Needs Assessment - 2016

Excellence in Mental Health Act in Minnesota

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EXECUTIVE SUMMARY

BACKGROUND
In March of 2014, Congress passed the Protecting Access to Medicare Act (H.R. 4302). This legislation includes provisions of the Excellence in Mental Health Act – an eight-state demonstration project and the single largest investment in community behavioral health in more than 50 years.

This demonstration project authorizes states to create criteria for “Certified Community Behavioral Health Clinics” (CCBHCs). CCBHCs will serve individuals with serious mental illness and substance abuse disorders through a wide array of comprehensive evidence-based practices that will include treatment, prevention, and wellness services.

This needs assessment is to be used to determine staffing, linguistic and cultural competence, and the evidence-based practice needs of the community that the CCBHC serves.

Of necessity, needs assessments use numbers and statistics to present information about people to give a sense of the issues that affect their lives. But when we present information about people with mental illnesses (MI) and substance use disorders (SUD), the adage “statistics are people with their tears wiped dry” is never more true.¹ Certainly, mental health and substance abuse providers and the people they serve know the stories and tears behind the statistics. This needs assessment aims to balance the data with the thoughts and feelings of the people most affected by MI and SUD.

FINDINGS
The population in Minnesota is becoming more diverse, with about one in five (19%) Minnesotans identifying as a Person of Color. Meanwhile, four percent of Minnesota adults have experienced a serious mental illness, and almost 8 percent of Minnesota’s adolescents ages 12 to 17 – more than 26,000 young people – experienced a major depressive episode. Persons of color in Minnesota – including each major racial group – have the highest percentage of individuals experiencing depressive symptoms and serious psychological distress.

Approximately 16% of Minnesota adults had either current depression or a substance use disorder in 2010: 6.9% with depression only, 7.2% with SUD only, and 1.5% with both. Significant regional differences exist in the type of substance abuse resulting in admission to treatment, signifying that there are geographical and cultural patterns related to substance use and abuse within the state.

There are profound shortages of qualified providers in the state. Nine of Minnesota’s 11 geographic regions have been designated as mental health
professional shortage areas by the Health Services Administration. The network of care often extends past the walls of the clinic, and may include law enforcement, county social services professionals, and schools, among others.

Feedback from providers of mental health services emphasized that if primary care services were more available, they could free up availability for inpatient adult psychiatry beds and residential crisis stabilization services. Key stakeholders noted that there is still a shortage of culturally responsive providers. More training and education is needed to build a culturally responsive workforce, and to increase representation of providers who come from diverse cultural groups.

Consumers of mental health and substance abuse services were generally satisfied with their care, but noted issues with costs and wait times. They felt that their providers generally included them in care planning, but wished for greater confidentiality regarding their services. Many also indicated that they used holistic practices such as mindfulness to deal with stress, and wished that their insurance would pay for more integrative therapies rather than a reliance on medications.

"I would like it if concerns were treated with less prescription medication and focus on life changes in diet, exercise, thinking, and stress management and medication only used in emergency situations or when all other techniques have failed."

The needs of special populations highlight the importance of cultural and linguistic sensitivity and competence in treatment. Although the groups were, in themselves, very unique, there were some common themes regarding preferred treatment characteristics that spanned cultural differences. Providers were encouraged to take the time to develop personal relationships with their clients, to respect cultural sensitivities about stigmas related to mental health, and to focus on healing, rather than treatment. As one Hmong person stated it, "Doctors fix your sickness and the Hmong way helps your soul."

First Implementers noted common themes in addressing the unmet needs of their service areas. These included: staffing, culturally-appropriate services, services for children, and reimbursement for travel time in greater Minnesota.

Implementers were asked to describe their model practices and include information on the percentage of staff who have been trained. Overall, the pattern of breadth of model practices versus depth (in terms of number of staff trained) can best be described as highly variable. In most cases, special populations are integrated into the mainstream service system rather than being served in separate programs tailored to their needs.

Each service area varied in terms of level of need, as indicated by the amount and type of substance abuse found in the geographic region, the intensity of mental health services that were accessed, and the unique cultural and linguistic needs of the populations in the area.
As work progresses toward certification, each First Implementer will need to address the specifics of its population needs and service offerings to ensure that they are truly closing identified gaps in care. The key issues will differ between metro and greater Minnesota, and even among First Implementers sharing county service areas, but the collaborative spirit that has permeated this endeavor will foster insights and learning that will benefit the state and its people.

Minnesota has begun an important journey toward developing a collaborative process of community mental and mental health care that will result in significant changes to the way care is delivered in the state.
DEMOGRAPHICS OF MINNESOTANS

GENERAL POPULATION
In 2014, Minnesota’s total population was 5,453,218, with over half living the seven-county metropolitan area. Population changes between 2010 and 2014 saw a trend towards more people living in the metropolitan area, as shown in Figure 1, below. People of Color (those who identify as a race other than White alone, and/or those who are Hispanic) make up 19% of the total population. Non-Hispanic White Minnesotans represent the remaining 81% of the statewide population.

Figure 1: Percent Population Change 2010-2014

In 2014, about 1 in 14 Minnesotans (7.2%) was foreign-born. Forty-five percent of Minnesota’s foreign-born population are naturalized U.S. citizens. The largest groups of foreign-born Minnesotans were born in Mexico (about 66,000); India (29,000); Laos, including Hmong (28,000); Somalia (26,000); Ethiopia (18,000); China, excluding Hong Kong and Taiwan (18,000); Thailand, including Hmong (17,000); and Vietnam (17,000). The primary language spoken at home by people age 5 and older in Minnesota is English. The next most common languages spoken at home are Spanish (about 185,000 speakers) and Hmong (65,000 speakers).

Between 2010 and 2014, the state has added four times as many people of Color as non-Hispanic White residents.
Populations of Color are distributed unevenly across the state, and are more likely to live in metro areas than rural areas.

Younger Minnesotans are more racially diverse than older Minnesotans. In three counties in Minnesota – Mahnomen, Nobles, and Ramsey – more than half of the population under age 5 is a child of color (69%, 63%, and 54%, respectively). Statewide, 31% of children under age 5 are children of color – either American Indian, Asian, Black, Multiracial, and/or Hispanic. See Figure 2 for a representation of the % change in populations of Color between 2000 and 2010.

**Figure 2: Percent Increase in Populations of Color**

Another way to show this trend is found in the figure, below.
Minnesota has a number of residents for whom English is not their primary language. Figure 4 shows the areas within the region where people over the age of 5 speak a language other than English and speak English “less than very well.”

**Figure 4: Percent of Population Aged 5 Years and Over Speaking Language Other than English at Home**
Minnesota has a low rate of uninsurance: 5.9% of Minnesotans were uninsured in 2014 compared to 11.7% for all Americans. About 6% of Minnesota children under 18 were uninsured in 2014, along with 16.3% of those ages 18-64, and only 0.9% of those age 65 and older. However, health insurance coverage in communities of color is still much lower than that of Minnesota's white residents, greatly affecting access to mental health, substance abuse, and other treatment services.

The median household income in 2014 was $61,500, compared to $53,700 for the U.S. as a whole. Minnesota's overall poverty rate was 11.5% in 2014. However, significant differences in poverty levels exist by race and ethnicity, particularly for children. More than 40% of Black and American Indian children lived in poverty in 2014, as well as 3 in 10 Hispanic children.

