

Introduction

The Mental Health Legislative Network (MHLN) was formed to advocate for a statewide mental health system that is of high quality, accessible and has stable funding. There are over 19 organizations in the MHLN all working to create visibility on mental health issues, act as a clearinghouse on public policy issues and to pool our knowledge, resources and strengths to create change.

This booklet was prepared to provide important information to legislators and other elected officials on the various issues affecting children and adults with mental illness and their families.

The following organizations are members of the Mental Health Legislative Network:

Barbara Schneider Foundation
Guild Incorporated
Mature Voices Minnesota
Mental Health Association of Minnesota
Mental Health Consumer/Survivor Network of Minnesota
Minnesota Association for Children's Mental Health
Minnesota Association of Community Mental Health Programs
Minnesota Association of Mental Health Residential Facilities
Minnesota Coalition of Licensed Social Workers
Minnesota Council of Child Caring Agencies
Minnesota Disability Law Center
Minnesota Psychiatric Society
Minnesota Psychological Association
National Alliance on Mental Illness of Minnesota
National Association of Social Workers
Office of the Ombudsman for Mental Health and Developmental Disabilities
People Incorporated
State Advisory Council on Mental Health
Subcommittee on Children's Mental Health
Tasks Unlimited
Vail Place

Executive Summary

What are Mental Illnesses?

Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Mental illnesses are biological brain disorders that affect about one in four adults and one in ten children. People affected more seriously by mental illness number about 1 in 17.

Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder.

Mental illnesses can affect persons of any age, race, religion, or income. Mental illnesses are not the result of personal weakness, lack of character or poor upbringing. Mental illnesses are treatable. Most people diagnosed with a serious mental illness can experience relief from their symptoms by actively participating in an individual treatment plan.

In addition to medication treatment, therapy, (such as cognitive behavioral therapy and interpersonal therapy), peer support groups and other community services can assist with recovery. The availability of transportation, a healthy diet, safe affordable housing, exercise, sleep, friends and meaningful paid or volunteer activities contribute to overall health and wellness, including recovery.

Some people need access to basic mental health treatment. Others need mental health services, such as case management (and/or care coordination) to assist them in locating and maintaining mental health and social services. Still others need more intensive, flexible services to help them live in the community.

Minnesota Mental Health System

The main access to the mental health system is through insurance – either private health plans or a state program such as Medical Assistance, MinnesotaCare and General Assistance Medical Care. For those who have no insurance or poor coverage, access is then through the county or a community mental health center.

Although we have increasingly effective treatments and rehabilitation, the current *mental health system* is fragile and is not always able to respond to the needs of children and adults with mental illnesses and their families. Sometimes the barrier is lack of insurance or limited benefits that do not cover community supports. Other times the barrier is lack of appropriate mental health professionals. And still another barrier are waiting lists for more intensive services. Too often people get worse while waiting for services, when earlier treatment would have helped to avoid complications.

Some people who have the most serious mental illnesses need additional services in the community such as affordable supportive housing, community supports, employment supports, educational services, respite care and in-home supports. These are sorely lacking statewide. An aging demographic exacerbates the workforce shortage created by longstanding inadequate wages and benefits for mental health providers.

The highest cost of these problems is a human one, but there are severe financial repercussions as well. Lack of care and treatment can result in a high percentage of adults who are homeless or incarcerated due to mental illness. The problem is especially striking among youth: 70% of juveniles in the justice system have a mental health diagnosis. Diverting people into treatment will save money.

For many years Minnesota has experienced a shortage of providers of mental health services. As the mental health system has begun to move toward evidence-based mental health treatment, best practices, and a focus on recovery, the need for changes in the education and training of the mental health workforce has become clear. As the population in Minnesota becomes more diverse, the need for the mental health workforce to reflect the people of Minnesota increases.

