

Improving Mental Health and Well-Being: A Vision for Minnesota's Public Health System

**A Report from the Mental Health Workgroup of the
State Community Health Services Advisory Committee**



October 2013

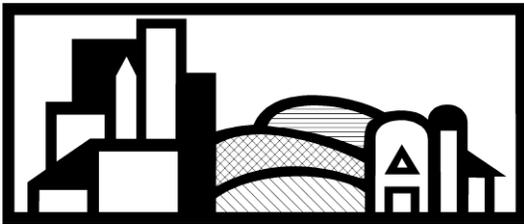


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Contents

Commissioner’s Letter.....	4
SCHSAC Chair’s Letter.....	5
Executive Summary	6
Introduction	10
Discussion and Recommendations.....	16
Appendix A. SCHSAC Mental Health Workgroup Charge and Membership.....	29
Appendix B. Georgetown Framework	32
Appendix C. Core Functions and Essential Services of Public Health.....	33
Appendix D. Bibliography	34
Appendix E. Additional Resources on Mental Health.....	42

Acknowledgments

We gratefully acknowledge the wisdom, commitment, passion, insight and dedication of the workgroup participants to the betterment of mental health in Minnesota, all of whom provided invaluable input into this report. For a list of all participants, please see [Appendix A](#).

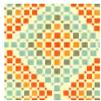


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Protecting, maintaining and improving the health of all Minnesotans

October 9, 2013

Bill Groskreutz, SCHSAC Chair
Faribault County Commissioner
Martin County Human Services Center
115 West First Street
Fairmont, MN 56301

Dear Commissioner Groskreutz:

Thank you for sending me the final report of the Mental Health Workgroup of the State Community Health Services Advisory Committee (SCHSAC). The recommendations and report thoroughly address the issues laid out in the work group charge and provide a vision and recommendations to strengthen Minnesota's public health approach to mental health and wellbeing. I accept this report and its recommendations.

I applaud the work group for its thoughtful and collaborative approach in laying out this vision. I believe that the recommendations in this report set the stage for enhancing public health activities that promote mental health and wellbeing for all Minnesotans.

I look forward to working with you and the SCHSAC as we take steps to implement these recommendations. Again, thank you for the excellent work.

Sincerely,

A handwritten signature in black ink, appearing to read "Ed Ehlinger", is enclosed in a light gray rectangular box.

Ed Ehlinger, MD, MSPH
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975



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October 7, 2013

Ed Ehlinger, MD, MSPH
Commissioner
Minnesota Department of Health
625 Robert St. N
P.O. Box 64975
St. Paul, MN 55164-0975

Dear Commissioner Ehlinger:

I am pleased to present to you the final report of the Mental Health Workgroup of the State Community Health Services Advisory Committee (SCHSAC). SCHSAC approved this report at its meeting on September 25, 2013.

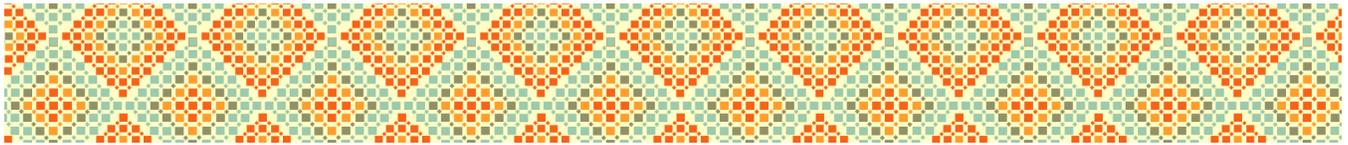
Mental health is a topic that routinely arises in local community health assessments, and yet the public health role in addressing it is unclear. Long viewed as an individual health issue, programs and strategies related to mental health have largely been isolated within the human services and health care systems. This workgroup was established to identify roles and responsibilities for public health that will complement existing efforts and improve mental health at a population level.

Through extensive cross-sector dialogue, the workgroup identified several recommendations relevant to both the Minnesota Department of Health (MDH) and community health boards (CHBs). Most important among these was the consistent request for stronger and more visible public health leadership related to mental health. Specifically, the workgroup strongly recommends that MDH work in partnership with the Department of Human Services (DHS) and key stakeholders to articulate a shared vision and identify 3-5 specific goals, outcomes, and indicators. Workgroup participants viewed this framework as something that could be replicated locally and would provide guidance for planning and implementing new approaches.

Collectively, these recommendations are aspirational; they set a path forward that, if implemented, will strengthen the public health approach to mental health. On behalf of SCHSAC I request your acceptance and approval of this report.

Sincerely,

Bill Groskretz, SCHSAC Chair
Faribault County Commissioner



Executive Summary

Improving Mental Health and Well-Being: A Vision for Minnesota's Public Health System

There are clear links between mental and physical health, and compelling reasons for public health, health care, human services, and other systems to work better together to address mental health. Mental health affects a person's ability to maintain good physical health and participate in health-promoting behaviors; conversely, serious physical health conditions—such as chronic pain or illness—can have a debilitating effect on mental health, and can inhibit one's ability to participate in mental health treatment and recovery.¹ Experiencing trauma, including historical trauma and early childhood trauma, has both physical and mental health impacts across the lifespan.² Strategies that improve physical health have also been documented to improve mental health, including physical activity, social support, nutrition, and sleep.

Despite the fact that mental health routinely emerges as a high priority in local public health community health assessments, the role of public health in implementing activities to address mental health has been unclear and undefined for many years. The State Community Health Services Advisory Committee (SCHSAC) recognized the need for clarity on this and commissioned a workgroup to provide guidance in this regard. This report documents the SCHSAC Mental Health Workgroup's process, discussions, and recommendations to further enhance the public health role in addressing mental health from the community and population perspective.

Public health systems do not operate at the individual level—for example, through the provision of individual clinical assessment or treatment. Rather, public health operates at the population level by monitoring population health, implementing strategies to improve health across communities and populations, and engaging communities to assess gaps in services and develop strategies to fill those gaps. The core functions of public health include *assessment*, *policy development*, and *assurance* (see [Appendix C](#)).

The *assessment* of population health includes monitoring and/or diagnosing and investigating health problems in the community. *Policy development* is a broad category of activity that encompasses educating and empowering people about health issues, mobilizing community partnerships to solve health problems, and developing policies and plans to

¹ U.S. Department of Health and Human Services. HealthyPeople.gov. (2013). [Mental health and mental disorders](#). *Healthy People 2020*. Accessed July 29, 2013.

² Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et al. (1998). [Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences \(ACE\) Study](#). *American Journal of Preventive Medicine* 14, 245–258.



support individual and community health efforts. *Assurance* refers to activities to maintain a competent workforce, identify gaps in health services, facilitate access to needed health services, implement quality improvement processes, and enforce laws and regulations that protect health and ensure safety. A recent publication from Georgetown University articulated a public health approach to children’s mental health and used these core functions as the foundation for their framework, and was used to guide workgroup discussions.³

For myriad reasons, public health approaches to mental health in Minnesota have been tenuous to date. However, there are action steps that the Minnesota Department of Health (MDH) and its partners at both the state and local level can take to strengthen the capacity of the public health system in this regard and improve mental health for all Minnesotans. This report outlines those steps. Over the course of a year, the Mental Health Workgroup, made up of participants with a variety of backgrounds and perspectives, discussed potential avenues to strengthen the public health role in promoting positive mental health and preventing illness. Broadly, the workgroup called for stronger state leadership, better communication about resources and best practices, improved efforts to collaborate and plan together, public education around mental health, and commitment to growing and developing positive mental health in communities. The convening role that public health departments often play, particularly at the local level, was identified as a critical asset.

Recommendations

More specifically, workgroup participants agree that public health programs and policy in this area can be significantly strengthened by:

Creating a Comprehensive State Framework to Improve Mental Health for All Populations

State agencies should work with stakeholders to develop a framework for mental health in Minnesota that includes a vision, guiding principles, goals and related sentinel indicators, key strategies, and roles for various statewide systems in implementing the framework.

Providing Leadership at the State and Local Level

Demonstrate leadership on mental health at the state and local level through advocacy, collaboration, policy and infrastructure development, and community engagement.

Recommendations

Public health programs and policy can be strengthened by:

- Creating a comprehensive state framework to improve mental health for all populations
- Providing leadership at the state and local level
- Improving data collection, dissemination, and coordination
- Promoting positive mental health
- Implementing strategies for the prevention and early identification of mental illnesses
- Facilitating access to mental health resources
- Addressing premature mortality of people with serious and persistent mental illness

³ Georgetown University Center for Child and Human Development. National Technical Assistance Center for Children’s Mental Health. (2005). [A public health approach to children’s mental health: A conceptual framework](#), p. 23.



Improving Data Collection, Dissemination, and Coordination

MDH and its partners should improve data collection, dissemination, and coordination related to mental health to a) monitor mental health and illness at the population level, b) improve awareness of positive mental health and protective factors for mental health, and c) better inform program planning, policy development, funding, and service delivery.

Promoting Positive Mental Health

Public health departments can promote and increase awareness of positive mental health, including lifelong developmental competencies that serve as critical protective factors in mental health and foster resilience.

Implementing Strategies for the Prevention and Early Identification of Mental Illnesses

MDH and local public health departments should implement primary and secondary prevention strategies, such as promoting healthy social and emotional development, providing parenting education, screening for social and emotional development and/or mental illness, and offering early intervention referral and follow-up.

Facilitating Access to Mental Health Resources

MDH and local public health departments can facilitate access to mental health resources by better publicizing available resources, educating staff and communities about existing resources, enhancing collaboration across systems, and improving referral and follow-up to existing programs and services.

Addressing Premature Mortality of People with Serious and Persistent Mental Illness

Nationally, people living with serious and persistent mental illness die an average of 25 years earlier than the general population, of the same major causes of death: diabetes, heart disease, and other tobacco- or obesity-related diseases. In Minnesota, people with serious and persistent mental illness die 24 years earlier than the general population. The public health system should address the specific needs of this sub-population within its health promotion and chronic disease prevention activities.

The workgroup discussions about each of these recommendations, described in greater detail in the full report, can be used as the foundation for future planning and a guide for action at the state and local levels. Recognizing that resources and capacity within the public health system are limited, and that fully implementing each of these recommended action steps would require a substantial investment of time and resources, the following activities may offer a starting place for the short term:



Where Can We Start?