However, as can be seen in the figure below, disparities exist in the overall health of populations. These health disparities also manifest when it comes to mental health and substance use disorder, as will be shown later in the report.

**Figure 5: Disparities in Mortality by Race in Minnesota: 2006 - 2010**

![Disparities in Mortality by Race](image)

### DEMOGRAPHICS OF PEOPLE WITH MENTAL ILLNESS

More than 500,000 adults in Minnesota have a mental illness, and between 2009 – 2013, four percent of Minnesota adults experienced a serious mental illness. Almost 8 percent of Minnesota's adolescents ages 12 to 17 – more than 26,000 young people – experienced a major depressive episode. Persons of color in Minnesota – including each major racial group – have the highest percentage of individuals experiencing depressive symptoms and serious psychological distress.

Less than half of Minnesota's residents living with a mental illness receive treatment services, according to data from 2008-2012. There is a sharp difference, however,
in treatment rates across racial and ethnic groups. Each major racial group is represented among Minnesota residents who experience depressive symptoms and serious psychological distress, but the percentage of people who receive treatment is dominated by White residents. Minnesota’s residents of color living with mental illness, substance abuse, or co-occurring disorders are underrepresented among those receiving treatment. Populations of color in Minnesota have the highest percentage of individuals experiencing depressive symptoms and severe psychological distress. However, just 25% of individuals who receive mental health treatment in Minnesota are persons of color. See Figure 6.14

Figure 6: Treatment vs. Symptoms by Race

Minnesota’s residents of color living with mental illness, substance abuse, or co-occurring disorders are underrepresented among those receiving treatment.
A Wilder Research study in Ramsey County evoked the following response: 

“In our community, we tend to farm out the culturally appropriate piece, but if that could become part of the general institution. When we depend on external people, those services are good only as long as those services are around... I look at the unintentional message – if you belong to the “other,” then go to the other agencies. There are other agencies doing cultural work.”

On average, Minnesota hospitals care for 1,077 mental health inpatients each day. Mental health diagnoses were three of the top five reasons for admission for children and adolescents aged 10-17 from 2010 to 2014. Individuals with mental illnesses are 38% more likely to be readmitted to the same hospital for mental illness treatment. The volume of inpatient and outpatient mental health visits across the state is shown below in Figures 7 and 8, respectively.

Figure 7: Inpatient Mental Health Visits in Minnesota
When examining the approximately 8% of Minnesota adults who were estimated to have current depression, we see subgroups who are more likely than their respective counterparts to have current depression. These higher-risk groups include: women; U.S. born adults; American Indians, blacks or Hispanics; adults with disability; and the unemployed.\textsuperscript{17}

A report by MN DHS in partnership with the National Alliance on Mental Illness (NAMI) contained the following responses.\textsuperscript{18}

As one young participant explains, “(providers) need to do more than tell you what needs to happen. They need to tell you how to do it.”

“I feel as if mental health provider should not be in an enclosed building.” – Youth response
**Adults with MI**
Wilder also collected survey data from 437 people who received services or their caregivers. Consumers were most likely to learn about services from health or mental health providers, and they rated those services as most helpful. Specifically, adults with mental health conditions found mental health therapy, counseling, or psychiatry to be the most valuable service they received.

When asked to rate the quality of the service they felt was most valuable for them, sixty percent of adults with mental health conditions rated the quality of this service to be very good, and an additional 34 percent rated the quality of service as pretty good, but could be better.

Many consumers believed that communication with providers and accessibility needed to improve. One-third of consumers said the services they received met all their needs, and just under two-thirds said the services they received met some of their needs. Yet, 45% of adults with mental health conditions said there was help they needed but were not able to get in the past 12 months. They were especially likely to say that they needed help with housing, personal support/companion services, and help with employment. Adults with mental health conditions most frequently identified eligibility requirements and cost of services as reasons they were not able to get the most needed service.

One-third of adults with mental health issues said it was difficult to access services. Consumers found it easier to access doctor primary care physician appointments than mental health counseling, therapy, or psychiatry. Waiting lists, provider availability, service costs, and provider qualifications sometimes made it difficult for consumers to receive services. Consumers rated eligibility and cost as the greatest barriers to access services.

**Caregivers**
Only one in five (21%) caregivers of children with mental health issues felt that the services they received met all of the child’s needs, and 71 percent felt the services met some of the child’s needs. Caregivers of children or youth with mental health conditions were most likely to say that their children had appointments with a doctor or primary care physician (95%). Other prevalent services included: mental health counseling, therapy, or psychiatry (76%); medication management (65%); support from a case manager, care coordinator, or social worker (62%); occupational therapy (OT) or physical therapy (PT) (51%), and support from a Personal Care Assistant (PCA) (49%).

When asked how services could better meet their needs, some caregivers again expressed their stress and frustration navigating the system of care for their children. Half of the caregivers said it was difficult for children to access services.
Other caregivers referenced shortages in service availability, limited school-based support, and a need for greater financial and other support for families.

Caregivers (55%) were most likely to learn about services from health or mental health care providers, and these sources of information were also those rated as most helpful. However, some caregivers felt as though they only learned about services through their own efforts.

Almost one-third of caregivers (31%) found Personal Care Assistants (PCAs) to be the most valuable service received by their child (although they found it easier to access counseling or therapy than to receive PCA services.) Thirteen percent of caregivers felt mental health counseling, therapy, or psychiatry was most valuable, while 11 percent selected medication management. No other services were selected by at least ten percent of the caregivers.

One-third of the caregivers found their case manager “very helpful.” Caregivers wanted case managers to be more knowledgeable and to have more ongoing communication with them. Two-thirds of the caregivers said that children with mental health issues received services at home.

Caregivers were more likely than representatives of the other survey respondents to say that they needed help that they were unable to get in the past 12 months. Caregivers of children with mental health issues were especially likely to say that they needed respite care, caregiver or family support, or crisis services. Service availability, intake processes, waiting lists, and service costs sometimes made it difficult for caregivers to receive services.

DEMOGRAPHICS OF PEOPLE WITH SUBSTANCE USE DISORDER

Minnesota adults with current depression are more likely to smoke cigarettes, use illicit drugs, and have a SUD. Even adults who show some mild depressive symptoms but without current depression are more likely than the others with no depressive symptoms to have a substance use disorder.20

Approximately 16% of Minnesota adults had either current depression or a substance use disorder in 2010: 6.9% with depression only, 7.2% with SUD only, and 1.5% with both. Those subgroups who were found to be more likely than their counterparts to have depression with a co-occurring SUD include: young adults (18-24), American Indians, adults with disability, and the unemployed were more likely than their respective counterparts to have co-occurring SUD and current depression.21
Admission to Minnesota treatment facilities in 2014 showed marked differences, depending on the substance being used and the county of admission. The following maps show these differences. 

Figure 9: Admissions for Amphetamine Use by County

Figure 10: Admissions for Methamphetamines Use by County
Figure 11: Admissions for Opioids Use by County

Figure 12: Admissions for Crack/Cocaine Use by County
A summary of the above data regarding admissions to Minnesota treatment facilities for drug and alcohol use can be found in the table below.\(^23\)

As can be seen, Norman, Cass and Crow Wing Counties have higher admissions to treatment facilities for alcohol. Hennepin County has the highest admissions for crack and cocaine use, followed by Ramsey County. The counties with higher admissions for marijuana use are Mahnomen and Norman. Admissions for methamphetamines are highest in Todd County, and admissions for opioids are highest for Mahnomen County.