Psychiatry, psychology, clinical social work, psychiatric nursing, marriage and family therapy and professional clinical counseling are often considered the “core” mental health professions. Currently, 70 of Minnesota’s 87 counties meet federal criteria as mental health professional shortage areas. Statewide, Minnesota has about 33 percent fewer psychiatrists per capita than the national average. Shortages in rural areas are particularly critical. The shortage of child and adolescent psychiatrists is even greater, with 4.6 child psychiatrists per 100,000 as compared to 6.7 nationally.

Workforce data on the remaining core mental health professions, such as psychology and social work are limited to licensing information collected by the state’s regulatory boards. These records also show disproportionate under-representation in rural counties. For example, a 2010 tally from the MN Board of Social Work shows that 44 out of 87 counties have five or fewer Licensed Independent Clinical Social Workers (LICSW). Of those 44 counties, 8 have no LICSWs. Community mental health programs cite large turnover rates for both licensed and entry-level employees.

Historically, poor reimbursement rates in public mental health programs have contributed to the problems of attracting and retaining mental health professionals. In 2006 and 2007 an increase of 23.7% was approved for psychiatrists and advanced practice registered nurses (APRN) and “critical access mental health providers” providing care covered by Medical Assistance. However, not included in this increase were essential providers and community providers of

mental health services such as adult day treatment, partial hospitalizations, crisis services, ACT, IRTS, MH-Targeted Case Management, and certain key service components of CTSS and ARMHS.

Minority ethnic communities find it difficult to find culturally responsive providers and therefore do not easily find access to mental health services.

Improved payment to mental health providers increases consumer purchasing power, attracts qualified professionals to public service and improves earlier access to treatment and supports saving money and time. Increased reimbursement enables agencies to hire and supervise qualified workers, which reduces turnover and also saves time and money. Without adequate salaries, qualified mental health professionals leave their careers.

While the mental health system has been overburdened for some time, recent events may cause an even deeper crisis. The global economic crisis has resulted in the loss of jobs, homes, health insurance, and stability for many Minnesota families. The Mental Health Legislative Network (MHLN) is especially concerned that in these economic hard times a fragile mental health system will become broken as more people seek care, as more people are un- or under-insured and as payment rates are reduced.

The key policy objectives of the Mental Health Legislative Network to address the current needs of our mental health system are:

- **Increasing access to effective mental health care**
- **Promoting integration of mental health, substance abuse and primary care**
- **Strengthening the mental health workforce**
- **Eliminating the disparities in mental health care**
- **Providing homes and jobs for people living with mental illnesses**
- **Providing supports and education that enable children to live with their families**
- **Ending the inappropriate use of the criminal and juvenile justice systems for children and adults with mental illnesses.**

The following three issues are among the top concerns for the Mental Health Legislative Network for the 2011 legislative session:

- 1. Maintaining mental health infrastructure grants,**
- 2. Maintaining funding and treatment funded by Minnesota health care programs, and**
- 3. Supporting people who will lose their personal care assistance services.**

Table of Contents

EXECUTIVE SUMMARY	2
TABLE OF CONTENTS	5
CRITICAL ISSUES FOR 2011	6
MAINTAINING MENTAL HEALTH INFRASTRUCTURE GRANTS	6
FUNDING FOR MENTAL HEALTH TREATMENT.....	6
PERSONAL CARE ASSISTANCE SERVICES.....	7
OTHER ISSUES	9
ADULT MENTAL HEALTH GRANTS.....	9
MAINTENANCE OF EFFORT	9
QUALIFIED PERSONNEL: LICENSED SOCIAL WORKERS.....	10
CULTURAL RESPONSIVENESS	10
SUICIDE PREVENTION.....	12
EDUCATION.....	12
JUVENILE JUSTICE.....	133
EMPLOYMENT	14
HOUSING	155
CRIMINAL JUSTICE	16
GLOSSARY OF TERMS.....	17

*For additional copies or if you have questions, please contact
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Mental Health Association of Minnesota at 612-331-6840, 1-800-862-1799.*

Critical Issues for 2011

Maintaining Mental Health Infrastructure Grants

In 2007 the governor and bipartisan legislature agreed to the largest investment in our mental health system in our state's history. This bipartisan effort created infrastructure grants for key issues. This includes respite care, mental health crisis teams, culturally diverse providers, evidence-based practices, supportive housing, school-based mental health services and specialized mental health services.