Assessment

- Include mental health in the community health assessment process, and share the data with appropriate audiences
- Create, track, or distribute population data on mental health
- Include mental health indicators in health impact assessments

Health Promotion

- Develop policy, systems, and environment change approaches that promote positive mental health in a community
- Boost protective factors, such as social connectedness
- Address the social determinants of health
- Incorporate mental health topics into existing health education strategies

Prevention

- Examine the research to inform programs and policy
- Apply best practices where they exist, e.g., maternal depression, depression and anxiety in children and youth, and suicide prevention

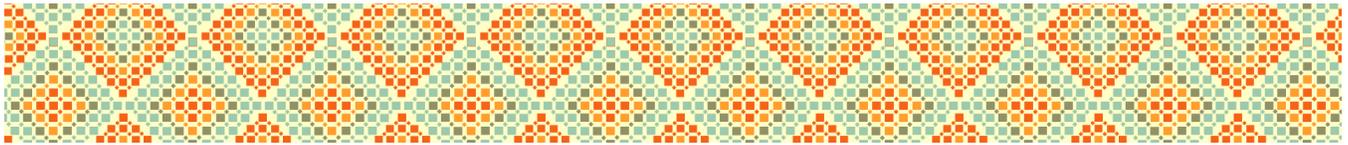
Treatment

- Work with partners to identify how public health strengths can be utilized to support mental health treatment provided through other systems

Reclaiming Health

- Work with partners to identify how the core functions of public health can support positive mental and physical health for people who have experienced mental illnesses
- Get involved in the *10 By 10* project to reduce health disparities for individuals with serious mental illness

To improve mental health and well-being at the population level, effective mental health treatment is necessary—but not sufficient. Similarly, public health strategies alone are also necessary, but not sufficient. With each system implementing coordinated strategies appropriate to their mission, vision, and values, health and human services systems can maximize their impact, and can better improve health for everyone.



Introduction

Mental Health as a Public Health Issue

Mental health is much better understood today than it has been in the past. Today, doctors and researchers describe mental illnesses as brain illnesses—physical conditions that can be effectively treated using a variety of strategies. Though there is much yet to learn about effective prevention, treatment, and recovery, health and social service systems are much better positioned today to improve the mental health and well-being of individuals and communities.

Unfortunately, the way in which health care delivery and payment has developed over time has created unnecessary and unhelpful barriers to achieving better individual and population health, particularly in mental health. Rather than looking at the whole person and understanding the interconnections between physical and mental health—and the broader connections to the social context around that individual—it is more common that symptoms are treated in a singular fashion by specialists working in isolation from each other. Mental health treatment has historically been seen as the purview of public and private mental health providers and human services agencies. Health care systems, despite efforts to integrate mental health into health care delivery, continue to face challenges in meeting the complex physical and mental health needs of their clients effectively. For public health systems, where the emphasis is on population health, the individual focus of service provision has kept mental health from being integrated into public health policy and practice both in terms of prevention and promotion and as it relates to funding, payment, and care delivery.

There are, however, clear links between mental and physical health and compelling reasons for providers to work better together to address mental health conditions. For example, mental illnesses are among the most common causes of disability. In any given year, 1 in 17 adults experiences a seriously debilitating mental illness.⁴ Mental health affects a person's ability to maintain good physical health and participate in health-promoting behaviors; conversely, serious physical health conditions—such as chronic pain or illness—can have a debilitating effect on mental health and inhibit someone's ability to participate in mental health treatment and recovery.⁵ Experiencing trauma, especially during early childhood but also throughout the lifespan, has both physical and

⁴ Kessler R.C., Chiu W., Demler O., Merikangas, K.R., and Walters, E.E. (2005). [Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication](#). *Archives of General Psychiatry* 62(6), 617-27.

⁵ U.S. Department of Health and Human Services. HealthyPeople.gov. (2013). [Mental health and mental disorders](#). *Healthy People 2020*. Accessed July 29, 2013.



mental health impacts across the lifespan.⁶ Historical trauma adds greater complexity and affects the health and well-being of individuals, families, and communities. Strategies that improve physical health have also been documented to improve mental health, including physical activity, social support, nutrition, and sleep.

There is new momentum for system change that has created opportunities to implement better approaches to mental health and illness. Nationally, federal agencies are prioritizing better coordination between health care and public health. For example, health care reform is charting new territory in linking health care quality, individual health outcomes, and population health. Additionally:

- The Centers for Disease Control and Prevention (CDC) has **developed a chronic disease plan** to integrate mental health into existing chronic disease monitoring and prevention activities.
- The Substance Abuse and Mental Health Administration (SAMHSA) contracted with Georgetown University's National Technical Assistance Center for Children's Mental Health to **develop a framework for a public health approach to children's mental health**, and has identified prevention and promotion as priorities for the current administration.
- Through federal health care reform funds, **Minnesota is developing new incentives to create better coordination** among health care, public health, human and social services, and other community providers through the State Innovation Model (SIM) project—a collaboration between the Minnesota Department of Human Services (DHS) and the Minnesota Department of Health (MDH).
- The *10 By 10* initiative—a state and national effort to reduce the disparity in life expectancy for people with serious and persistent mental illness by ten years, within ten years—is **improving the way in which mental health providers attend to the physical health needs of people with serious mental illnesses**, and is currently looking to public health and health care systems to prevent chronic disease within this high-risk sub-population.

Information about these and other initiatives are listed in the [Bibliography](#) and [Resources](#) ([Appendices D](#) and [E](#)).

For Minnesota's state and local public health system, some mental health activities occur in isolated program areas. Many have come and gone sporadically, like suicide prevention, while others are more institutionalized, such as family home visiting and early childhood screening programs. Maternal, Infant, and Early Childhood Home Visiting

⁶ Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et al. (1998). [Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences \(ACE\) Study](#). *American Journal of Preventive Medicine* 14, 245–258.



(MIECHV) grants support the highest risk families in their communities with evidence-based home visiting services and promote a strong link between local public health and infant mental health consultants.

There are also components of emergency preparedness and response that address mental health; local Statewide Health Improvement Programs (SHIP) and Community Transformation Grant (CTG) programs that incorporate mental health in some way; and Health Care Home and other health policy efforts that touch on mental health. Several community health boards⁷ (CHBs) are engaged in other mental health activities at the local or regional level, including initiatives focused on reducing stigma, assessing mental health of the population, screening and identifying individuals with depression or other mental health concerns, and medication management. These activities offer a starting place upon which to build and expand.

Existing activities, however, are not systematic or coordinated—rather, they are often isolated efforts taking place where there are resources, relationships, and political will. Despite the fact that mental health routinely emerges as a high priority in community health assessments, the role for public health in implementing activities to address mental health has been unclear and undefined for many years. The State Community Health Services Advisory Committee (SCHSAC) recognized the need for clarity on this and commissioned a workgroup to provide in this regard. This report documents the SCHSAC Mental Health Workgroup’s recommendations for how to address this by encouraging public health leaders, practitioners and policymakers to partner together with mental health leaders, providers, and policymakers to improve mental health from the community and population perspective. By working collaboratively together, we can make significant improvements in both physical and mental health that will be evident at both the individual and population levels.

Workgroup History and Approach

MDH and SCHSAC have long recognized the importance of addressing mental health through a public health lens. To develop a thoughtful approach to this work, a cross-agency state planning team made up of leadership from MDH and DHS convened to develop a workgroup charge, recruit membership, and plan workgroup meetings. From the start, the state planning team strived to maintain clear and transparent communication and a collaborative process. The group was committed to implementing a workgroup process that was as inclusive and as effective as possible.

Beyond the 15 official members specified in SCHSAC bylaws, the state planning team reached out to other individuals and organizations to invite them to attend and fully par-

⁷ The community health board (CHB) is the legal governing authority for local public health in Minnesota. CHBs have statutory responsibility under the Local Public Health Act, and must address and implement the essential local public health activities. CHBs in Minnesota take a number of forms, including single-county and multi-county boards.



ticipate in the meetings as interested parties. Workgroup meetings consistently involved approximately 30 participants from a wide range of organizations, including mental health providers, local public health leadership and staff, county commissioners, state agency leadership and staff, tribal representation, health plans, hospitals, community organizations and coalitions, and interested individuals. A full list of participants is included in [Appendix A](#).

The workgroup was asked to examine how MDH and local public health can play leadership roles related to mental health and to develop recommendations for needed public health models and/or policies as they related to mental health. To carry out this task, the group reviewed relevant literature, discussed cross-system collaboration, identified existing activities and opportunities, and developed recommendations. The workgroup met quarterly between September 2012 and July 2013, and occasional conference calls were held between meetings for new or absent participants.

The state planning team used the Georgetown monograph to inform the workgroup process.⁸ The model is founded in the core functions of public health—assessment, assurance, and policy development. The authors have adapted the language describing these functions for a broader audience, and connected them to four primary areas of activity in mental health: promotion, prevention, intervention, and reclaiming health (see [Appendix B](#) for a visual depiction of the Georgetown framework, and [Appendix C](#) for an illustration of the core functions of public health). In particular, the planning team appreciated that mental health was not presented as a zero-sum, linear construct (in which a person either has health or has illness), but as a multi-dimensional construct in which people *without* a mental health diagnosis can have poor mental health and people *with* a mental health diagnosis can have positive mental health (see figure, below). Resilience—which has a multitude of definitions across different professional literatures—is the linchpin: in this context, it can be thought of as the presence of positive mental health even in the presence of risk factors for or actual mental illness.

Two additional concepts described in the model proved helpful to the planning team: the concepts of **positive mental health** and **mental health of a community**. There is some debate in the research literature over what constitutes positive mental health, but the authors of the Georgetown framework define it as “high levels of life satisfaction and positive affect (emotional well-being) and psychosocial functioning (psychological and social well-being).” Mental health of a community simply refers to the “collective well-being of a community,” as indicated by the aggregated well-being of its members and other community characteristics related to well-being.⁹ This approach applies a public health perspective to mental health by taking a health condition and looking at it from the community perspective: How prevalent is this illness in a community? How

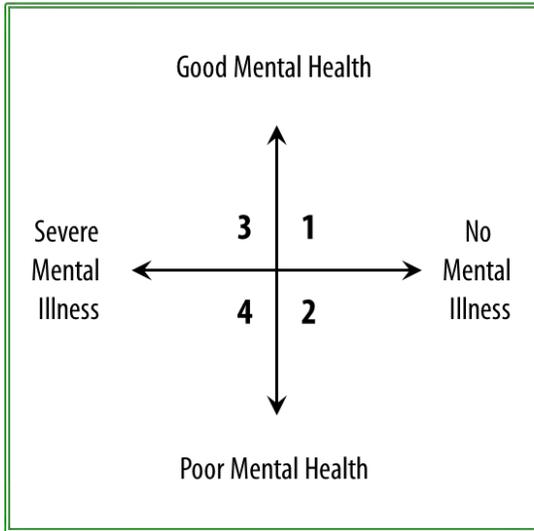
⁸ Georgetown University Center for Child and Human Development. National Technical Assistance Center for Children’s Mental Health. (2005). [A public health approach to children’s mental health: A conceptual framework](#), p. 23.