Minnesota Student Survey trend data on self-reported alcohol and marijuana use for Minnesota ninth-graders between 1992 and 2013 shows that alcohol usage dropped dramatically through 2013. Males and females followed a similar pattern over time,
but females consistently reported slightly higher usage of alcohol than males. Reports of marijuana usage have decreased greatly since the peak in 1998, but have appeared to level off since about 2007.24

The same survey found that, in the past month, more than one-quarter of eleventh-graders (27.6%) had used alcohol, 16.5% had used marijuana or hashish, and 7.0% had used prescription drugs not prescribed for them. In the past 12 months, 2.7% had used over-the-counter drugs to get high; 2.3% had used LSD, PCP or other psychedelics; 1.6% had used MDMA, GHB, or Ketamine; 1.2% had used any form of cocaine; 1.0% had used inhalants to get high; 0.8% had used methamphetamines.25

According to a 2010 survey of adult Minnesotans:26

- Just under one-fifth (18%) reported binge drinking (defined as consuming, on a single occasion, 4 or more drinks for women and 5 or more drinks for men) in the past month.
- About 10% acknowledged that they used illicit drugs in the past year. Marijuana was the most commonly used illicit drug, followed by nonmedical use of prescription drugs (pain relievers, tranquilizers, sedatives or stimulants). Approximately 8% of Minnesota adults reported use of marijuana in the past year, and 38% of them (3% of all adults) reported using it once a week or more often during the past year or on 4 or more days during the past 30 days. Almost 4% of Minnesota adults reported misuse of prescription drugs. Use of other illicit drugs is relatively uncommon, with less than 1% of adults in Minnesota reporting use of them during the past year.
- Similarly, both any drinking and binge drinking in the past month were more common among men than among women. Marijuana use also showed the same pattern with men reporting more use than women for both any use in the past year as well as frequent use (defined as smoking marijuana once a week or more during the past year or on 4 or more days in the past 30 days). While men were slightly more likely than women to report misuse of prescription drugs during the past year, the difference was not statistically significant.
- The prevalence of drinking in the past month was highest among those who were 25 or older but younger than 65, and lowest among seniors. However, binge drinking was most prevalent among young adults (33%) and the rates decreased as age increased. In addition, among those who were younger than the legal drinking age of 21, about one in three (33%) reported drinking during the past month and 27% reported binge drinking in the past month.
- The illicit drug use during the past year was much more prevalent among young adults (ages 18 to 24) than older adults, with seniors showing the
lowest rates. The rates of marijuana use, both any use and frequent use, among young adults were more than twice as high as those aged 25 to 44 and almost five times higher than those aged 45 to 64. Similarly, the rate of misuse of prescription drugs among young adults was more than two times the rate for the 25-44 age group and more than four times the rate for the 45-64 age group.

• Whites had the highest rate of any drinking in the past month (60%), and American Indians as well as whites had the highest rates of binge drinking in the past month (20% and 19%, respectively). American Indians had the highest rates of illicit drug use with 21% reporting marijuana use in the past year and 11% reporting misuse of prescription drugs in the past year.

• Approximately 3% of Minnesota adults met the criteria for alcohol dependence, with an additional 5.6% meeting the criteria for alcohol abuse. Drug use disorders were less common; 1.2% showed dependence symptoms and less than one percent met the criteria for drug abuse. Overall, 8.8% of Minnesota adults reported symptoms for substance abuse or dependence.

• The analyses showed that, even after controlling for marital status, employment status, income and education, age and gender were consistently found to be significant predictors for substance use disorders: Women and older persons had lower odds of having substance use disorders than their counterparts. In addition, after controlling for other factors, American Indians were found to have higher odds of having both alcohol and drug use disorders than whites, and African Americans had lower odds of having an alcohol use disorder compared to whites. In 2014, Minnesota had the fifth lowest age-adjusted mortality rate from drug overdoses.27

The following table comes from a DHS statewide study of lifetime and past year use of illegal drugs by demographic characteristics.28 As can be seen, substance use and abuse varies significantly by demographic characteristics.
The same study reported the percent of adult respondents who would seek treatment if they thought they had an alcohol or drug problem. Individuals in this study who actually had a substance use disorder were more likely to respond “no” to seeking out treatment than respondents who did not have a substance abuse disorder. These results are shown below.
Effect of Treatment
A 2013 Legislative Report identified the following effects of treatment:\textsuperscript{29}

- Most Minnesotans who enter treatment complete it and show considerable improvement in substance use, employment, housing, criminal behavior, and participation in recovery support groups. Studies that follow Minnesotans after treatment show that abstinence from substance use and other benefits tend to persist.
- Economic studies across settings, populations, methods and time periods consistently find the primary economic benefits of SUD treatment result from post-treatment reductions in health care costs and reduced crime.
- The disease of addiction, like other illnesses, is most successfully treated and arrested in its early stages.

Listening Sessions from the MN DHS Alcohol and Drug Abuse Division
In 2015, the MN Department of Human Services held a series of listening sessions.\textsuperscript{30}
The following quotes are reflective of the comments provided by participants.

“What works in the metro areas does not necessarily work in the rural areas.”

“Develop relationships with refugee/migrant communities.”

“Increase the treatment options for deaf and hard of hearing.”

“The fact that counties are currently solely financially responsible for detox services is the driver behind underfunding and loss of detox beds and facilities.”
“Stop criminalizing people and the issue: frame substance abuse and addiction as a public health concern rather than a criminal justice issue.”
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

MENTAL HEALTH WORKFORCE

Nine of Minnesota’s 11 geographic regions have been designated as mental health professional shortage areas by the Health Services Administration. Figure 7 illustrates the ongoing need for more mental health professionals in Minnesota.

Figure 17: Mental Health Professional Openings and Projected Growth Rate

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Current Employment</th>
<th>Total Projected Openings, 2010-2020</th>
<th>Projected Growth Rate, 2010-2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists (a)</td>
<td>290</td>
<td>180</td>
<td>25.4%</td>
</tr>
<tr>
<td>Psychologists (a)</td>
<td>2,420</td>
<td>1,900</td>
<td>24.4%</td>
</tr>
<tr>
<td>Social Workers, Mental Health and Substance Abuse (b)</td>
<td>2,180</td>
<td>1,200</td>
<td>28.7%</td>
</tr>
<tr>
<td>Social Workers, Child, Family, &amp; School (b)</td>
<td>5,660</td>
<td>2,000</td>
<td>7.3%</td>
</tr>
<tr>
<td>Social Workers, Healthcare (b)</td>
<td>2,580</td>
<td>1,040</td>
<td>22.8%</td>
</tr>
<tr>
<td>Social Workers, Other (b)</td>
<td>390</td>
<td>120</td>
<td>6.2%</td>
</tr>
<tr>
<td>Marriage &amp; Family Therapists (c)</td>
<td>820</td>
<td>640</td>
<td>50.3%</td>
</tr>
<tr>
<td>Mental Health Counselors (c)</td>
<td>2,180</td>
<td>1,130</td>
<td>34.0%</td>
</tr>
<tr>
<td>Advanced Practice Psychiatric Nurses (d)</td>
<td>303</td>
<td>No data*</td>
<td>No data*</td>
</tr>
<tr>
<td>Statewide, All Occupations</td>
<td></td>
<td>1,041,750</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

SOURCE: Minnesota Department of Employment and Economic Development (DEED)
(a) Data does not reflect those who are self-employed.
(b) Data is collected according to federal standard occupation codes identifying type of work being done which may not correlate to employer terminology. Data does not distinguish between licensed and unlicensed. Data is reliant on employer nomenclature.
(c) Data does not distinguish between licensed and unlicensed.
(d) Data is not collected for this occupational category/distinct role.
(e) Includes new and replacement openings.