Policy Recommendations:

- Maintain funding for the Mental Health Infrastructure grants.

Mental Health Treatment Funded by Minnesota Health Care Programs

Mental health services are funded by private insurance, county grants and Minnesota Health Care Programs – including Medical Assistance, General Assistance Medical Care and MinnesotaCare. Medical Assistance is particularly important as people with serious mental illnesses rely heavily on Medical Assistance for treatment.

There are some very important services funded by Minnesota's health care programs, referred to as the model benefit set, such as Assertive Community Treatment (ACT) teams, Intensive Residential Treatment Services (IRTS), Children's Therapeutic Services and Supports (CTSS), Adult Rehabilitation Mental Health Services (ARMHS), residential treatment for children, Crisis Services and Case Management or Care Coordination. The model benefit set was part of the bipartisan 2007 mental health initiative and it was hoped that this benefit set would, over time, be adopted by the health plans. The payment rates for these services have been low and providers struggle to keep providing these services within the payment rates. Any cuts to payment rates or elimination of services will decimate the mental health system.

Policy Recommendations:

- Maintain current payment rates for mental health services
- Maintain services and treatment currently covered under Minnesota Health Care Programs.
- Maintain other services that enable people to live in the community such as CADI waivers.

Personal Care Assistance (PCA) Services

Personal Care Assistance Services are in-home services that support people to live at home and in the community. Both children and adults with mental illnesses use PCA services. Some children with serious mental illnesses need to be guided and watched so that they don't harm themselves or others and need ongoing guidance and cuing with every day activities such as grooming, homework, etc. Adults with mental illnesses may need assistance with shopping, cooking, laundry, balancing a checkbook and housekeeping. Some adults with very serious mental health and cognitive problems also need hands-on supervision with basic hygiene and daily living. Changes made to the PCA program in 2009 that will go into effect on July 1, 2011 will result in 2500 to 3000 people losing their PCA services – many of whom are children and adults with mental illnesses and many from communities of color.

PCA services do work for adults and children with mental health and other cognitive problems. PCA services are highly cost effective, are provided on a daily basis, and are available statewide, unlike some mental health services. Both children and adults with mental illnesses have been able to utilize PCA services as part of a plan of care to help them function in their home and community. PCA services are often provided in conjunction with services such as Adult Rehabilitative Mental Health Services (ARMHS) or Children's Therapeutic Services and Supports (CTSS), which are only offered a few hours a week and are geared toward skills-building, rather than to the daily maintenance and help at home which PCA offers. In part because of the availability of PCA services to persons with mental illnesses, Minnesota has been able to significantly reduce the use of institutional services. PCA services are an essential part of Minnesota's community support service system for children and adults with mental illnesses and other disabilities.

The 2009 Legislature allocated \$8 million in 2012-13 to develop alternative services for persons with mental illnesses. State funded alternatives do not adequately exist as a resource statewide, and are unable to fill the void created by the new restrictions on access to PCA services. A new federal option called the Community First Choice Option ("1915 k") shows much promise, enabling assistance to help a person "acquire, maintain or enhance skills and functioning". It also provides a 6 percent increase in the federal Medicaid match on an ongoing basis, while not requiring any expansion of Minnesota's Medicaid income eligibility.

Policy Recommendations:

- Amend PCA eligibility criteria to assure that children and adults with mental health diagnoses, behavioral or cognitive problems have continuing access to ongoing help in order to continue living at home and to function effectively in their communities.

- Participate in the federal Community First Choice state plan option designed to provide help at home for persons with disabling conditions, and which carries an enhanced federal rate.
- Develop and implement any alternative services in a way that ensures assistance without interruption for those who may lose eligibility due to 2009 changes in eligibility criteria.
- Continue to improve the assessment process to increase the quality of the review of the person's need for assistance, and the implementation of services that will maximize independence and recovery for persons with mental illnesses.
- Assure that the new requirements for referrals to other mental health and support services are properly implemented by training assessors and providing specific contact information on available services accessible within the person's geographic area.
- Improve the availability and quality of training for PCA agency staff.
- Generate usable data on referrals made to mental health services and other home care services, subsequent services obtained by individuals trying to stay in their homes, and client outcomes required to be reported by counties, tribes and health plans quarterly to DHS for public dissemination.