⁹ *ibid*, pp. 24-25.



does it affect the community as a whole? What kinds of strategies can be implemented throughout a community to improve well-being across the population?

Figure. A multi-dimensional model for understanding mental health and illness.



The quadrants can be explained as follows:

- Quadrant 1:** People have good mental health and no mental illness.
- Quadrant 2:** People may have severe stresses on their health, but do not have a mental illness.
- Quadrant 3:** People may have mental illnesses, but still have good mental health. With a secure income, strong support from family and friends, and a home and a job to return to after episodes of illness, a person may cope well with the challenge of having a mental illness.
- Quadrant 4:** People have mental illnesses, and also severe stress on their mental health. They may be unemployed, living in poverty and poor housing, and with little family or social support. They may experience stigma and discrimination, and have little access to education and satisfying work opportunities. Quadrant 4 represents the people with the greatest needs for both mental health services and community support.

“There is a tendency to view mental health as an attribute of the individual, to emphasize the importance of more proximal psychological factors, and in turn to underestimate the impact of the wider social and structural determinants. A job, an income and good education are all critical to positive mental health, as is having close supportive relationships. There is, therefore, a need for integrated, inter-sectoral policy initiatives.”¹⁰

Lastly, the planning group appreciated the framework’s emphasis on mobilizing communities across multiple systems: education, human services, public health, corrections, and others. While the monograph itself feels academic, it helped provide the planning team with a context for understanding what prevention means in the context of mental health. The planning team borrowed definitions from the monograph, and structured workgroup meetings around the themes of assessment, promotion, and prevention.

The first workgroup meeting was spent sharing perspectives from public health and human services and articulating aspirations. The second meeting focused on data sources related to mental health, and “how we know what we think we know” about the prevalence of mental illness and related risk and protective factors. The third discussed mental health promotion and the prevention of mental illnesses. The final meeting reviewed draft recommendations and prioritized key items. This report summarizes those conversations, and articulates the desired action steps for both state agencies and local public health.

Hopes and Guiding Principles

One of the first tasks the workgroup completed together was the development of hopes and guiding principles for working together. These hopes and principles were posted visibly at meetings, and guided the group’s thinking about

¹⁰ Barry, M.M. (2009). [Addressing the determinants of positive mental health: concepts, evidence and practice](#). *International Journal of Mental Health Promotion* 11(3), p. 9.



each topic. This was particularly important and helpful to the group process, given the diversity of perspectives among participants. It gave the group energy, and set a positive tone for subsequent conversations.

For guiding principles (or ground rules), the workgroup adopted a slightly modified version of the “three simple rules” that guide SCHSAC meetings: seek first to understand, make expectations and assumptions explicit, and think about the part and the whole. Workgroup participants stressed the need for discussion and process, valuing all voices, honoring cultural practices and traditions, and creating realistic and actionable recommendations.

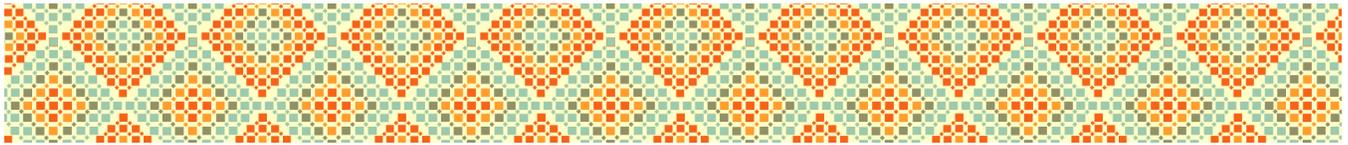
These guiding principles shaped the conversation, as well as the recommended action steps put forward in this report. They set the tone for dialogue that was respectful, insightful, and productive. The guidance provided in the next section reflects this wisdom and thoughtfulness.

Mental Health Workgroup Hopes

We hope that in our time together, we:

- Think about health holistically;
- Think creatively, emphasizing opportunities to address mental health everywhere, rather than creating new “boxes;”
- Bridge related problems (syndemics);¹¹
- Identify opportunities to make upstream investments in mental health;
- Promote wellness and reduce reliance on systems;
- Emphasize early childhood and create policies to better protect developing brain architecture;
- Seize the opportunity to address and reduce the stigma of mental illness;
- Develop a more effective response to the first episode of mental illness;
- Integrate a multi-generational, family-oriented approach;
- Honor culture, including cultural practices and traditions, throughout our discussions; and
- Institutionalize initiatives so that they are sustained.

¹¹ A “syndemic” has been defined as “a set of linked health problems involving two or more afflictions, interacting synergistically, and contributing to excess burden of disease in a population. Syndemics occur when health-related problems cluster by person, place, or time. For example, the SAVA syndemic is comprised of substance abuse, violence, and AIDS, three conditions that disproportionately afflict those living in poverty in US cities. To prevent a syndemic, one must prevent or control not only each affliction but also the forces that tie those afflictions together.” See: [CDC: Program Collaboration and Service Integration Definitions](#).



Discussion and Recommendations

The State and Local Public Health Partnership

Because of the diversity of perspectives and experience on this workgroup, significant time was spent discussing the public health system and its core functions (see [Appendix C](#)). The core functions of public health include:

- *Assessment* of population health, including monitoring and/or diagnosing and investigating health problems in the community;
- *Policy development*, which includes educating and empowering people about health issues, mobilizing community partnerships to solve health problems, and developing policies and plans to support individual and community health efforts; and
- *Assurance* of a competent workforce, access to needed health services, public health program and policy quality and effectiveness, and the enforcement of laws and regulations that protect health and ensure safety.

The Georgetown framework, which was used to guide workgroup discussions, also uses these core functions to articulate its vision for a public health approach to mental health.

Minnesota’s public health statute specifies that public health activities are to be carried out in partnership between CHBs at the local level, and the state health department (i.e., MDH). Consequently, the workgroup developed recommendations to guide action at both the state and local levels. Within each broad recommendation is specific advice for the local public health system and for MDH and its state agency partners.

Finding Common Ground

Over the course of a year, the workgroup discussed a range of topics, starting with data and assessment of community mental health, and concluding with conversations about mental health promotion and prevention of mental illness. At the core of every conversation was a clear desire for MDH and DHS to work together toward shared mental health goals. **The primary recommendation from this workgroup is the development of a state framework for mental health that will identify shared goals and desired outcomes.** Local public health leaders and community organizations strongly advocated for leadership from the two primary state agencies, MDH and DHS, in collaboration with others, to establish a path forward that could be followed at the local level. Workgroup members specifically advocated for the creation of a “mental health cabinet” at the executive level, to guide and coordinate mental health activities across relevant state agencies.

While public health and human services professionals use different approaches in their work—human services activities are generally more focused at the individual level, and



public health activities are typically more focused at the community or population level—workgroup members found mental health offered an ideal opportunity to improve collaboration. For example, resilience is built out of individual, family, and community factors; it is an asset that can be fostered through both population-based health promotion approaches and reinforced through individual mental health treatment. The value and respect for each professional approach was implicit in every conversation. Particularly in this time of change in the health care system, there are opportunities to rethink the way multiple agencies interact and work towards common goals. The workgroup embodied this collaborative approach, and sought to develop advice that reflects respect for different perspectives.

Similarly, workgroup members urged CHBs to take a leadership role locally, in collaborating and engaging with communities in assessing community mental health. Participants often returned to the convening role played by public health departments in mobilizing communities and in engaging with community partners for planning and policy development. Public health systems also have particular skills in identifying and mapping community needs and resources that other systems lack. In addition, in many counties there are already children’s mental health collaboratives, family service collaboratives, and local advisory councils in place that can be built upon to incorporate a population health lens and create a more coordinated system from upstream promotion and prevention activities to mental health treatment and recovery approaches.¹²

In addition to the primary recommendation to create an overarching state framework, other recommendations were articulated that provide guidance to MDH and the local public health system regarding action steps that can be taken at any point to better address mental health going forward. The workgroup presents these recommendations with the expectation that further discussion is needed at the state and local levels, to address the capacity of the public health system to carry out these activities effectively. These recommendations document the desires of the group to improve public health approaches to mental health; the next step is to articulate the infrastructure that needs to be in place and develop an implementation plan. The workgroup would like to see state agencies and local communities evaluate their resources and look for opportunities to create a different approach to mental health in Minnesota.

Recommendations

The workgroup identified a number of action steps which, if implemented, would greatly strengthen state and local efforts to address mental health comprehensively—from prevention and promotion through treatment and recovery. The workgroup acknowledges that resources to implement these steps are not readily available, but urges MDH, DHS, and local public health departments to begin work

¹² For more information from the Minnesota Department of Human Services, visit: [Children’s Mental Health and Family Services Collaboratives, Local Mental Health Advisory Councils](#).



where possible. The limited resources available highlight the very real need for a coordinated response at the state and local levels for maximum effectiveness.

1. Create a comprehensive state framework to improve mental health for all populations.

State agencies should work with stakeholders to develop a framework for mental health in Minnesota that includes a vision, guiding principles, goals and related sentinel indicators, key strategies, and roles for various statewide systems in implementing the framework.

There was strong consensus among workgroup participants that state-level coordination and leadership is needed in order to guide state and local public health programs and policy on mental health. Workgroup participants strongly encourage partnership between MDH and DHS, in particular, and value the participation of other relevant state agencies, such as the Minnesota Departments of Education and Corrections.

Participants view the framework as providing a shared vision and specific objectives to strive toward at both the state and local levels. As one workgroup participant stated, public health efforts to reduce tobacco have been a coordinated effort between state and local health departments, with the state addressing the issue “from the air” and local health departments from “on the ground.” Local public health leaders and staff are looking to the state for leadership, guidance, and support, and workgroup participants strongly encourage MDH and DHS, together with their local partners, to engage in a concerted effort to articulate an organized vision for moving forward.

The workgroup encourages the use of a Results-Based Accountability¹³ approach to develop the framework, which should include:

- 3-5 outcomes, including indicators and strategies that can be implemented by each partner; indicators should reflect positive mental health as well as risk factors for diagnosed mental illness
- A specific process for involving American Indian communities and diverse cultural linguistic groups represented in Minnesota
- Strategies that value and encourage culturally-specific approaches
- Clear definitions of the roles for the various state and local systems in implementing the framework

Upon completion, MDH should work in partnership with the local public health system to implement their respective portions of the framework.

¹³ Results-Based Accountability is an approach for “turning the curve” on a particular problem or challenge. It is made up of population accountability (about the well-being of whole populations) and performance accountability (about the well-being of client populations). It is a step by step process to identify program and/or population strategies and develop and monitor performance measures. For more information, see: Friedman, Mark. (2005). *Trying hard is not good enough*. FPSI Publishing. Also visit: [Results-Based Accountability Implementation Guide](#).



2. Provide leadership at the state and local level.

Demonstrate leadership on mental health at the state and local level through advocacy, collaboration, policy development, and community engagement.