The workforce shortages are more significant when accounting for the need for culturally appropriate mental and behavioral health care. Diversity among the mental health workforce does not reflect population levels in the state, as shown in Figure 18.33
DHS Adult Mental Health Initiatives

Adult Mental Health Initiatives are organized regionally across the state. The map, below, shows this regional organization.
SUBSTANCE ABUSE PREVENTION WORKFORCE

According to a 2013 Legislative Report from the Alcohol and Drug Abuse Division, access to publically-funded treatment in Minnesota is determined by county, tribe or prepaid health plan responsible for providing a timely assessment; determination of the level, intensity and duration of treatment service; and treatment authorization. There is widespread awareness that cost-containment policies enacted by some placing authorities prevent timely access to assessment and treatment, have created barriers that impede access to services, and can result in harm to individuals seeking treatment, their families and communities. Work is underway to address these issues.
**ALCOHOL TOBACCO AND OTHER DRUGS: REGIONAL PREVENTION COORDINATORS**

Prevention Initiatives are organized regionally across the state. The map, below, shows this regional organization.

*Figure 20: Alcohol Tobacco and Other Drugs: DHS Regional Prevention Coordinators*

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**OTHER PROVIDERS:**

**DIRECT CARE AND TREATMENT:**

The Minnesota Department of Human Services (DHS) operates an array of residential and treatment programs serving people with mental illness,
developmental disabilities, and chemical dependency at nearly 200 sites statewide. Services include:

- Anoka-Metro Regional Treatment Center (AMRTC) serves people who have a mental illness in a campus-based setting. Many patients have complex medical histories. It is a 110-bed psychiatric hospital, divided into 25-bed units.
- Community Behavioral Health Hospitals (CBHHs) provide short-term inpatient psychiatric care at seven 16-bed sites in communities across the state.
- Minnesota Specialty Health Systems are residential programs for persons with serious mental illness. Facilities are located in Wadena, Willmar, and St. Paul, with a facility in Brainerd that serves people who also have an acquired brain injury.
- Child and Adolescent Behavioral Health Services (CABHS) program in Willmar provides inpatient psychiatric hospital services.
- Minnesota Intensive Therapeutic Homes (MITH) provides an alternative to institutional placement for children and adolescents with severe emotional disturbance (SED) and serious acting out behaviors.
- Community Addiction Recovery Enterprise (C.A.R.E.) provides inpatient and outpatient chemical dependency and substance abuse services.
- DHS operates five community dental clinics that provide services to people with developmental disabilities, severe or persistent mental illness or traumatic brain injury who could not get care from other community providers.
- Community Support Services (CSS) provides individualized clinical consultation and technical assistance. Nine mobile teams across the state strengthen the community living of people with clinically complex challenges.
- The Minnesota Life Bridge Program supports adults who have developmental disabilities and exhibit severe behaviors that present a risk to public safety.
- Day Training and Habilitation vocational programs locations around the state provide a wide range of individualized vocational training and support.
- Forensic Services serves people committed as mentally ill and dangerous or other commitment types who present a public safety risk, and also serves people with mental illness who the court has ordered for evaluation and treatment before the start of a criminal trial.

A map of Direct Care and Treatment Services is shown below in Figure 21.35
**Figure 21: Direct Care and Treatment Services**

**LAW ENFORCEMENT:**
Law enforcement is often contacted to intervene when someone is having a mental health crisis. Although many law enforcement officers have received crisis intervention training, many have not. In addition, many law enforcement officers do not initially contact crisis teams to intervene.

As a result, individuals may be arrested, taken to jail, or brought to the nearest emergency room for stabilization. For most individuals who are arrested and incarcerated, robust mental health treatment is not provided while they are in custody. It can be difficult for those individuals to access psychotropic meds.36
**COUNTY SOCIAL SERVICES:**
County Social Services are another key provider of services and supports to individuals living with MI and/or SUD. Recent legislation has allowed counties, health care providers, and mental health providers to share welfare data to assist with service coordination.37

**EDUCATION:**
Minnesota’s K-12 education system serves as an important entry point to services for children and adolescents. School-linked mental health grants allow schools to host a mental health professional on-site. DHS found this program has been the first point of contact for services for children with serious emotional disturbance, as well as for students of color.38

Higher education institutions provide counseling and other services that can often act as the initial point of entry for young adults.

**TRIBES:**
American Indians may receive services through federal Indian Health Services or tribal facilities.
ACCESS TO AND SATISFACTION WITH MI SERVICES

MENTAL HEALTH SERVICE AVAILABILITY:
In 2014, DHS conducted a statewide analysis of mental health services and gaps around the state. Figures 10 and 11 indicate that a majority of adult and children’s mental health services have limited availability throughout the state.39

Figure 22: Adult Mental Health Service Availability

Figure 23: Children’s Mental Health Service Availability

3/14
**Provider Feedback:**

**Lead Agencies: Adults**
Wilder surveys with 79 lead agencies\(^7\) (all counties and one tribe, with input from the managed care organizations) found that adult mental health services were less likely to be rated as meeting or exceeding demand than both disability services and older adult services. Home and community-based services were most often rated as meeting demand. The services considered least likely to meet demand were inpatient psychiatry beds; Mental Health Court services; mental health services offered in adult correctional facilities; integrated primary care/behavioral health services; and permanent supportive housing. Service providers were least likely to see availability of psychiatric prescribers as meeting the needs of adults with mental health conditions. However, it’s important to remember that only 41 percent of the lead agencies felt “very confident about all or most” of their ratings regarding service availability for children and adults with mental health issues.

For most services, availability has not changed over the past two years. However, evidence-based trauma-informed services have become more available over the past two years, while psychotropic medication, inpatient hospitalization, and residential treatment were rated as being less available. Most often, lead agencies said that adults with mental health conditions went to the hospital when needed services were not available. Shortages in the availability of prescribers and an inability to retain or recruit providers were rated by lead agencies as most often causing gaps in available services.

About half of lead agencies believed that if primary care services were more available they could free up availability for inpatient adult psychiatry beds and residential crisis stabilization services. To accomplish this, lead agencies reported they needed more funding and resources for programs, more providers, more housing with services, providers willing to work with consumers with difficult behaviors, and more affordable housing. Unfortunately, most lead agencies (67%) did not identify any strategies that were underway. For those who could identify some strategies, lead agencies generally had not seen much impact from them.

**Lead Agencies: Children**
Lead agencies reported that few mental health services for children and youth—9% of all services assessed for children and youth with mental health issues—met or exceeded the demand for those services. The services most often rated as meeting demand fell into the category of home and community-based services, including: specialized supplies and equipment, case management, consumer directed community supports, environmental accessibility adaptations, and assistive technology. But as with services for adults, only 42 percent of the lead agencies felt “very confident about all or most” of their ratings regarding service availability for
children and adults with mental health issues, so results need to be interpreted cautiously.