Other Issues for 2011

Adult Mental Health Grants

Adult mental health grants provide funding for a variety of county mental health services such as Community Support Programs, housing support services, consumer run drop-in centers, peer support and recovery oriented mental health services, which can not be billed to Medical Assistance or private insurance. These services provide essential support for people as they leave more intensive treatment services and live in their community.

Policy Recommendations:

- Maintain funding for Adult Mental Health grants.

Maintenance of Effort (MOE)

Many mental health services need county funding. In 2006, the legislature required counties to “maintain” their funding levels at the same amount as they did in 2004 and 2005. In the 2009 legislative session, due to the economic crisis, counties sought flexibility under these MOE provisions.

An agreement was reached that provided clarity on how to determine base levels and allowed some flexibility on major changes experienced by a county. As the economic crisis worsens, the MOE system may come under further pressure. While many counties face financial difficulty, it would be short sighted to allow counties to make further reductions in mental health services and would add additional costs.

The 2009 Legislature required the Commissioner of Human Services to propose an alternative means of funding and providing services. The proposal will create a new consolidated county property tax contribution across all mandated health and human services programs that will function as an equalized levy. However, without a specific proposal on the table, advocates are unwilling to abandon MOE.

A competing effort to reformulate state requirements for county services was also passed in 2009. A State-County Results, Accountability, and Service Delivery Redesign Council will be established with representatives of counties, legislators and unions. The council will review and certify the formation of service delivery authorities (SDA) either in a large county or a group of counties. These SDAs could obtain waivers from current laws in order to change the delivery of human services. There is no guarantee that new delivery methods will work as intended, or that these changes will not amount to service cuts. Consumers and families were not a part of the council.

The difficulties faced by many county governments are real. However, the current proposals to address these concerns are likely to come at the expense of mental health consumers. Instead of clarity, these proposals have created greater uncertainty over sources of funding and service provision requirements. Without adequate input from consumers and their advocates, these reforms run the risk of damaging the mental health system they are intended to repair.

Policy Recommendations:

- Do not allow any further reductions of county funded mental health services.
- Require that service changes reflect the input of mental health advocates.

Qualified Personnel: Licensed Social Workers

In 1987, county, city and state social workers were exempted from new licensure regulations established for all Minnesota social workers. Removing this exemption from social work licensure will ensure public protection. When government employed social workers are licensed, clients and their families can be confident that the social workers have met professional standards for education, examination, supervision, and continuing education.

Licensure complements the public protection provided by the DHS Fair Hearings process. The Fair Hearings process addresses client complaints about decisions made by county, city and state social service agencies. The independent social work licensing board, rather than an employer, is the appropriate entity to address client complaints about the unethical or incompetent practice of specific licensed social workers.

Policy Recommendation:

- Remove the licensure exemption for county, city and state social workers.

Cultural Responsiveness

Minnesota is becoming increasingly diverse. Population changes will have an impact on both access to and effectiveness of mental health services. Stigma about mental illness and the lack of culturally responsive mental health professionals are key factors in addressing access to care.

The Wilder Foundation 2006 study found that youth from minority racial or ethnic groups were one-third to one-half as likely to receive mental health services as white youth. Completion of treatment and quality were also different, with African American youth being less likely to complete treatment.

Mental health treatment disparities were cited in the state's federal block grant application as an issue to be addressed. While much of the research in this area has focused on African Americans, the results may well apply equally to other groups.

In an article in *Psychiatric Services*, December 2005, the authors cited disparities in both access to and quality of mental health services for racial and ethnic minority groups. They found that there was inadequate early detection, high drop out rates from treatment, and inappropriate use of antipsychotic medications with African Americans. A 2005 report by the federal agency, Substance Abuse and Mental Health Services Administration (SAMHSA) stated that while disparities are reduced, there is a lower use of counseling or therapy by African Americans; and African Americans with higher income and education levels are less likely to access mental health treatment.