The workgroup strongly urged MDH and local public health to be proactive on mental health topics, and to create space for a public health role in addressing mental health from a population-based perspective. The first example of such leadership at the state level is the continued engagement of a task force or committee to develop a state mental health framework, as referenced above in Recommendation 1.

Further, the group urges leadership at the state level to seek resources to build infrastructure and capacity to address mental health. Workgroup participants acknowledged that many of the action steps recommended in this report will require infrastructure investment to be carried out. Workgroup members look to the state to take specific steps to build capacity and infrastructure within the public health system to address mental health, and to engage others in dialogue about mental health and wellness.

MDH should:

- Advocate with the Governor's office for the creation of a Mental Health Cabinet that will coordinate mental health-related activities across state agencies
- Secure long-term funding for the state and local public health system from multiple sources, and distribute dedicated funding to local public health for mental health activities
- Create a focal point within the agency to continue development and implementation of a state framework for mental health; coordinate activities internally and across state agencies; and promote a mental health focus in all public health activities throughout the agency, including health policy and health care reform initiatives

Specifically, the workgroup requested not only that a focal point for mental health be created within MDH, but that staff and leadership also work to integrate mental health throughout the agency's programs. For example, workgroup participants specifically asked that MDH advocate for the inclusion of mental health requirements and indicators in health care home, behavioral health home, and Accountable Care Organization regulations. In addition, mental health can be incorporated into Statewide Health Improvement Program (SHIP) efforts, health promotion and chronic disease prevention strategies, community and family health programs, health policy, and other areas of the department.

Local public health leadership and staff can embrace the convening role that public health plays in their communities to:

- Implement community engagement efforts that build coalitions to improve mental health in communities
- Collaborate across systems to bring a population health perspective to existing mental health initiatives



3. Improve data collection, dissemination, and coordination.

Improve data collection, dissemination, and coordination related to mental health to:

- a) Monitor mental health and illness at the population level,
- b) Improve awareness of positive mental health and protective factors for mental health, and
- c) Better inform program planning, policy development, funding, and service delivery.

The workgroup spent considerable time discussing what is known about mental health and illness, how it is known, and what needs to be better understood in order to better prevent illness and promote resilience for positive mental health. Few data sources exist that provide a good understanding of the prevalence of either illness or positive mental health, outside of service provision data available from either the public mental health system or private insurance claims data. While some workgroup participants were familiar with surveys like the Minnesota Student Survey, many reported learning about mental health through news media, anecdotes, working relationships with others, and experience. They also reported wanting to know more about indicators of positive mental health, like life satisfaction and quality of life; cultural perspectives on mental well-being; availability of services; trends in population mental health and illness over time; connections between substance abuse and mental illness; and best practices for addressing mental health for culturally specific groups.

Workgroup participants consistently emphasized the importance of measuring and communicating information about positive mental health, and including qualitative data sources in addition to utilizing or expanding quantitative surveys. Further, in keeping with public health's interest in health equity and the guiding principles articulated by the workgroup, participants strongly encourage MDH and local public health to be intentional about reaching out to American Indians and the many cultural groups living in Minnesota, to better understand mental health and illness in these communities and to assure that our data systems are culturally sensitive and representative.

To better enhance our understanding of mental health and illness at the population level, the workgroup articulated the following recommendations for state and local public health:

At the state level, MDH should:

- a) Consistently collect and communicate mental health data using existing statewide data systems, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), the Minnesota Student Survey, the Pregnancy Risk Monitoring System (PRAMS), and Family Home Visiting evaluation data;
- b) Identify ways to gather information from populations that are not well-represented in existing data sources; and
- c) Work in partnership with DHS to assess existing data systems, coordinate across relevant state agencies, and collaboratively develop new data sources to fill gaps.



Specifically, MDH should:

- Utilize BRFSS to collect and report on mental health data by regularly including the CDC's mental health survey module in addition to the Adverse Childhood Experiences survey module; the mental health module is the only existing mechanism for collecting population-based data about mental health and illness for adults that is not tied directly to service provision
- Continue to participate in and report on mental health indicators in the Minnesota Student Survey
- Develop a way to collect mental health related information from local health departments
- Use Adverse Childhood Experiences data responsibly—not to highlight inevitability of mental illness but to show where cycle can be broken
- Identify and communicate data related to positive mental health
- Study and disseminate information about disparities in mental health between different populations

At the local level, CHBs can ensure that mental health indicators are included in community health assessments and improvement plans—particularly indicators of positive mental health—and can convene community partnerships to coordinate data collection and analysis.

Specifically, the workgroup encouraged the local public health system to:

- Embrace the local public health role as a convener at the local level for assessment and planning; the group identified opportunities for collaboration with other regional stakeholders for assessment purposes, including local mental health initiatives and collaboratives funded through DHS, and charitable hospitals required to conduct community health needs assessments
- Use both qualitative and quantitative data sources, and include data from other systems, e.g., jails, detox centers, law enforcement calls, education/early detection and intervention programs, and health care, including the charitable hospital community benefit assessment process
- Conduct (locally) broad sector focus groups around mental health prevention and promotion
- Assess readiness for mental health promotion/prevention at the local level, using the Statewide Health Improvement Program (SHIP) readiness tool as a model
- Support local data collection efforts, such as encouraging schools to participate in the Minnesota Student Survey or partnering with them on school-based data collection strategies
- Engage local public health leaders on this issue through the Local Public Health Association



“Those of us who experience psychiatric symptoms are commonly told that these symptoms are incurable, that we will have to live with them for the rest of our lives... Nothing about recovery was ever mentioned. Nothing about hope. Nothing about anything we can do to help ourselves. Nothing about empowerment. Nothing about wellness. Now the times have changed. Those of us who have experienced these symptoms are sharing information and learning from each other that these symptoms do not have to mean that we must give up our dreams and our goals, and that they don't have to go on forever. We have learned that we are in charge of our own lives... We are good parents. We have warm relationships with our partners, parents, siblings, friends, and colleagues. We are climbing mountains, planting gardens, painting pictures, writing books, making quilts, and creating positive change in the world.”¹⁴

4. Promote positive mental health.

Promote and increase awareness of positive mental health, including lifelong developmental competencies that serve as critical protective factors in mental health and foster resilience.

Workgroup participants were particularly interested in the concept of positive mental health presented in the Georgetown monograph, and in the notion that everyone can have positive mental health—including those with a diagnosed mental illness. Resilience, which has many definitions, can be thought of in this context as the presence of positive mental health even in the presence of risk factors or actual mental illness. Built out of individual, family and community factors, resilience is a trait that both public health promotion and mental health treatment approaches can specifically address.¹⁵ There was strong consensus within the group that public health can play an important role in promoting positive mental health and resilience at the population level, while these assets can be reinforced at the individual level by mental health treatment programs.

Similarly, as with other health conditions, public health can work to address known risk and protective factors for mental health, such as trauma, poverty, social connectedness, family health, neighborhood quality, coping and problem solving skills, education, and racism. Workgroup members conveyed a desire for both MDH and local health departments to utilize a strengths-based perspective throughout their program activities, as opposed to an illness or deficit model. Using a population-based approach to promote protective factors, in particular, will help improve positive mental health over the lifespan. This includes promoting early childhood social and emotional development.

MDH should champion primary prevention and promotion for mental health. More specifically, MDH can:

- Articulate what positive mental health is and help to educate others about it
- Serve as a resource on mental health for the local public health system
- Help to build local capacity to address mental health and promote resilience through training, technical assistance, funding, and other resources
- Conduct a statewide campaign to promote positive mental health and wellness skills
- Support local/statewide efforts to reduce the stigma associated with mental illness, such as the *Make It OK* campaign¹⁶

¹⁴ Mead, S. and Copeland, M.E. (2000). [What recovery means to us](#). *Community Mental Health Journal* 36(3), 315-28.

¹⁵ For further discussion, see: National Research Council and Institute of Medicine. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. (O'Connell, M.E., Boat, T., Warner, K.E., Eds.). (2009). [Preventing mental, emotional and behavioral disorders among young people: Progress and possibilities](#). Washington, DC: National Academies Press.

¹⁶ The *Make It OK* campaign is produced by a partnership of Minnesota mental health advocacy organizations, providers, health care systems and hospitals. It is an initiative to educate the public about mental illnesses and reduce the stigma associated with talking about it. See: [Make It OK](#).



Local public health departments can implement health promotion and health education strategies specifically addressing mental health to increase awareness about positive mental health and its determinants and foster resilience, by addressing key protective factors, such as healthy attachment with caregivers in early childhood and positive family environments, social connectedness and access to social support, adequate employment and income, safe and vibrant neighborhoods, and appropriate coping and problem solving skills.¹⁷

5. Implement strategies for the prevention and early identification of mental illnesses.

Implement primary and secondary prevention strategies, such as promoting healthy social and emotional development, providing parenting education, screening for social and emotional development and/or mental illness, and offering early intervention referral and follow-up.

Health advocates, providers, and professional associations strongly encourage the use of standardized screening instruments to identify potentially serious health conditions early. Early identification, diagnosis, and treatment of health conditions, including mental illnesses, can improve recovery, prevent potentially long-term complications, and reduce both the financial and human costs associated with serious illness. Screening programs are particularly important for conditions that go undiagnosed and untreated without such intervention. Identifying and treating mental illness early can reduce its impact, and improve positive mental health where treatment and follow-up resources are available.

MDH and its partners in local public health departments have a long history of implementing screening and follow-up programs that promote healthy child development. In the context of mental health, early childhood social and emotional development provides the foundation for lifelong positive mental health. Public health departments have also used screening instruments to identify postpartum depression and, in some areas, depression among older adults and the elderly.

In 2013, MDH began developing a *prenatal to three* framework.¹⁸ Participants in the Mental Health Workgroup valued this effort, and encouraged MDH and local health departments to expand on activities currently taking place. For example, research has found a significant impact of caregiver depression on child development. Existing efforts at the state and local level can be augmented to specifically address this issue.

As infrastructure is developed within the public health system, information about best practices in the prevention of mental illness can be identified and disseminated throughout the statewide public health system, and incorporated into existing programs where appropriate. MDH and local health departments can improve relationships and referral

¹⁷ Barry, M.M. (2009). [Addressing the determinants of positive mental health: concepts, evidence and practice](#). *International Journal of Mental Health Promotion* 11(3), 4-17.

¹⁸ For more information: Minnesota Department of Health. (2013). [Building power for babies: Developing a prenatal to three plan for Minnesota \(PDF: 204KB / 2 pages\)](#).



processes from public health programs to mental health providers; provide educational information and assistance to child care programs about caregiver depression; and partner together to improve maternal depression screening and referral in pediatric primary care settings. State and local public health should pay specific attention to assuring cultural sensitivity, so that families and children are supported in appropriate ways.