Lead agency representatives rated inpatient child and youth psychiatry beds, psychiatric prescribers, and residential placements for children and youth with aggressive behaviors as the largest or most significant gaps. For those gaps ranked as most significant by the lead agencies, all were seen as having an impact on school-age children. Lead agency staff also identified specific barriers associated with rural locations and the magnitude of client needs.

The availability of most services for children and youth has not changed over the past two years. But lead agencies also reported psychotropic medication, inpatient hospitalization, and residential treatment has become less available over the past two years while evidence-based trauma-informed services, school-based services, and services for young children had become more available. When examining only Trauma-Focused Cognitive Behavior Therapy, which showed the greatest increase over time, and the availability of psychiatric prescribers, which showed the greatest decrease over time, we find that changes in both of these services were distributed across the state, although no strong patterns were seen across the state.

Lead agencies frequently said that children and youth did not receive any alternative services when needed services were not available, although lead agency staff said that some children and youth received services outside of the county (25%) or from providers who were farther away (19%).

Many lead agencies did not have strategies in place to address barriers, with some believing that they did not have the resources or responsibility to address these gaps. Most lead agencies did not identify any strategies that were underway. And while some progress was being made, lead agencies generally had not seen much impact from the strategies that were underway. Further, one-quarter of lead agency staff did not know what strategies would help increase service availability, while others often suggested increasing reimbursement rates and availability of providers. Lead agencies often assigned responsibility for reducing gaps to the state. Thirty-two percent of the lead agencies did not know what would be needed.

**Service Providers: Adults**

Surveys were also conducted with 344 service providers. These individuals agreed with lead agencies that the shortage of prescribers and funding issues contributed to the gaps.

**Service Providers: Children**

Service providers were least likely of the survey respondents to see residential services as meeting the needs of children and youth, particularly services for children and youth with aggressive behavior (60%), children under age 13 (55%), children with developmental delays (DD) or Pervasive Developmental Disorder (PDD) (50%), and adolescents with sexual acting out (45%). Out-of-home respite
care was also selected by 45 percent of the providers as a service that does not meet the needs of children and youth with mental health issues in Minnesota.

Providers perceived long waiting times and caregiver/family issues to be the biggest barriers to children and youth with mental health conditions receiving services. They agreed that the shortage of prescribers contributed to the gaps, but were more likely to highlight reimbursement rates and funding issues. They also ranked psychiatric prescribers and residential services as the largest or most significant gaps for children under age 13.

**Key Stakeholders: Adults**
Wilder conducted surveys and in-depth interviews on topics such as culturally sensitive services with 30 other key stakeholders such as advocacy organizations. They noted that some resources have been allocated at the county level to create more programs that are designed for specific immigrant or cultural groups, but there is still a shortage of culturally responsive providers. More training and education is needed to build a culturally responsive workforce, and to increase representation of providers who come from diverse cultural groups. Representatives from diverse communities need to be more involved in discussing and designing intervention and support services. The key stakeholders said the most critical gaps in the service system are the lack of crisis services and shortage of psychiatry services.

**Key Stakeholders: Children**
Stakeholders acknowledged that some resources have been allocated at the county level to create more programs that are designed for specific immigrant or cultural groups. But there is a shortage of culturally responsive providers.

Two services gaps were considered most critical: Lack of crisis services and a shortage of psychiatry services. Other gaps included: inadequate care coordination or integrated care; a lack of flexibility in waivered services requirements that do not align well with the needs of people with mental health issues (i.e., geared towards physical and developmental disabilities, without recognizing the impact of symptoms of mental health issues); and early intervention services.

Stakeholders noted a number of challenges that make it difficult for youth to transition smoothly from one system to the next. There are philosophical differences in how one works with children and how one works with adults, and most providers are siloed within one system. For many youth, the first mental health episode occurs in this transition age, and it can be difficult for them to find enough support from either system.

The stakeholders generally agreed that co-occurring SUDs pose significant challenges to youth with mental health conditions. Several noted the importance of addressing physical issues and mental health in a more integrated fashion, while also saying that providers currently lack the training to understand and successfully address co-morbidities.
Several stakeholders noted challenges related to the county-driven system of care, with a perception that county-driven services result in variable standards, quality, eligibility, and requirements. A few also noted that there can be challenges between the counties and DHS related to care coordination or systems development. Another theme that emerged was the relative lack of services in rural areas, and the additional challenges related to transportation. One informant noted that there are also cultural disparities that have disproportionate impacts across the state, with additional shortages for Native American, African American/Black, Latino, Hmong, and Somali children and youth.

**CONSUMER FEEDBACK**

A survey was shared with CCBHC agencies and providers to help better identify the needs of their communities. In many cases, peers were enlisted to administer the survey to individuals experiencing mental illness and/or substance abuse disorders. As of June 6, 2016, 80 individuals had responded to the survey. Responses to some of these questions are summarized below.

Most respondents (90%) indicated that they had a medical health care provider. Most visits to this provider were either for the annual check-up (84%) or for health concerns that came up during the year (71%).

In contrast, less than half (48%) of respondents indicated that they currently had a mental health provider. An additional 12% said that they didn’t have a mental health provider, but would like to. Most saw this provider for regularly scheduled therapy or counseling appointments (59%), prescription refills or medication management (41%), or to get a referral to other services (12%).

When asked what they did when feeling anxious, depressed, or experiencing mental health symptoms, less than half (45%) said that they called their mental health provider. Other narrative responses included “contacting a friend with similar experiences,” “going to the psych ward,” “calling my ARMHS worker or going to the community center.” Responses such as “mindfulness,” “exercise and looking at things to be grateful for,” and “meditation” were also noted as ways to deal with the situation by several respondents.

When specifically asked about alternative practices or providers, some respondents indicated that they used supplements or vitamins (30%), over-the-counter medications (20%), homeopathy (22%), and traditional healers (7.5%). Narrative responses included self-relaxation, mindfulness, exercise, meditation, and yoga, among other approaches.

Respondents indicated that they wanted more affordable services (42%), greater collaboration with their other providers (39%), and expanded clinic hours (36%).
Narrative responses indicated that several respondents wanted insurance to pay for more non-medication treatments and to cover integrative health care, among some responses asking for more clinic locations in their area.

Barriers to care included expense (37%) and other expenses (30%), scheduling issues (32%), and long wait times (29%). Narrative responses mentioned prior authorizations, small offices, lack of confidentiality, and expense.

Most (46%) respondents were very satisfied or somewhat satisfied (31%) with their current mental health services. No respondents said that they were very dissatisfied.

Most respondents (55%) said that their providers included their input when developing a care plan for their mental health needs. One in ten (9%) said that this did not happen, and 36% found the question not applicable.

In comparison, 19% of respondents said that their providers included their input when developing a care plan for their chemical health needs. Five percent said that this did not happen, and 76% found the question not applicable.

Most respondents said that their doctor or medical health provided never talked with their mental health providers about their health care goals and needs. Eight percent indicated that this was done often, 7% said sometimes, and 25% said not at all.

Most respondents were neutral about whether their providers included their important cultural/spiritual practices in care planning. Thirty percent agreed (22%) or strongly agreed (8%), and 14% disagreed (12%) or strongly disagreed (2%).

Most respondents agreed (39%) or strongly agreed (43%) that their providers showed respect and consideration for their gender and sexuality.

To get information, most respondents said they would research the Internet (74%) or contact their provider (70%). Other responses included consulting friends or family (56%) or research using hardcopy resources such as books or brochures (30%). Narrative responses included talking to their case manager or ARHMS worker, calling the Crisis Line, using their electronic chart, or going to a traditional healer or homeopath.

