Primary Care should add this to its list of federally fundable objectives under the Rural Hospital Flexibility Program.	○ Flex Program Grant FFY 2007 to Arrowhead EMS: "Rural Behavioral Health Inter-Facility Transfer Education Project" - The goal of this project to assist rural EMS providers, including facility staff, in developing a starting point for use of standardized behavioral health guidelines related to planning and fulfilling inter-facility transfers involving patients presenting at rural hospitals an acute behavioral crisis. ○ Flex Program Grant 2008-09 to Arrowhead EMS: "Behavioral Crisis Mgmt. for EMS Leadership" - Training targeted to EMS leadership to develop local agency response protocols and provide guidance in assessment and care practices for first responders and inter-facility rural care providers when faced with behavioral crisis patients requiring treatment and transportation.
B-6. Create an understandable guide to the current payment system for mental health care for rural primary care and rural mental health providers. The current system reflects a complex combination of payment methodologies and has become very difficult to understand and use. As a result, rural providers and administrative staff may not know how to obtain reimbursement for specific mental health services; this can lead to restrictions on patients' access to care. Also, since billing and coding patterns do not always accurately reflect diagnoses and treatment delivered, payment patterns do not accurately reflect actual incidence of certain conditions. Therefore the occurrence of these conditions in the community as a whole is understated. The payment system guide should include concrete examples of how to access, interpret and blend payment mechanisms and sources to most accurately reflect patient diagnosis and treatment, while simplifying and clarifying billing and coding procedures for providers. The Minnesota Department of Human Services, in cooperation with other payers and representatives of the provider community, should be charged with developing this guide, using information from the Minnesota Mental Health Action Group.	*Specific update not available on this recommendation.*
C) State and Federal Policies and Programs This set of recommendations is meant for policymakers including the legislature, state agencies and the federal government.	
C-1. Expand state-funded health professional loan forgiveness programs to include psychologists, social workers and other	○ Rural Physician Loan Forgiveness Program: This program is offered to primary care medical residents (including

mental health professionals who agree to work in rural areas. Currently, the Minnesota Department of Health's Office of Rural Health and Primary Care administers state-funded loan forgiveness for physicians, nurses, mid-level providers and dentists. To address the shortage in rural areas, this program should be expanded to include psychologists, social workers and other mental health professionals. Funding for the overall program should be increased so as not to draw needed funds away from professions already included in the program.	Psychiatry residents) who plan to practice for at least 30 hours per week, for at least 45 weeks per year, for a minimum of three years in a designated rural area. o Urban Physician Loan Forgiveness Program: This program is offered to primary care medical residents (including Psychiatry residents) who plan to practice for at least 30 hours per week, for at least 45 weeks per year, for a minimum of three years in an underserved urban community o Federal National Health Service Corps (NHSC) Loan Forgiveness Program: includes Clinical Psychologists, Clinical Social Workers, Psychiatrists, Mental Health Counselors, Psychiatric Nurse Specialists, Marriage & Family Therapists o Minnesota State Loan Repayment Program (SLRP): includes Clinical Psychologists, Clinical Social Workers, Psychiatrists, Mental Health Counselors, Psychiatric Nurse Specialists, Marriage & Family Therapists
C-2. Support efforts to expand public program coverage of telehealth consultations by mental health professionals. Medicare currently covers teleconsultations by psychiatrists, clinical nurse specialists, clinical social workers and clinical psychologists for beneficiaries living in rural health professional shortages areas. State level efforts to expand this coverage to the Medical Assistance program and other public health care programs should be supported.	o Effective October 1, 2006, MHCP covers delivery of mental health services through telemedicine. Telemedicine delivers mental health services using two-way interactive video which: o Extends limited resources o Expands the geographical area over which a mental health provider can offer direct service o Saves time & energy without compromising quality o Allows providers and the recipient greater flexibility and increased access to services o Allows recipients to receive needed services without having to travel long distances o Services provided via telemedicine have the same service thresholds and authorization requirements as services delivered face-to-face. MHCP does not reimburse for connection charges, or origination, set-up or site fees.
C-3. Eliminate the funding rule for the Medical Education and Research Costs (MERC) program that requires small sites to have at least a 0.5 FTE health professional student in any given discipline to receive training reimbursement. Work group members reported—and Minnesota Department of Health data confirmed—that this rule, which was instituted during the 2003 legislative session, has resulted in substantially reduced training reimbursements to many small rural hospitals, clinics, pharmacies and other training sites. While MERC reimbursement does not support mental health training sites, it does support primary care training sites needed to promote and develop collaborative, interdisciplinary practice models.	o In 2004 and 2005, clinical training sites that hosted fewer than 0.5 FTE trainees from an eligible clinical training program were eliminated from the distribution, as were any advanced practice nursing programs sponsored by organizations not part of the Minnesota State Colleges and Universities (MnSCU) system, the University of Minnesota Academic Health Center, the Mayo Clinic, or the Private College Council. o Legislation in 2007 requires the Commissioner to review the impact of the revised distribution on sponsoring institutions and clinical training sites with low numbers of eligible trainees and report the findings to the Legislature by January 15, 2009.
C-4. Eliminate the copayments on psychopharmaceuticals for Medicaid and MinnesotaCare instituted in the 2003 legislative session. Creating financial barriers to care can be risky, particularly in the area of mental and behavioral health. If patients are unable to afford their medications, or if they cut back on doses as a result of financial pressures, their conditions may deteriorate, causing worsening symptoms and even a need for emergency and/or inpatient care.	o As of Oct. 2007, All parents and single adults and households without children with incomes not exceeding 75 percent of FPG, who are not pregnant, pay $3 copay per prescription o As of Oct. 2007, Single adults and households without children, with incomes greater than 75 percent but not exceeding 175 percent of FPG, pay $3 copay per prescription which is subject to a $20/month maximum
C-5. Support the Minnesota Mental Health Action Group's (MMHAG) efforts to develop best practice and benefit models to	*Specific update not available on this recommendation.*