Additionally, MDH should work to improve screening rates for mental health across the lifespan and across settings, provide information about resources for follow-up on positive screening results, and encourage DHS to include screening requirements in all public program contracts. MDH should also promote depression and general mental health screenings for school age children and adolescents, and should provide primary care clinics with training and resources on the use of standardized tools approved by the two agencies for this age group.

6. Facilitate access to resources.

MDH and local public health departments can facilitate access to mental health resources by better publicizing available resources, educating staff and communities about existing resources, enhancing collaboration across systems, and improving referral and follow-up to existing programs and services.

The workgroup identified lack of information about mental health resources as a critical need in communities and encourages MDH and the local public health system to better address this need. Information must be made more easily accessible to the public. Some called for mapping existing resources in local communities, while others suggested the development of resource directories. Regardless of the specific solution, public health departments work with a variety of individuals and organizations, and often provide resource and referral information. This information needs to include local mental health supports. MDH can work with DHS to identify the variety of supports that may be available in different communities.

One way in which a partnership between public health professionals and mental health providers can benefit the wider community is in helping service providers understand and improve community outreach and education efforts. For example, mobile mental health crisis teams exist in nearly every region and provide services for individuals with or without insurance coverage. Public health practitioners can assist in educating the community about this service, and in helping service providers develop strong community outreach strategies. Children's mental health collaboratives, family service collaboratives, and service providers are often required by DHS to engage communities and provide public education and outreach. These are strengths that public health can bring to collaborative partnerships.

Further, some workgroup participants specifically encouraged the public health system to play a role in connecting the various services that might be attached to an individual or a family receiving mental health treatment and supports, including educational, vocational, or housing supports.



7. Address premature mortality of people with serious and persistent mental illness.

Nationally, people living with serious and persistent mental illness die an average of 25 years earlier than the general population, of the same major causes of death: diabetes, heart disease, and other tobacco- or obesity-related diseases. In Minnesota, people with serious and persistent mental illness die 24 years earlier than the general population. The public health system can do more to address the specific needs of this sub-population within its health promotion and chronic disease prevention activities.

The *10 By 10* project is a state and national effort to reduce the disparity in lifespan by ten years, within ten years. Minnesota's statewide project has, to date, largely targeted mental health providers to improve their ability to address the physical health of their clients. This topic provides an excellent opportunity for collaboration between public health and mental health systems at the state and local level. There is a great deal that can be done to change health care practice and to incorporate this effort into existing statewide approaches to health improvement. Local state health improvement program (SHIP) and Community Transformation Grant (CTG) grantees can identify opportunities to integrate this group as part of their efforts to improve population health. There is a growing body of research and other resources that can guide program activities related to tobacco cessation, nutrition, and physical activity with this population.¹⁹ In Minnesota, a successful pilot project was implemented in 2011 to develop policy and protocol changes within Assertive Community Treatment programs to improve overall health and wellness among people with serious and persistent mental illness. Public health and mental health professionals who are interested in learning more can get involved with the state effort; information is available on the DHS website (and listed in [Appendix E](#)).

Unmet Needs

Several special populations were noted during workgroup discussions that illustrate some of the unmet needs around mental health. There was extensive discussion about jail health and the high prevalence of individuals with mental illness in the corrections system; about the myriad challenges facing military veterans, including mental illness; and mental health disparities between different cultural groups. Historical

¹⁹ See, for example:

Kessler, R.C., Chiu, W.T., Demler, O., Walters, E.E. (2005). [Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication](#). *Archives of General Psychiatry* 62(6), 617-627.

Viron, M., Baggett, T., Hill, M., and Freudenreich, O. (2012). [Schizophrenia for primary care providers: How to contribute to the care of a vulnerable patient population](#). *American Journal of Medicine* 125(3), 223-230.

Morris, C., Waxmonsky, J., Giese, A., Graves, M., and Turnbull, J. (2007). [Smoking cessation for persons with mental illness: A toolkit for mental health providers \(PDF: 4.15MB / 55 pages\)](#). University of Colorado at Denver. Health Sciences Center, Department of Psychiatry.

National Alliance on Mental Illness (NAMI). [Hearts and minds](#).



trauma experienced by American Indian and African-American populations, in addition to trauma experienced by immigrants and refugees in the context of civil war and genocide, all require culturally specific approaches to be developed and expanded, not only in regard to mental health treatment but to prevention and promotion as well. While in some cases new strategies may need to be developed, there are some activities—including the proliferation of trauma-informed systems and environments, and the expansion of evidence-based mental health treatment—that are already beginning to be implemented and can be expanded.

Where can we start?

- Assessment
- Health Promotion
- Prevention
- Treatment
- Reclaiming Health

While developing potential policy solutions to these specific and complex issues was beyond the scope of this workgroup, participants felt it was important to elevate them and recommend public health leadership on these complex realities going forward. In particular, workgroup members described the urgent need for systems-level policy development and planning expertise in developing new solutions around these topics. For example, participants asked that public health departments help devise and advocate for alternatives to jail for individuals with mental illness. In this context, public health can bring an understanding of how the needs of an individual connect to a larger family or community context. There is also new momentum across state agencies to help support families affected by incarceration to help maintain strong family attachments that could be similarly replicated at the local level.

For those just beginning to identify mental health needs in their communities and developing program activities, the following items may provide a helpful starting point:

Where Can We Start?

Assessment

- Include mental health in the community health assessment process, and share the data with appropriate audiences
- Create, track, or distribute population data on mental health
- Include mental health indicators in health impact assessments

Health Promotion

- Develop policy, systems, and environment change approaches that promote positive mental health in a community
- Boost protective factors, such as social connectedness
- Address the social determinants of health
- Incorporate mental health topics into existing health education strategies

Prevention

- Examine the research to inform programs and policy
- Apply best practices where they exist, e.g., maternal depression, depression and anxiety in children and youth, and suicide prevention



Treatment

- Work with partners to identify how public health strengths can be utilized to support mental health treatment provided through other systems

Reclaiming Health

- Work with partners to identify how the core functions of public health can support positive mental and physical health for people who have experienced mental illnesses
- Get involved in the *10 By 10* project to reduce health disparities for individuals with serious mental illness

There are certainly many additional unmet needs, and special populations that need attention. Public health professionals have a unique voice and perspective to add, and should create and welcome opportunities to bring a population health focus to these special topics. What will it take to get there?

Concluding Comments

At the final meeting of the workgroup, MDH Assistant Commissioner Ellen Benavides and DHS Assistant Commissioner Dave Hartford reaffirmed their commitment to interagency collaboration and leadership to implement the recommendations developed by the SCHSAC Mental Health Workgroup. Specifically, they proposed to jointly lead and staff a process to develop and implement a state framework for mental health that includes a vision, guiding principles, goals, and related sentinel indicators, as well as strategies and roles for various statewide systems in implementing the framework. Key aspects of this work include improved data collection, dissemination, and coordination between state agencies, providers, and local partners—to better inform prevention strategies and early identification of mental illnesses, in addition to promoting positive mental health in communities.

In September 2013, after the full membership of SCHSAC has reviewed and discussed the recommendations included in the Mental Health Workgroup report, the two Assistant Commissioners will jointly re-convene participants of the SCHSAC Mental Health Workgroup to develop an implementation plan. Further, there is a commitment to bring the plan to the 2014 Community Health Conference, an annual conference sponsored by SCHSAC, for discussion.

While the framework and work plan are being developed, there are steps that MDH and local public health can take to better incorporate mental health throughout agency activities. The workgroup called for stronger state leadership, better communication about resources and best practices, improved efforts to collaborate and plan together, public education around mental health, and commitment to growing and developing positive mental health in communities.



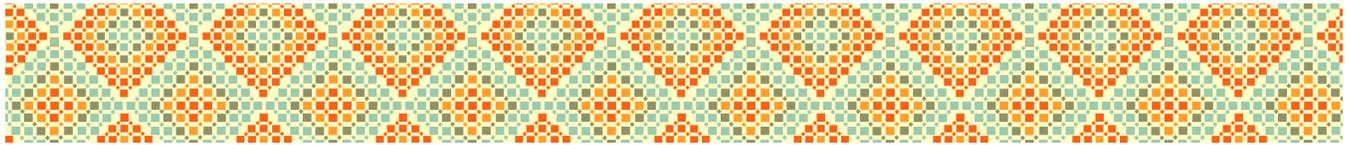
To strengthen mental health and well-being at the population level, effective mental health treatment is necessary—but not sufficient by itself. Similarly, public health strategies alone are also necessary, but not sufficient alone. When leaders and professionals in public health and human services work together to implement coordinated strategies appropriate to their mission, vision and values, these two distinct and complex systems will maximize their impact, and improve health for everyone.



Appendices

- Appendix A:** Charge and Membership
- Appendix B:** Georgetown Model
- Appendix C:** Core Functions and Essential Services of Public Health
- Appendix D:** Bibliography
- Appendix E:** Mental Health Resources





Appendix A

SCHSAC Mental Health Workgroup Charge and Membership

Charge

The SCHSAC Mental Health Workgroup will:

- Examine current literature on the public health role in the promotion of good mental health and the prevention of mental health problems.
- Conduct an environmental scan of current activity to address mental health within the public health arena, and identify gaps across state agencies, including the Departments of Human Services, Education, Veterans, Housing, and others as appropriate.
- Develop recommendations for needed public health models and/or policies as they relate to mental health across state agencies and their local partners.

Background

Mental health is an important public health issue. It is closely related to the health of children, chronic diseases, premature deaths, and behavioral issues due to human made and natural disasters, as well as poverty, racism, poor housing, and lack of education that are fundamental determinants of health. We can collectively address these issues when we incorporate strategies to address social determinants of health. The focus of addressing mental health needs across the continuum should incorporate a prevention, treatment, and recovery model.

SCHSAC will examine how MDH and local public health can play a leadership role in raising public awareness about mental health issues, including disparities, and develop a policy agenda with respect to mental health. By clarifying the public health role in mental health, state and local public health officials will be better able to work collaboratively with other agencies, e.g., health and mental health care, education, human services, community-based organizations to focus “upstream” on primary and secondary prevention activities, and to provide leadership in numerous mental health policy discussions, including:

1. Identifying and strengthening local public health’s role in primary prevention for mental health.
2. Integrating mental health and Health Homes, vis à vis the Affordable Care Act §2703, which are specific to high needs populations, well as the work that Health Care Homes have done to incorporate the needs/certification/payment models for people with chronic conditions in primary care settings.
3. Working with the Governor’s Health Reform Task Force to ensure that mental health needs are addressed.
4. Participating in the *10 By 10* initiative to reduce premature death/increase the lifespan for persons with a mental illness.
5. Working with the Community Transformation Grant that includes system changes to improve mental health outcomes.
6. Participating in the Institute for Clinical Systems Improvement (ICSI) Diamond model for treating depression in primary care settings, reimbursing providers and collecting quality measures.
7. Reviewing the implications of the findings from the Adverse Childhood Events Study (ACES) to develop public health priorities and inform preventive strategies.