When asked what one thing they would change about their medical and mental health experience that would help them take better care of themselves and result in better health, responses included the following statements:

- I would like to be treated with dignity and respect and listened to in regards to my psychical health when I need to go to an ER. Because ER’s staff does not
listen to me, I do not go to the ER even if it is medically necessary and my regular health team thinks I should. I would rather die with respect and dignity than being treated like shit, less than human or like I am stupid. I know my body very well and know more than they do about what I need for my health and my treatment.

- More feeling understood rather than just listened to.

- Allow more coverage for integrative medicine.

- Have a good support system, instead of just being a number somewhere along the line. They don’t normally follow up with you. Everything is made out to sound manageable but yet isn’t when you get out of the office and back into the "work, family, school" way of life again.

- Providers showing less judgmental attitudes, more compassionate.

- That the health care providers help me to fix the problem rather than medicate the problem.

- Affordable services, more locations for services, less long waits for appointments.

- I would like it if concerns were treated with less prescription medication and focus on life changes in diet, exercise, thinking, and stress management and medication only used in emergency situations or when all other techniques have failed.

- Make complimentary medicine readily available to more people and have insurance pay for these services. I pay out of pocket for most of my health care, but it works and keeps me healthy! Many more people could experience the benefits of alternative therapies if people did not have to pay out of pocket for these services and it would lower overall medical costs!

- Better explanation of what services are covered under insurance and the ability to choose services (ie medication) that are covered.

When asked what other information they would like to give regarding quality and accessibility of medical health, mental health, and chemical health services, responses included the following statements:

- The paperwork can be overwhelming. It would help if someone could help fill it out.
• For insurance to be more open to covering alternative/integrative care.

• The costs keep going up. This does not seem right to me. That it should be so expensive to stay healthy and not everyone has the same ability to get care.

• Providers to get training on body language, self awareness.

• All the providers I have encountered whether for myself, spouse or children they rush you out the door and on to the next client / patient.

• I would like it if concerns were treated with less prescription medication and focus on life changes in diet, exercise, thinking, and stress management and medication only used in emergency situations or when all other techniques have failed.

• Not enough MH services, and sometimes there are long wait times to get in (2-3 months for a psych eval), and those going to a residential program can have a week or 2 wait as well. By the time the bed is open for them, many are no longer interested, and are back out using again. Helping them at the time they are ready is critical, and I see some slipping through the cracks.

• We need more MH clinicians, and more CD treatment options locally.

Responses came from a variety of counties, including: Hennepin Scott, Ramsey, Dakota, Carlton, Mcleod, Crow Wing, Chisago, Carver, Cass, Morrison, Benton, Winona, Faribault, Stearns, Otter Tail, Beltami, Itasca, Olmsted, Wadena, Goodhue, Todd, Cook, St. Louis, and Polk County in Wisconsin.

Respondents ranged in age between their late 20s to over 65 years old. Most respondents were female (70%) and White (87%). Their primary language was English for 96%, with one Spanish speaker, one Russian speaker, and one Portuguese speaker. Six respondents (7%) were veterans.
THE NEEDS OF SPECIAL POPULATIONS

Although the health status of Minnesotans overall is quite high – Minnesota is often names one of the healthiest states in the nation – there are significant disparities in health factors and health outcomes between the state’s majority white population and its populations of color and American Indians. The figure below from the 2012 Minnesota Statewide Health Assessment, displays just how broad these disparities are.43

It is not in the scope of this report to identify mental and chemical health needs of all underserved populations. However, the following section describes several populations with significant unmet need: American Indian, Asian, Hispanic/Latino, the homeless, Somali, older adults, and veterans.

AMERICAN INDIAN POPULATIONS
The American Indian/Alaska Native community has consistently experienced lower health status when compared with the rest of the country, and experience chronic liver disease and cirrhosis at a rate 4.7 times higher than the general population. In the U.S., about 7 out of 10 Native Americans now live in a metropolitan area, compared with less than 5 out of 10 in 1970. 44

In Minnesota, American Indians number 60,916, or 1.1% of the total population. Minnesota’s American Indian population is projected to increase to nearly 63,700 by 2035, with the largest populations living in the Twin Cities area (17,650), the Headwaters (13,720), Beltrami County (10,750), and the Arrowhead (9,110). This population is anticipated to see a slower growth rate than other minority groups, with an increase of only 13% projected between 2005 and 2035 and declining populations projected for Hennepin and Ramsey counties. The average age of American Indians in Minnesota is expected to become older, with the population in the under 15 age group projected to fall considerably.45
A series of focus groups was conducted in Ramsey County to better understand why Native Americans in Ramsey County are less likely to use services and county resources than the rest of the population. Focus group participants brought up the themes of relationship-building, valuing experience, understanding and honoring the impact of historical trauma, creating programming that fits an Urban Native audience, and using a holistic care model. To some extent, most of these themes will be generalizable to the rest of the state, and so are detailed more fully below.

There are cultural and historical factors that play a role in discouraging Native Americans from seeking behavioral health and other health care services. The focus groups stressed the importance of building strong, lasting relationships, not just from organization-to-organization, but also from person-to-person. In the Native American culture, it is important to spend time building trust and showing respect to the other person. Another theme was the valuing of experience over credentials or education. Many Native Americans clients would feel more comfortable working with someone who has less education but more experience connecting with Native American people and culture. The impact of collective, intergenerational trauma, compounded by discrimination, racism and oppression, cannot be overemphasized. If a client comes in for treatment or assistance and is not able to receive services right then, misses an appointment and no one calls or checks to reschedule, or
cannot decipher complicated paperwork, the person may not seek help again. The focus groups told of the desire by Native Americans to create their own programming and models, and stressed the need for holistic care. The concept of holistic care in this community means providing care that builds on a personal relationship, connects the person to the community and to their spiritual traditions, works to heal the whole family system, and looks at the broader social/historical history of trauma and its impact.

**Native American Tribes: Adults**

Wilder conducted surveys and in-depth interviews with representatives of eight Native American tribes. Some tribal stakeholders reported that mental health services are often less accessible for tribal members than home and community-based services; others had different perceptions. Three representatives indicated they do not provide any direct mental health services, which very much limits the availability of mental health services on those reservations. This means in order to get services, tribal members usually have to travel off the reservation, making distance and transportation a barrier for accessing services. Representatives also noted a lack of cultural responsiveness from outside mental health providers as a barrier.

One tribal representative believed their tribe had strengths in dual diagnosis management, with a good working relationship between mental and chemical health staff, but most tribal representatives noted gaps in mental health and chemical dependency dual diagnosis service provision. One tribal representative said that although many people are dually diagnosed with chemical dependency and a mental health condition, providers are poorly prepared to manage coexisting conditions due to siloed methods of payment for care, and the lack of shared information between systems. Another representative echoed that sentiment, saying they would need to overhaul treatment facilities and services to ensure reimbursement for those services. Another representative described a lack of communication between emergency departments, hospitals, substance abuse treatment providers, and mental health service providers. One tribal representative also noted an opiate addiction crisis in some tribal communities, linking the crisis to health care providers over prescribing opiate medications. A couple other tribal representatives said they felt prepared to manage other complex and coexisting conditions. For example, one tribe created a new software system to help coordinate services across multiple systems to meet client needs.