A 2008 study submitted to the MN Board of Social Work states: "Comparing the number of licensees who identify themselves from a minority ethnic group with the numbers of minority populations within the state, it is easily observed that this is an underserved area of great concern."

Policy Recommendations:

- Continue funding loan forgiveness programs to prepare providers from ethnic minorities with the qualifications to be eligible for third party reimbursement, including loan forgiveness and scholarships for bilingual/bicultural aspiring providers.
- Ensure children are placed in foster homes or treatment facilities that have culturally responsive providers and programs.
- Provide affordable and easily accessible interpreter services for all children and families who are not proficient in the English language and need mental health services and look at requiring health plans to include a certain number of culturally responsive providers in their network.
- Require cultural training and responsiveness as a requirement for licensure and licensure renewal.
- Provide grants to allow bridging between mental health community and ethnic communities, including stipends for internships for bilingual and bicultural providers.
- Continue to fund grants to nonprofit organizations that ensure that culturally responsive mental health services are provided to individuals throughout the state.

Suicide Prevention

Minnesota's suicide rate has increased each year since 2000 with over 500 deaths by suicide per year, making suicide a leading cause of violent death in Minnesota. More than 90% of suicides are associated with diagnosable mental illness and/or substance abuse.

Many populations have unique concerns related to suicide, and high suicide rates often reflect the disparities in adequate access to mental health services. Of all age groups, persons 75-84 years of age have the highest suicide rate, and suicide is the second leading cause of death for 15-34 year olds; ten percent of college students report having seriously considered suicide at least once in the past year. The suicide rate for American Indians is approximately two times higher than for any other racial or ethnic group. The number of active-duty U.S. Soldiers who die as a result of suicide is on track to exceed last year's rate, which was at an all-time high (as reported by the U.S. Army in September, 2008).

Stigma associated with psychiatric illness, lack of knowledge, and symptom recognition about clinical depression prevents timely and appropriate treatment that would save lives.

The impact of suicide on families and communities is devastating. The loss of life by suicide is inestimable, but public investment in suicide prevention yields public benefits. For example, the MDH estimates economic savings to the state of \$658,500 for each youth saved by preventing suicide.

Policy Recommendations:

- Maintain funding for the MN Statewide Suicide Prevention Plan programs.
- Provide routine depression screening and follow-up care in primary care and behavioral health settings.

Education

Children spend their days in school. Children with mental illness do not fare well in schools. Poor outcomes in schools lead to frequent suspensions, falling behind, truancy, and dropping out of school, with the final stop being the juvenile justice system. More must be done to support school success with these children.

Bullying creates a hostile environment. Schools must take a strong stand against bullying of any kind and all children should feel safe in school.

Policy Recommendations:

- **Maintain grant funding for school-based mental health services; update and simplify rules to community providers to contract and link services with schools.**
- **Require the Department of Education to recommend model mental health curricula to school districts.**
- **Support the “Safe Schools for All” bill.**

Juvenile Justice

Nearly 70% of youth in the juvenile justice system have one or more diagnoses for mental illness. This is a critical issue in Minnesota with long term implications. In 2007 the Department of Corrections, in partnership with state and local agencies, established the Juvenile Justice and Mental Health Initiative to improve the outcomes for youth in the justice system with mental illness or co-occurring disorders.