8. Implementing the recommendations of the Maternal Child Health (MCH) Taskforce recommendations for infant, child and adolescent mental health.
9. Demonstrating productive alliances between public health and mental health systems, e.g., suicide prevention, mobile crisis response teams, environmental health impacts on mental health and DHS' Strategic Prevention Enhancement (SPE) grant to align Mental Health Prevention with Substance Abuse Prevention and Primary Care.

Methods and Resources

A SCHSAC workgroup will be convened consisting of SCHSAC members, local public health department and other state agency representatives, as well as interested community stakeholders/content experts as needed. The workgroup will be staffed by MDH and will begin meeting in the spring of 2012.

Products

Potential products include the articulation of the role of public health in the promotion of good mental health and the prevention of mental health problems, an environmental scan of current activities to address mental health within the public health arena, and recommendations for needed public health models and/or policies as they relate to mental health.

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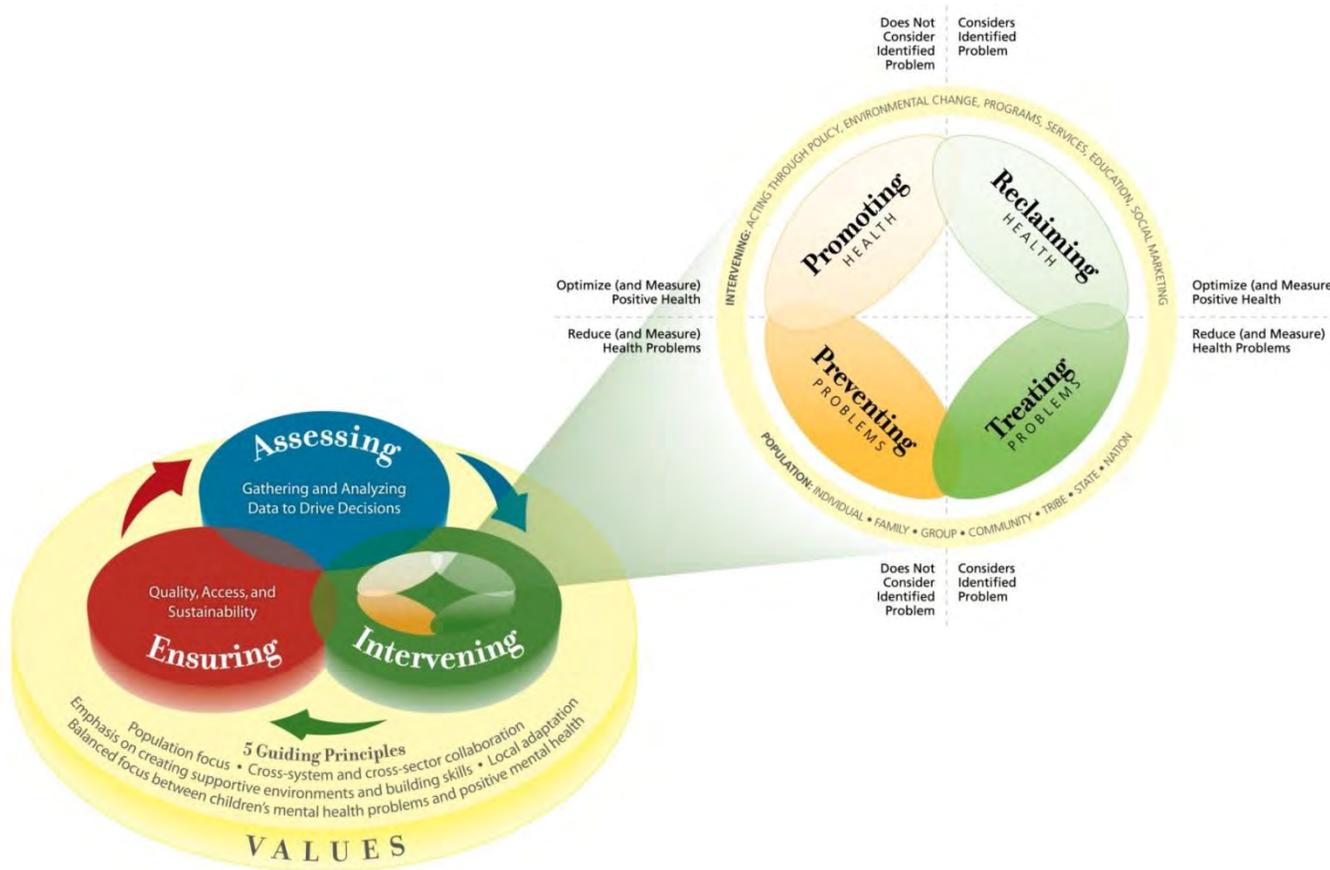
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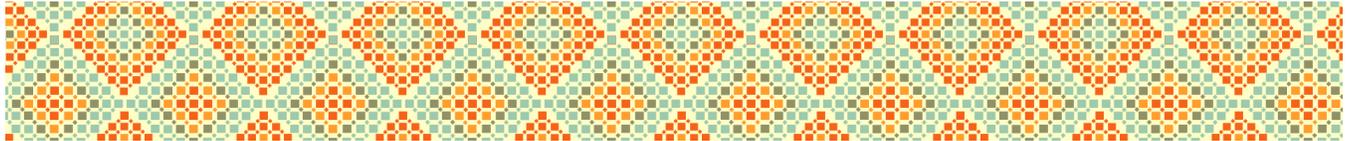
Appendix B

Georgetown Framework

A conceptual framework for a public health approach to children’s mental health.



Source: Georgetown University Center for Child and Human Development. National Technical Assistance Center for Children’s Mental Health. (2005). [A public health approach to children’s mental health: A conceptual framework](#).

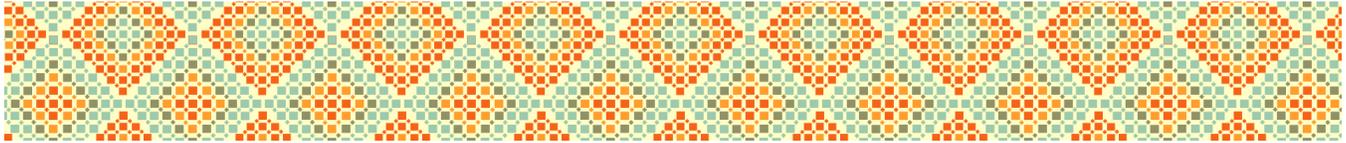


Appendix C

Core Functions and Essential Services of Public Health



Source: U.S. Department of Health and Human Services. Public Health Functions Steering Committee. (1994). [Public health in America](#). Public Health Functions Project.



Appendix D

Bibliography

Descriptions and excerpts are taken from abstracts, introductions, and publishers' notes.

Overview/Background

Georgetown University Center for Child and Human Development. National Technical Assistance Center for Children's Mental Health. (2005). [*A public health approach to children's mental health: A conceptual framework.*](#)

A number of recent developments have begun pointing the way toward a new approach to children's mental health in the United States. Hope for a new approach is inspired by successful examples of public health efforts in the area of children's physical health, increased recognition of the positive impact of System of Care values, and greater understanding of the ways healthy environments can enhance children's development. Public health principles suggest that the new approach should focus on reducing mental health problems among children for whom a problem has been identified, and helping all children optimize their mental health. This monograph advances an approach to children's mental health that applies public health concepts to efforts that support children's mental health and development. The approach is presented in a conceptual framework comprised of three major elements: values that underlie the entire effort, a process that consists of three core public health action steps/functions, and a new model of intervening that provides the range of intervention activities required to implement a comprehensive approach. The range of activities includes promoting positive mental health, preventing mental health problems, treating mental health problems, and re/claiming optimal health while addressing a mental health problem.

U.S. Department of Health & Human Services. National Prevention Council. (2011). [*National prevention strategy.*](#)

The National Prevention, Health Promotion, and Public Health Council (National Prevention Council), called for by the Affordable Care Act, provides coordination and leadership at the federal level and among all executive agencies regarding prevention, wellness, and health promotion practices. It is composed of the heads of 17 federal agencies and chaired by Surgeon General Regina Benjamin. With input from the public and interested stakeholders, the council developed a National Prevention and Health Promotion Strategy (National Prevention Strategy). The strategy provides an unprecedented opportunity to shift the nation from a focus on sickness and disease to one based on wellness and prevention. It presents a vision, goals, recommendations, and action items that individuals and public, private, and non-profit organizations can use to reduce preventable death, disease, and disability in the United States.

See also: [Introduction and Overview \(PDF: 2.22MB / 9 pages\)](#); [Priority: Mental & Emotional Well-Being](#).

Community Assessment, Prevention & Promotion

Deloitte. Access Economics. (2009). [*The economic impact of youth mental illness and the cost effectiveness of early intervention \[Issue Brief\] \(PDF: 1.47MB / 66 pages\).*](#)

Access Economics was commissioned by the headspace Centre of Excellence in Youth Mental Health, part of Orygen Youth Health Research Centre to estimate the cost of youth mental illness in Australia and the potential cost effectiveness of early intervention in youth mental health. The report is structured as follows. The rest of this chapter provides



background information on mental illness and how it directly affects youth. Chapter 2 presents the current prevalence of mental illness in Australia by age and gender. Chapters 3 and 4 respectively discuss the health system costs and other financial costs associated with mental illness. Other financial costs include productivity losses (due to lower employment rates, worker absenteeism and premature death), career and other costs, as well as deadweight (efficiency) losses (DWLs) from transfer payments, such as government welfare and income support payments. Chapter 5 presents the ‘burden of disease’ estimates, which refers to the years of healthy life lost due to disability and premature mortality caused by mental illness, and is measured by disability adjusted life years (DALYs). Chapters 6 and 7 examine the types of interventions and the cost effectiveness of early intervention to treat and prevent a larger proportion of mental illness in people aged 12-25 years in Australia. Chapter 8 summarizes the costs by type of cost and who bears them, compares mental illness with other diseases, and draws conclusions from the analysis of cost effective interventions to develop a set of recommendations for Australian and state/territory governments, building on strategies recommended in previous evidence-based reviews.

Barry, M.M. (2009). [Addressing the determinants of positive mental health: concepts, evidence and practice.](#) *International Journal of Mental Health Promotion* 11(3), 4-17.