One tribe noted that mental health is not integrated with primary care, yet 70-80 percent of psychotropic medications are prescribed by family doctors in private practice who do not necessarily have training in mental health. This creates a disjointed service delivery system. On the reservation, this is less of a problem because doctors and therapists work in the same division. Another tribal representative noted a misalignment between tele-psychiatry and cultural sensitivities.
Five tribal representatives believed that stigma around receiving mental health care was the main barrier to receiving care. One representative said that the majority of their mental health patients are court ordered, and many do not seek preventative or early intervention services. Transportation and distance to services were also identified as barriers for mental health services, as these were often more limited on-reservation, and tribal members would have to travel far to receive services. While most representatives said that it was relatively easy to find out about services, one representative noted that the general population does not really know how to find out about services.

**NATIVE AMERICAN TRIBES: CHILDREN**

Tribal members noted much unmet need for tribal members, although most tribes provide some services that are readily available including early childhood services and counselors or a mental health presence in schools, although two tribes said no services were readily available. Other tribes provide some outpatient services, often including things like psychological testing.

For tribes that do not act as a lead agency or provide their own mental health services, there are large gaps in services for children and youth with mental health conditions including long waits for diagnostic assessments, respite care, inpatient care, and services for special populations (eating disorders, autism, etc.)

According to tribal representatives, people find out about services most regularly through referrals or word-of-mouth. The need for clear communication between the state, county, tribe, and clients about available services was mentioned in several interviews. Five tribes noted stigma in receiving services for mental health conditions as a barrier in accessing services.

**ASIAN POPULATIONS**

Minnesota’s percentage of Southeast Asian population ranks first in the nation. Southeast Asian includes Burmese, Cambodian, Hmong, Laotian, Thai, and Vietnamese. In Minnesota, the three largest Asian populations are the Hmong, Asian Indians, and the Chinese. From 2000 to 2010, all categories of Asian population grew in Minnesota. 48

The Hmong population is still the largest Asian population in Minnesota, increasing 45.6% from 2000 to 2010, and estimated 20,738 persons. They are mainly concentrated in the Hennepin and Ramsey County area, with Ramsey County having the largest Hmong population at 34,374, which is 59% of the Asian population in Ramsey County.

Among all states, Minnesota is home to the second largest number of Hmong, the third largest population of Laotians, the fifth largest population of Burmese, the
sixth largest population of Cambodians, and the sixteenth largest population of Vietnamese. Refer to the chart, below, for a representation of the ten largest Asian populations in Minnesota.

Figure 25: Ten Largest Asian Populations in Minnesota

There are Asians living in every county of Minnesota with enclaves scattered throughout the state. In general, Minnesota Asians are concentrated in the seven-county metropolitan region. Hennepin County has the largest total Asian population at an estimated 70,439. Ramsey County has the second largest population of Asians at an estimated 58,248. Over half of the Asian population in Minnesota lives in these two counties. For a representation of this population distribution, please see the map, below.
Approximately 22% of Minnesota’s Asian households are linguistically isolated. Linguistic isolation is when no one 14 years old and over speaks only English or speaks a non-English language and speaks English “very well.”
Minnesota is home to diverse Asian and Pacific Islander ethnic groups, many who come to the U.S. legally as refugees and asylum seekers, for employment, or for family reunification. Those who come to the United States as refugees or asylum seekers are fleeing persecution from their county of origin. For example, a large number of the Hmong has resided in Laos and Thailand before coming to the United States.

Uninsurance varies across Asian population groups. Cambodian, Hmong, and Vietnamese have the highest percentage of uninsured. In contrast, over 90% of Chinese, Laotian, Korean, Filipino, and Asian Indians do have health insurance.
Wilder Research conducted an assessment of mental health needs and services for the Hmong community in Ramsey County. A representative sample of responses can be found below.49

“I use the traditional ways first. If the Hmong traditional ways don’t help – then I go see my American doctor.” – Adult community member

“In the Hmong community, confidentiality is very important because when Hmong people seek help from you as a doctor and you are not careful and happen to say things about them and others find out – they will no longer trust you.” – Adult community member

“Adults don’t go to others for help because the Hmong community gossips a lot. Parents care a lot about their name – they don’t want to have a bad family name.” – Young adult community member

“I think that Hmong people don’t tap into services until they are in a crisis and that’s always the mode that we operate under.” – Community leader

“There is help, but are you willing to seek help if you are unable to speak English and talk to the doctor about your problems? It won’t be effective.” – Adult community member
“Parents – they may not believe in that therapy stuff. They might not approve of going through the American way.” – Youth community member

“Doctors fix your sickness and the Hmong way helps your soul.” – Adult community member

**HISPANIC/LATINO ORIGIN POPULATIONS**

Overall, about 5 percent of Minnesotans identify themselves as Hispanic or Latino in origin. The Latino population is the fastest-growing minority group in Minnesota. Based on 2010 Census data, the Latino population is expected to double from 4.74% (258,200) in 2010 to 8.5% in 2035.50

![Figure 29: Population Projected Growth for Latinas in Minnesota](image)

Three metro counties: Hennepin, Ramsey, and Dakota, have the largest population of Latinos. Two rural counties: Watonwan and Nobles, have the highest percentages of Latinos based on the population. These five counties were the focus of a mental health needs assessment of Latinos in Minnesota.51 The conclusions of this study are discussed, below.
According to the study, the sub-populations of Latinos with the greatest mental health needs are undocumented persons, children with emotional and behavioral disorders, and survivors of domestic violence. Sub-populations of Latinos that are currently underserved are uninsured, undocumented, and LGBTQ groups. Trauma, depression, anxiety disorder violence, mood disorder, substance abuse, grief/loss, and child sexual abuse are the leading mental health concerns of Latinos living in Minnesota. The main barriers in accessing mental health services and remaining in mental health treatment are language, transportation, and lack of culturally appropriate and linguistically appropriate services.

Latinos were found to be currently underutilizing services because they prefer flexible, comprehensive, and holistic services that are flexible, incorporate their culture, and meet all their needs. They want family-focused services. Latinos are reluctant to seek services at county-operated mental health clinics because "there is a lot of mistrust of government... I think people who are not documented are worried that if they come to a government service, that somehow they're going to be reported to the government."

Family members, extended family, and the community play a significant role in supporting Latinos in seeking mental health services. Community members often
support each other and educate each other about mental illness and mental health resources, which reduces stigma.

**HOMELESS POPULATIONS**

Wilder Research has conducted a study of the homeless in Minnesota every three years since 1991. According to the study, the number of homeless in Minnesota has been increasing over time.

*Figure 31: Minnesota Homeless Population Trends*

![Graph showing trends of Minnesota homeless population](image)

These numbers represent an undercount, since many homeless people outside the shelter system are not found on the night of the study. This is especially true of youth on their own, who often couch-hop or find other temporary places to stay, and homeless people in greater Minnesota where there are fewer shelters. It is estimated that about 14,000 people are homeless on any given night in Minnesota.

Racial disparities are persistent in the Minnesota homeless population. The disparities are most prevalent among African American and American Indian populations. Youth – especially those age 18 – 21 – are the age group most at risk of homelessness. Older adults, age 55 and over, are the age group least at risk.