There was consensus that mental illness plays a huge part in why young people end up in the juvenile justice system and that the juvenile justice system is not an appropriate system to serve as the last resort for mental health care. Four themes emerged from the group:

- **The need to collect data that better informs the process and to share data without jeopardizing the legal interests of youth as defendants;**
- **The need for post-screening coordination to facilitate getting help;**
- **The need to better engage families and caregivers as partners;**
- **The need for evidence-based, community-based mental health interventions that are effective with justice involved youth.**

Policy Recommendations:

- **Address racial disparities by reviewing how race, gender and ethnicity may impact diagnostic assessments and placement in treatment facilities.**
- **Employ culturally specific treatment and therapists to ensure equitable outcomes.**
- **Request the State to address racial disparities in regard to diagnosis, placement in treatment and treatment success/failure by race, gender and ethnicity.**
- **Analyze statewide needs and resource analysis regarding treatment for justice involved youth with severe mental health issues.**
- **Develop co-occurring (MI/CD) programming for youth involved in multiple systems of care (including juvenile justice).**
- **Change correctional and residential licensing standards to address the needs of the population and include licensing mental health professionals**

(i.e. JDAI standards) to respond to the 70% of youth in juvenile justice who have mental health and chemical dependency concerns.

- Provide funding for at least one mental health discharge planner at the Red Wing Juvenile Detention Facility.

Employment

Many people with mental illness can and wish to work but are not working. According to recent research, 70% of adults with a serious mental illness would like to have a job. Employment is viewed as an important part of recovery and supported employment for people with a serious mental illness is considered an evidence-based practice.

Unfortunately, for many people with a serious mental illness, employment eludes them. People with a serious mental illness have the highest unemployment rate, which is costly to the individuals and to our communities.

Of the adults with a serious mental illness using case management, 75% were reported to be looking for work or not in the labor force. Barriers to employment included: stigma and discrimination, fear of losing health benefits, lack of vocational services and lack of transportation. The unemployment rate and lack of employment services to assist people with a mental illness is a national and state disgrace.

The Extended Employment Project for People with Serious Mental Illness (EE-SMI) uses interagency collaboration, individualized supported employment and consumer involvement in the planning, development, oversight and delivery of services. Support services can include: job coaching, facilitation of natural supports, supportive counseling, coordination of support services, job development or placement, training in social skills and money management. A key feature of this program is that ongoing employment supports are provided. Providers can also help with career advancement and to find a new job. This program includes providers who are working to meet the fidelity standards of the evidence-based practices of supported employment.

There are currently 19 projects covering 53 counties under the state funded EE-SMI program serving 1353 people. Large counties, such as: St. Louis, Hennepin, Dakota only have one project with limited capacity, with 39% of counties not having any project. In SFY 10, there were 1,353 people served across all projects. People who had jobs worked over 254,000 hours and earned over 2 million dollars in wages.

This program has faced reductions over the last couple of years, from a high of \$1.65 million to now below \$1.3 million. The loss of funds has resulted in fewer people with mental illnesses obtaining support in finding and keeping employment.

Minnesota is one of ten states participating in the Johnson & Johnson - Dartmouth Community Mental Health Program i to increase access to evidence-based supported employment (SE), also known as Individual Placement and Support (IPS), for adults with serious mental illness who are interested in improving their work lives. This national program systematically works with states to implement supported employment following the evidence-based guidelines. The program is administered in each participating state through the collaboration between the state mental health authority and the state vocational rehabilitation administration.

Policy Recommendations:

- Maintain funding for the EE-SMI program.
- Explore the Medicaid 1915(i) option to pay for supported employment.

Housing

The availability of affordable housing is an acute societal problem. It is particularly acute for people with mental illnesses who not only need affordable housing but also require a flexible array of supports to enable them to live successfully in the community. For people with serious mental illnesses, the shortage of community housing options is a crisis situation that creates incredible hardship for people and wastes scarce state and public resources.

If an individual is on Social Security and Supplemental Security Income (SSI), there is not one housing market nationwide they can afford. A Wilder Foundation study has found that 47% of the homeless in Minnesota have a mental illness. A major factor leading to homelessness is the lack of affordable housing.

A crisis homeless situation currently exists in Minnesota. High unemployment, home foreclosures, lost savings, no medical insurance, and lack of necessary resources and support systems have resulted in many adults and children flooding our homeless shelters. Many people are turned away because the shelters are full.