Positive mental health is recognized as a key resource for population well-being and the social and economic prosperity of society. This paper provides an overview of current concepts of positive mental health and its contribution to the health and well-being of society. Frameworks for promoting mental health are presented, together with an overview of key concepts and principles underpinning this multi-disciplinary area of practice. Drawing on empirical studies, the article reviews the determinants of positive mental health across the lifespan. Enhancing factors for promoting mental health at the structural, community and individual levels are identified. The growing evidence base on the effectiveness of mental health promotion interventions is discussed, and the implications of addressing the psychosocial determinants of mental health for policy and practice are considered.

Bellonci, C., Jordan, P.E., Massey, O.T., Lieberman, O., Zubritsky, C., and Edwall, G. (2012). [Reframing mental health practice for children, youth, and families: In search of developmental competencies to improve functioning across life domains \(Issue Brief; PDF: 401KB / 8 pages\).](#) **Outcomes Roundtable for Children and Families.**

The Outcomes Roundtable for Children and Families (ORCF)—a consortium of researchers, youth, family members, providers, and policymakers—undertook an exercise to identify key factors impacting children’s mental health in the era of recently passed legislation, including the Mental Health Parity and Addiction Equity Act of 2008 and the Patient Protection and Affordable Care Act (PPACA). As mental health parity and healthcare reform is implemented, the ORCF has identified a series of indicators that could be tracked to ensure children’s mental health needs are being promoted that are consistent with the mission and vision of the Substance Abuse and Mental Health Services Administration (SAMHSA). The first step in this work was to identify key, core lifetime outcomes that all families want for their children. These core outcomes are that children are “at home, in school and out of trouble”—outcomes that are no different for parents whose children experience mental illness.

Boris, N.W., Larrieu, J.A., Zeanah, P.D., Nagle, G.A., Steier, A., and McNeill, P. (2006). [The process and promise of mental health augmentation of nurse home-visiting programs: Data from the Louisiana Nurse-Family Partnership.](#) *Infant Mental Health Journal* 27, 26-40.

The Nurse-Family Partnership (NFP) model is a well-studied and effective preventive intervention program targeting first-time, impoverished mothers and their families. Data documenting the negative impact of maternal depression and partner violence on the developing young child can be used to make a strong case for augmenting NFP programs to focus on mental health problems impacting the mother–child relationship. This article reviews the rationale for and



process of augmenting an NFP program in Louisiana. Data on the prevalence of depression and partner violence in our sample are presented alongside a training protocol for nurses and mental health consultants designed to increase the focus on infant mental health. The use of a weekly case conference and telephone supervision of mental health consultants as well as reflections on the roles of the mental health consultant and the nurse supervisor are presented.

Centers for Disease Control and Prevention. (2011). [*Public health action plan to integrate mental health promotion and mental illness prevention with chronic disease prevention, 2011-2015 \(PDF: 830KB / 20 pages\)*](#).

Mental health (MH) is increasingly recognized by the public health community as critical to good health. An estimated 26 percent of Americans age 18 and older suffer from a diagnosable mental disorder in a given year. The estimated lifetime prevalence of any mental disorder among the U.S. adult population is 46 percent. The interconnections between chronic disease, injury, and mental illness (MI) are striking. For example, tobacco use among people diagnosed with a MI condition is twice that of the general population. In addition, the evidence is extensive for associations between MI and chronic diseases, such as cardiovascular disease, diabetes, obesity, asthma, arthritis, epilepsy, and cancer. Injury rates for both intentional (e.g., homicide) and unintentional (e.g., motor vehicle injuries) injuries are 26 times higher among people with a history of MI than for the general population... Integrating MH and public health programs that address chronic disease is a challenging but essential task in protecting the health of Americans. The Division of Adult and Community Health (DACH) in the National Center for Chronic Disease Prevention and Health Promotion at the Centers for Disease Control and Prevention (CDC) has a mission to prevent death and disability from chronic disease and to promote healthy behaviors. With this report, DACH outlines its goal to include the promotion of MH as a part of its efforts to prevent chronic disease.

Compton, M.T. (2009). [*Clinical manual of prevention in mental health*](#). Arlington, VA: American Psychiatric Publishing.

[This book] serves as a comprehensive guide to applying proven prevention tools in psychiatric units, outpatient clinics, consultation-liaison services, and private office settings. [It] provides psychiatrists, psychologists, residents, and allied mental health professionals with important clinical and research advances in risk and protective factors, prevention principles, evidence-based preventive interventions, and health promotion related to mental and behavioral disorders. Developed by more than 30 expert contributors... Clinical Manual of Prevention in Mental Health is a compilation of the latest evidence of prevention principles for mood disorders, anxiety disorders, substance abuse, schizophrenia, and other psychiatric disorders.

Edwall, G.E. (2012). [*Intervening during childhood and adolescence to prevent mental, emotional and behavioral disorders*](#). The National Register of Health Service Psychologists.

Developments on multiple fronts are rapidly converging to create focused attention on the possibilities of preventing mental, emotional and behavioral disorders through interventions with children, youth and their families and communities... In this brief overview, specific developments in the study of trauma, neurodevelopment and resilience will be described. All of these in turn are contributing to a transformed understanding of a public health approach to the mental health of children and adolescents, producing a model in which both wellness and disease amelioration have prominent roles.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et al. (1998). [*Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences \(ACE\) Study*](#). *American Journal of Preventive Medicine* 14, 245–258.

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being. The study is a collaboration between the



Centers for Disease Control and Prevention and Kaiser Permanente's Health Appraisal Clinic in San Diego. More than 17,000 Health Maintenance Organization (HMO) members undergoing a comprehensive physical examination chose to provide detailed information about their childhood experience of abuse, neglect, and family dysfunction. To date, more than 50 scientific articles have been published and more than 100 conference and workshop presentations have been made. The ACE Study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. Progress in preventing and recovering from the nation's worst health and social problems is likely to benefit from understanding that many of these problems arise as a consequence of adverse childhood experiences.

See also: [CDC: Adverse Childhood Experiences Study](#).

Graham, M., Nagle, G., Wright, C., and Oser, C. (2012). [Altering the developmental trajectory of public policy: Three state success stories in infant mental health](#). *Zero to Three* 33(2), 66-72.

Early child development professionals naturally prefer playgrounds and classrooms to legislative arenas; however, they have existing strengths, skills, knowledge, and data sorely needed by policymakers who rely on those closest to an issue – the advocates, researchers, program directors, and consumers – to give them evidence of need and guidance toward solutions. Examples of policy initiatives successfully undertaken in Florida, Louisiana, and Minnesota demonstrate the effectiveness of cultivating relationships, recognizing critical windows of opportunity, and articulating the robust science of early childhood. These strategies will comfortably and powerfully push infant mental health policies and practices away from “the biggest bang for the buck” to smarter investments that produce desired results.

National Research Council and Institute of Medicine. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. (O’Connell, M.E., Boat, T., Warner, K.E., Eds.). (2009). [Preventing mental, emotional and behavioral disorders among young people: Progress and possibilities](#). Washington, DC: National Academies Press.

Mental health and substance use disorders among children, youth, and young adults are major threats to the health and well-being of younger populations which often carry over into adulthood. The costs of treatment for mental health and addictive disorders, which create an enormous burden on the affected individuals, their families, and society, have stimulated increasing interest in prevention practices that can impede the onset or reduce the severity of the disorders. Prevention practices have emerged in a variety of settings, including programs for selected at-risk populations (such as children and youth in the child welfare system), school-based interventions, interventions in primary care settings, and community services designed to address a broad array of mental health needs and populations. Preventing Mental, Emotional, and Behavioral Disorders Among Young People updates a 1994 Institute of Medicine book, Reducing Risks for Mental Disorders, focusing special attention on the research base and program experience with younger populations that have emerged since that time.

See also: [Summary \(PDF: 652KB / 45 pages\)](#).

Kobau, R., Seligman, M.E., Peterson, C., Diener, E., Zack, M.M., Chapman, D., et al. (2011). [Mental health promotion in public health: perspectives and strategies from positive psychology](#). *American Journal of Public Health* 101(8), e1-9.

Positive psychology is the study of what is “right” about people—their positive attributes, psychological assets, and strengths. Its aim is to understand and foster the factors that allow individuals, communities, and societies to thrive. Cross-sectional, experimental, and longitudinal research demonstrates that positive emotions are associated with numerous benefits related to health, work, family, and economic status. Growing biomedical research supports the view



that positive emotions are not merely the opposite of negative emotions but may be independent dimensions of mental affect. The asset-based paradigms of positive psychology offer new approaches for bolstering psychological resilience and promoting mental health. Ultimately, greater synergy between positive psychology and public health might help promote mental health in innovative ways.

Lando, J., Williams, S.M., Williams, B., Sturgis, S. (2006). [A logic model for the integration of mental health into chronic disease prevention and health promotion](#). *Preventing Chronic Disease: Public Health Research, Practice and Policy* 3(2), 1-5.

Mental illnesses such as depression or anxiety affect an individual's ability to undertake health-promoting behaviors. Chronic diseases can have a profound impact on an individual's mental health; in turn, mental health status affects an individual's ability to participate in treatment and recovery. A group of mental health and public health professionals convened to develop a logic model for addressing mental health as it relates to chronic disease prevention and health promotion. The model provides details on inputs, activities, and desired outcomes, and the designers of the model welcome input from other mental health and public health practitioners.

Luby J.L., Barch, D.M., Belden, A., Gaffrey, M.S., Tillman, R., Babb, C., et al. (2012). [Maternal support in early childhood predicts larger hippocampal volumes at school age](#). *Proceedings of the National Academy of Sciences of the United States of America* 109(8), 2854-9.

Early maternal support has been shown to promote specific gene expression, neurogenesis, adaptive stress responses, and larger hippocampal volumes in developing animals. In humans, a relationship between psychosocial factors in early childhood and later amygdala volumes based on prospective data has been demonstrated, providing a key link between early experience and brain development. Although much retrospective data suggests a link between early psychosocial factors and hippocampal volumes in humans, to date there has been no prospective data to inform this potentially important public health issue. In a longitudinal study of depressed and healthy preschool children who underwent neuroimaging at school age, we investigated whether early maternal support predicted later hippocampal volumes. Maternal support observed in early childhood was strongly predictive of hippocampal volume measured at school age. The positive effect of maternal support on hippocampal volumes was greater in non-depressed children. These findings provide prospective evidence in humans of the positive effect of early supportive parenting on healthy hippocampal development, a brain region key to memory and stress modulation.

Minnesota Department of Health. Center for Health Statistics. (2013). [Adverse childhood experiences in Minnesota: Executive Summary \(PDF: 687KB / 4 pages\)](#).

This report marks the first time that the Minnesota Department of Health has collected data regarding the effects of adverse childhood experiences (ACEs) on the lifelong health and well-being of adults in Minnesota. For two decades, research by the Centers for Disease Control and Prevention (CDC) and other states has demonstrated over and over again the powerful impact of ACEs on health, behavioral, and social problems. An extensive and growing body of research documents that adverse childhood experiences (ACEs)—those causing toxic levels of stress or trauma before age 18—are specifically linked to poor physical and mental health, chronic disease, lower educational achievement, lower economic success, and impaired social success in adulthood.