address rural mental health needs in the primary care setting.	
C-6. Provide Medical Assistance reimbursement for care management and coordination of appropriate mental health patients at the primary clinic level. Some rural patients with complex mental health and physical health needs could be helped at the primary clinic level with care management services that could include regular follow-up by nurses or social workers for medication monitoring and counseling. Most primary care clinics do not have the resources to provide this type of service without a reimbursement.	o In 2008, the Minnesota Legislature passed health care reform legislation that expanded medical homes to serve not only children with special health care needs, but adults with chronic and complex health conditions, calling this expanded concept "health care homes". The legislation includes payment to primary care providers for partnering with patients and families to provide coordination of care. The term "health care home" can be considered synonymous with "medical home".
C-7. Establish an access-to-care standard for the Medical Assistance and other public health care programs that recognizes both distance to services and waiting time. Currently, geographic distance to care is defined in statute as an access indicator. Given the long waiting time sometimes required to see a mental health practitioner, these should also be factored into the access standard.	*Specific update not available on this recommendation.*
C-8. Promote development and use of electronic health records in mental/chemical/behavioral health. Ensure that the rural mental health community is represented in state level discussions on developing and implementing electronic health records. Electronic health records are especially needed in the areas of mental, behavioral and chemical health because of the fragmentation of the treatment system.	o Several significant mandates were enacted in the 2007 and 2008 legislative sessions that impact all health care providers in Minnesota: o A mandate that all health care providers and hospitals have an interoperable electronic health record (EHR) system by 2015. o A requirement to develop a statewide implementation plan to meet the 2015 interoperable EHR mandate. o The requirement to establish uniform health data standards by 2009. o A requirement that all health care providers and payers establish and use an e-prescribing system by January 1, 2011.
C-9. Support the development of crisis response teams through collaboration among the Minnesota Department of Human Services, counties and health plans. This might include rural regional urgent mental health care clinics, cross-trained crisis response teams or mental health telemedicine networks.	o In 2006, DHS State Operated Services (SOS) began providing inpatient psychiatric care for adults in dispersed 16-bed psychiatric hospitals in Greater Minnesota rather than in larger, institutional facilities on regional treatment center campuses. Development of the new hospitals, called Community Behavioral Health Hospitals, is part of a redesign of community mental health services in Minnesota. SOS was asked to operate the hospitals by regional planning work groups, which have been collaborating over the past several years to build a broad array of adult mental health treatment capacity in smaller settings, closer to individuals' communities, homes, and natural supports of family and friends. Community Behavioral Health Hospitals are short-term, acute psychiatric hospitals employ about 35 staff, including mental health professionals specializing in psychiatry, nursing, psychology and social work. Referrals for admissions are processed 24 hours a day through a Centralized Pre-Admission center where medical necessity and medical stability is assessed to insure an appropriate placement at an appropriate level of care. See www.dhs.state.mn.us o 2006 update on adult mental health crisis response services: www.dhs.state.mn.us/main/groups/publications/documents/pub/dhs16_136571.pdf

C-10. Promote mental health emergency quality improvement projects in Critical Access Hospitals through funding from the Medicare Rural Hospital Flexibility grants. The Office of Rural Health and Primary Care administers the federally funded Medicare Rural Hospital Flexibility (Flex) Program in Minnesota. In publicizing and distributing Flex mini-grants, the ORHPC should encourage development of quality improvement projects focused on Critical Access Hospitals' mental health emergency response capabilities.	o FFY 2007: Flex Grant to St. Gabriel's, Little Falls for $22K to improve early identification of mental health needs of elementary school students. o FFY 2007: Flex Partnership Grant to Arrowhead EMS for $15K to continue EMS inter-facility transfer training. o FFY 2006: Flex Partnership Grant to Arrowhead EMS for $15K to develop training and provide training statewide for EMS agencies on inter-facility transfers for behavioral health emergencies. o FFY 2006: Flex Grant to Avera Marshall for $25K to enhance behavioral health services in SW MN through an architectural study for an in-patient unit.
C-11. Improve and bring Medicare coverage for mental illness to parity with physical illness coverage. The current Medicare Part B coinsurance rate for mental health services is 50 percent as opposed to 20 percent for physical health services. This high coinsurance rate creates a barrier to care for Medicare beneficiaries.	o *The Mental Health Parity Act of 2007* - House and Senate have reached an agreement in July 2008 on the policy framework for legislation that would require employers and health insurers to cover mental illnesses at the same level as physical illnesses. No funding mechanism was included in the agreement. If passed, the plan would affect mental health coverage for 113 million people, including 82 million enrolled in federally regulated plans that are funded by employers and 31 million people who are enrolled in state-regulated health plans.
C-12. Create a coordinated data collection and analysis system for mental health incidence, prevalence and treatment data in Minnesota. This database should be developed in coordination with the Minnesota Departments of Health, Human Services, and Corrections, health plans, Minnesota Mental Health Action Group and other mental health stakeholder groups representing consumers and providers.	*Specific update not available on this recommendation.*

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