A Bridges certificate is a housing subsidy - recipients pay 1/3 of their income for rent and the Bridges subsidy covers the remainder while waiting for a federal Section 8 certificate. The allocation for the current biennium will serve an estimated 542 households at an average cost of \$5,000 per year. The long waiting lists for the federal Section 8 housing certificates has made it even more difficult

for people to get on the Bridges program, with the average time on the Bridges program going from 2.1 years in 2003 to 7 years in 2008. In Hennepin County only nine households entered the Bridges program during SFY09, and none exited.

Policy Recommendations:

- Increase funding for Bridges certificates.
- Provide immediate emergency funds to cities throughout Minnesota to help address homelessness issues.
- Investigate the Medicaid 1915(i) program for supportive housing.

Criminal Justice

Many people with mental illnesses experience repeated encounters with the criminal justice system without ever receiving treatment or support services for their illness. Many lose their health care and financial benefits after entering the criminal justice system and upon release have no way to obtain medication or treatment. Inmates who have a mental illness are more likely than other inmates to have been homeless or unemployed. Upon discharge into the community they face additional obstacles such as difficulty obtaining medications and treatment, finding work, re-establishing family relationships and avoiding further contact with the criminal justice system.

Policy Recommendations:

- Maintain the current number of prison discharge planners.
- Maintain the current mental health and chemical health treatment programs in the prisons.
- Maintain the funding for public defenders.

Glossary of Terms

Mental health services and concepts are often described with technical terms and acronyms. This glossary contains some of the key terms used in the document.

Adult Crisis Services: Emergency services that provide prompt therapeutic intervention to those experiencing a psychiatric emergency.

Adult Rehabilitative Mental Health Services (ARMHS): A rehabilitative program for persons who have a mental health diagnosis and could benefit from services to regain skills related to independent living, involvement in the community or managing their mental health.

Assertive Community Treatment (ACT): a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illnesses.

Care Coordination: A process that links children with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

Case Management: A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health, mental health and human service needs.

Children's Therapeutic Services and Supports (CTSS): A flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to address the mental illness that impairs and interferes with the individuals' abilities to function independently.

Community Behavioral Health Hospitals (CBHH): free standing 15 bed state owned and run facilities that provide short term, acute inpatient psychiatric services.

Community Mental Health Centers (CMHC): Providers of comprehensive mental health services, offering outpatient, home-based, school, and community-based programs to individuals and families.

Drug Formulary Committee: An advisory group that makes decisions

on which drugs will be covered by Minnesota's publicly funded health care programs.

Electroconvulsive Therapy (ECT): The administration of a strong electrical current that passes through the brain to induce convulsions. It is usually only considered after a patient's illness has not improved after other treatment options have been tried.

Intensive Residential Treatment Services (IRTS): A time-limited residential mental health treatment for people with mental illnesses who are in need of restrictive settings and are at risk of significant functional deterioration. IRTS are designed to develop and enhance psychiatric stability, and the ability to live in a more independent setting.

Maintenance of Effort (MOE): State requirements for county spending on social services, based on historical levels.

Medical Assistance (MA): Minnesota's Medicaid program. They provide payment for health care services on behalf of eligible low-income individuals with limited income and high medical expenses.

Mental Health: Defined by the World Health Organization as "a state of well-being in which the individual realizes his or her abilities, can cope with normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community."

MinnesotaCare: A state program that provides subsidized health care coverage to low and moderate-income families and individuals.

Personal Care Assistance (PCA): A program which provides services to persons who need help with day-to-day activities to allow them to be more independent in their own home.

Prepaid Medical Assistance Program (PMAP): A health care program that pays for medical services for low-income families, children, pregnant women, and people who have disabilities.

State Medical Review Team (SMRT): A unit of the Department of Human Services that determines disability in consultation with medical professionals appointed by the commissioner. A primary function of the SMRT is certifying disability for people who are applying for Social Security Administration (SSA) disability benefits.

State Operated Services (SOS): A division of the Minnesota Department of Human Services. It consists of an array of campus and

community-based programs serving people with mental illness, developmental disabilities, chemical dependency and traumatic brain injury as well as people who pose a risk to society.