Substance Abuse & Mental Health Services Administration (SAMHSA). (2010). [*The eight dimensions of wellness* \(PDF: 1.81MB / 1 page\)](#).

Part of a wellness initiative, this one page poster illustrates the eight dimensions of wellness: social, environmental, physical, emotional, spiritual, occupational, intellectual, and financial. Promotes communication among mental health consumers, professionals, and primary care providers.

Wilder Research. (2013). [*The Hennepin County youth mental health and wellness dashboard: a framework to consider how family, school and community factors contribute to mental health*](#).

In 2011, the Hennepin County Children's Mental Health Collaborative commissioned Wilder Research to develop a dashboard of key indicators that could be used to not only describe mental health problems among youth who live in Hennepin County, but to also consider ways in which youth positive mental health and well-being is promoted or negatively impacted by neighborhood conditions, school environments, and family characteristics. The resulting Youth Mental Health and Wellness Dashboard is intended to provide local stakeholders with consistent information that can be used to identify needs in the county and guide strategic planning efforts across multiple child-serving systems.

See also: [Summary](#) (PDF: 400KB / 4 pages); [Full Report](#) (PDF: 1.14MB / 55 pages).

Supporting Treatment & Recovery

Anthony, W.A. (1993). [*Recovery from mental illness: The guiding vision of the mental health service system in the 1990s*](#). *Psychosocial Rehabilitation Journal*, 16(4), 11-23.

The implementation of deinstitutionalization in the 1960s and 1970s, and the increasing ascendance of the community support system concept and the practice of psychiatric rehabilitation in the 1980s, have laid the foundation for a new 1990s version of service delivery for people who have mental illness. Recovery from mental illness is the vision that will guide the mental health system in this decade. This article outlines the fundamental services and assumptions of a recovery-oriented mental health system. As the recovery concept becomes better understood, it could have major implications for how future mental health systems are designed.

Golden, O., Hawkins, A., Beardslee, W. (2011). [*Home visiting and maternal depression: Seizing the opportunities to help mothers and young children*](#). Urban Institute.

...By drawing on research as well as new interviews with low-income mothers, home visitors, and other service providers, this guide offers practical insights about how home visiting programs can enhance their own work and their links to other programs in the community—such as mental health treatment—to better serve depressed mothers and their young children.

Jaeckels, N. (2009). [*Early DIAMOND adopters offer insights: Six-month results on depression care*](#). *Minnesota Physician* 23(1).

Over the past year, 30 primary care clinics in Minnesota have participated in a ground-breaking initiative known as DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction), which changes the way care for patients with depression is delivered and paid for in the primary-care setting. DIAMOND... incorporates the following components: 1) a validated screening tool—the PHQ9—for assessment and ongoing management of depression; 2) a patient registry for systematic monitoring and tracking; 3) use of evidence-based guidelines and a stepped-care approach to treatment modification or intensification; 4) A relapse prevention plan for patients ready to move out of the



program; A care manager to educate, coordinate, and trouble-shoot services for patients; and 6) a psychiatrist to serve as a liaison to the care manager for consultation and caseload review.” This article provides an overview of the DIAMOND model and 6-month evaluation results.

Mead, S. and Copeland, M.E. (2000). [What recovery means to us.](#) *Community Mental Health Journal* 36(3), 315-28.

Recovery has only recently become a word used in relation to the experience of psychiatric symptoms. Those of us who experience psychiatric symptoms are commonly told that these symptoms are incurable, that we will have to live with them for the rest of our lives, that the medications, if they (health care professionals) can find the right ones or the right combination, may help, and that we will always have to take the medications. Many of us have even been told that these symptoms will worsen as we get older. Nothing about recovery was ever mentioned. Nothing about hope. Nothing about anything we can do to help ourselves. Nothing about empowerment. Nothing about wellness. Now the times have changed. Those of us who have experienced these symptoms are sharing information and learning from each other that these symptoms do not have to mean that we must give up our dreams and our goals, and that they don’t have to go on forever... And it is only with this vision and belief for all people that we can bring hope for everyone.” This article presents recommendations for how healthcare providers and other professionals can support individuals with mental illness in recovery.

Melek, S.P. (2012). [Bending the Medicaid healthcare cost curve through financially sustainable medical-behavioral integration \[Issue brief\].](#) Milliman.

This paper presents a recommendation to provide more behavioral healthcare services to Medicaid beneficiaries, not less, through integrated medical-behavioral healthcare programs. It also presents some data to assess the value opportunity for doing this integration, discuss the language of integrated/collaborative care, address the challenges in achieving financially sustainable integration models, and look at recent innovations and pilot programs that are focused on delivering better healthcare, attempting to achieve better clinical and financial outcomes, and providing input for the case that medical-behavioral integration innovations can work well.

Reinke, M.B, Edwall, G., Nygaard, P., and Zakelj, J. (2011, October). [Collaborative psychiatric consultations.](#) *Minnesota Medicine*.

A 2010 Minnesota law required the Department of Human Services to develop a collaborative psychiatric consultation service for primary care practitioners and other health care professionals, with an initial focus on those who prescribe medications for children. Use of the service will be required for prescribers of certain psychotropic medications for children enrolled in fee-for-service Medical Assistance, the state’s Medicaid program. This article discusses the impetus for the law, explains the new medication review requirements, and describes plans for the consultation service.

Slade, M. (2009). [100 ways to support recovery.](#) Rethink Mental Illness.

This is a guide for mental health staff, which aims to support the development of a focus on recovery within our services. It provides different ideas for working with service users in a recovery-oriented fashion. It is written on the basis of two beliefs: First, recovery is something worked towards and is experienced by the person with mental illness. It is not something services can do to the person. The contribution of staff is to support the person in their journey toward recovery. Second, the journey of recovery is individual. The best way of supporting an individuals’ recovery will vary from person to person... At the heart of this report is a conceptual framework to identify what types of support may be useful...



Trangle, M., Mager, G., Goering, P., and Christensen, R. (2010, June). [Minnesota 10 By 10: Reducing morbidity and mortality in people with serious mental illnesses](#). *Minnesota Medicine*.

Persons with schizophrenia, schizoaffective disorder, and bipolar affective disorder in Minnesota are dying much younger than their age- and sex-matched cohorts. A new initiative, MN 10 By 10, is designed to engage key constituencies in addressing modifiable risk factors in order to lengthen these individuals' lives.

Williams, S.B., O'Connor, E.A., Eder, M., and Whitlock, E.P. (2009). [Screening for child and adolescent depression in primary care settings: A systematic evidence review](#). *Pediatrics* 123, e716-e735.

Depression among youth is a disabling condition that is associated with serious long-term morbidities and suicide. This article assesses the health effects of routine primary care screening for major depressive disorder among children and adolescents aged 7 to 18 years... Although the literature on diagnostic screening test accuracy is small and methodologically limited, it indicates that several screening instruments have performed fairly well among adolescents... Available data indicate that selective serotonin reuptake inhibitors, psychotherapy, and combined treatment are effective in increasing response rates and reducing depressive symptoms... Limited available data suggest that primary care-feasible screening tools may accurately identify depressed adolescents and treatment can improve depression outcomes.

Other Resources

Bryan, C.J. and Rudd, M.D. (2010). [Managing suicide risk in primary care](#). New York, NY: Springer.

Citizens League. Minnesota Mental Health Action Group. (2005). [Roadmap for mental health system reform in Minnesota \(PDF: 1.16MB / 216 pages\)](#).

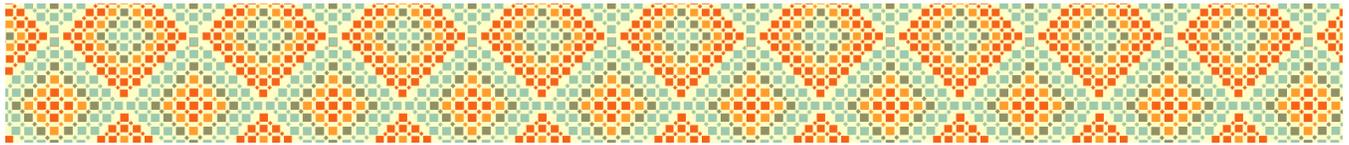
Minnesota Department of Health. Maternal and Child Health Advisory Task Force. Infant, Child, and Adolescent Mental Health Workgroup. (2009). [Summary report \(PDF: 876KB / 31 pages\)](#).

Minnesota Department of Human Services. Alcohol and Drug Abuse Division. (2012). [Minnesota prevention systems alignment plan \(PDF: 3.19MB / 157 pages\)](#).

Minnesota Department of Health. Office of Rural Health and Primary Care. (2005). [Rural Health Advisory Committee's report on mental health and primary care \(PDF: 836KB / 114 pages\)](#).

Substance Abuse & Mental Health Services Administration. [Strategic prevention framework](#).

World Health Organization. (2004). [Prevention of mental disorders: Effective interventions and policy options: Summary report \(PDF: 673KB / 68 pages\)](#).



Appendix E

Additional Resources on Mental Health

Education, Programs, and Services

[Make It OK](#): Produced by a partnership of Minnesota mental health advocacy organizations, providers, health care systems and hospitals, this campaign seeks to educate the public about mental illnesses and reduce the stigma associated with talking about it and seeking help.

Substance Abuse and Mental Health Services Administration (SAMHSA)

[Toolkit for Community Conversations about Mental Health](#)
[National Registry of Evidence-based Programs and Practices](#)

Minnesota Department of Human Services (DHS)

DHS oversees state funding for mental health programs and services for children and adults.

[Adult Mental Health Division](#)
[Children's Mental Health Division](#)
[Children's Mental Health and Family Services Collaboratives](#)
[Local Mental Health Advisory Councils](#)

Mental Health Recovery Resources

[Intentional Peer Support](#): Information, training, and other resources related to peer support approaches to recovery.

[Mary Ellen Copeland](#): Wellness Action Recovery Plan and Recovery Books

[Minnesota Mental Health Consumer/Survivor Network](#): A peer-based wellness and recovery organization that offers specific tools, like the Wellness Recovery Action Plan, to help those experiencing mental illness recover and maintain wellness.

National Alliance on Mental Illness (NAMI)

[NAMI Minnesota](#): An education and advocacy organization with anti-stigma campaign resources, training programs like Mental Health First Aid, and other support groups and materials.

[National Alliance on Mental Illness \(NAMI\)](#)

Trauma

[National Center on Domestic Violence, Trauma, and Mental Health](#): A national training and technical assistance center that provides training, information, consultation and other support for developing trauma-informed environments and strategies.