More than half (55%) of all homeless adults in Minnesota report a significant mental illness. 60% of long-term homeless adults have a serious mental illness, compared to 49% of other homeless adults. 26% of long-term homeless adults have a substance abuse disorder diagnosis, compared to 17% of other homeless adults.
Traumatic brain injury also represents a considerable health concern among the homeless population. Nearly 1/3 of homeless adults have histories that suggest likely traumatic brain injury. One third of homeless adults report a cognitive impairment (confusion, memory issues, or indecisiveness to the point that it interferes with daily activities), and 44% report a physical, mental, or other condition that limits either they work they can do or their daily activities.

Health conditions often occur together, with 42% of homeless adults having more than one of the three most common conditions (significant mental illness, chronic health condition, or substance abuse disorder). One in ten (11%) reports all three.
Two-fifths of homeless adults say that they need to see a health professional for physical health problems (38%) or for emotional health problems (40%), and one half (51%) need to see a dentist. Ten percent report needing services related to alcohol or substance abuse issues.

Between 2/3 and ¾ of homeless adults have received recent care for their conditions but a sizeable fraction have not. Three quarters (76%) of homeless adults who report a significant mental illness also report receiving inpatient or outpatient mental health care in the previous two years. Two thirds (66%) of homeless adults who report a substance abuse disorder also report receiving inpatient or outpatient treatment in the previous two years.

**Older Adult Populations**

Concern is growing about the lack of appropriate mental and behavioral health services available for older adults. In addition, growing numbers of older adults develop symptoms of dementia as they age, and require specialized care. In addition, depression and anxiety can often manifest in older adults. Hospitals are reporting that they experience difficulties finding appropriate care for older adults who are ready to be discharged. In tandem with this trend, hospitals find that they are unable to accept other patients because of the care being received by an older adult already admitted to the unit, or are unable to admit an older patient because of the level of risk posed by younger or more aggressive patients currently being served.52

**Somali Populations**

Somali refugees began arriving in Minnesota in 1993, following a 1991 civil war that left 45% of the Somali population displaced. An estimated 50,000 or more Somalis now live in Minnesota. Minnesota has the largest Somali population in the US. 96% of Somali people speak a language other than English, and 51% of Somali people speak English less than “very well” compared to 4% of the general population.53
A study of Somali mental health was performed in 2014, and is summarized below. Due to the stressors of relocating as well as the war trauma experienced, there is a high prevalence of Post Traumatic Stress Disorder, Depression, and Generalized Anxiety Disorder in the Minnesota Somali population. Often, members of the Somali community refuse to talk about mental health issues because they believe they will be stigmatized. Somali refugees currently utilize clinics and hospitals to receive care for physical symptoms, and are then given medications for physical ailments when the root cause was later found out to be mental illness.

Somalis will first look to religion for mental health support. Virtually all of the Somali population is Muslim; mosques and other places of worship have been found to be major supports for the Somali population. While families and family-based supports are considered supports, because of the stigma around mental illness, families have been shown to shun mentally ill members of the family. Somalis are unlikely to seek help from mental health clinics, but instead utilize medical clinics because in Somali culture it is not taboo to seek help for a physical symptom.

Few practicing mental health professionals speak Somali’s native language, but therapists have reported that they find it difficult to pick up on nonverbal queues when using an interpreter. Within the Somali culture, it is customary to ask community members to pray for each other to get better. Because of this, Somalis may worry that interpreters will go to the community with this stigmatizing information.

Perception of time is a large barrier that can create a gap in providing mental health services to this population. Oftentimes practitioners are finding that Somali clients will arrive a day late, a day early, or several hours before or after the arranged meeting. This has made it hard for practitioners who are paid by the unit rate and can't be reimbursed for missed meetings.
It is recommended that health professionals address symptoms, rather than giving a label or diagnosing a mental health issue, due to the strong stigma that the Somali population associates with mental illness. By emphasizing the physical symptoms of psychological distress, like having low energy or not sleeping enough, instead of emotional symptoms, practitioners can bypass this stigma. Through bringing up the symptoms and framing them in a culturally-sensitive way to avoid this stigma, this population can be reached.

VETERAN POPULATIONS
As of September 30, 2015, there were 361,129 veterans in Minnesota, making up about 7 percent of the state’s population. 26,000 of these veterans are women. Since September 11, 2001, more than 66,000 Minnesotans have been discharged from active duty, with 43,000 having served in a combat zone. In January 2015, 297 veterans were identified as homeless by the Department of Housing and Urban Development.55

According to a Wilder Research study about veterans’ needs in Northeastern Minnesota, the majority of veterans continue to mention concerns about the system and process of care as barriers to their experience with services.56 These problems manifest most frequently as long wait times related to inadequate supply of service providers, a theme mentioned by veterans, family members, and service providers alike. A representative sample of quotes from the study can be found below.

Spouse of veteran (Kuwait): “It is an absolutely insane process... they do not have enough mental health providers to treat the population. There is like one provider per 3,500 people up here. There is a 4 to 8 months wait in order to get mental health services, unless you check yourself in to a partial hospitalization program or you end up going to the psyche ward at the hospital. The only mental health provider in Rapids just closed. The areas here like Hibbing and Virginia... they can't handle the load that they already have, so they try to refer people to Duluth. It's just really bad. Mental health, chemical dependency, and that kind of stuff, you're looking at months and months and months and months and months out.” (Phone interview)

Spouse of veteran (Iraq and Afghanistan):“Even if my husband thought he had a touch of that [PTSD], he wouldn't go for it or go through with it because he doesn't want it on his record. Let's say he went in for depression because he is military... there is military record. He knows that they would automatically put that on his record... so he avoids it. So, isn't that interesting that you have this problem? This is just sort of a national thing where they talk about the soldiers that need care. What can we do? They need mental health care. Well, a lot of them don't want to because they know what it will look like on their record. So, they don't. So he's never utilized any care.” (Phone interview)
Sibling of veteran (Vietnam): “As a Marine Corps veteran, he said that they were always taught Marines show no weakness. And to admit you were homeless, to admit you needed help was showing weakness. So he absolutely refused to let anybody help him. He lived on the streets for a while. He was homeless. I’ve said this many times to people that I have met... I’ve said, ‘You need to know that you have to reach out to these guys because they don’t reach out for themselves. They totally believe that, as my brother did, he served his country and he shouldn’t ask for anything back, and he certainly would not ask to show any weakness.’ And that directly affects their health because in his mind, if your body is unhealthy and need something, you did something wrong and that is a sign of weakness. To get him to agree to see a doctor to get medical help was extremely hard.” (Phone interview)

The Wilder Research study about veterans’ needs in Northeastern Minnesota also documented veteran’s comments regarding substance abuse services, as shown below.57

Veteran and service provider: “Being a veteran, I’ve been through vet administration and chemical dependency stuff in my past. One thing that would be important if you’re going to provide services to veterans with chemical dependency... you should have the education and knowledge of their experience because otherwise guys like me aren’t really going to share. We’re not going to talk about some of the stuff. You need somebody that is going to relate. A vet who was in combat isn’t going to start opening up to a group of young kids. That individual therapy is so important.” (Phone interview)
MINNESOTA FIRST IMPLEMENTERS

Six organizations have been selected to serve as First Implementers of the Excellence in Mental Health Demonstration Project. See Figure 35 for a map showing the First Implementers and their service locations.

Figure 35: First Implementer Service Locations
OVERVIEW OF THE FIRST IMPLEMENTERS

The areas served by the six first implementers range from the northwest tip of Minnesota to the southwest corner of the state. Three are in the metropolitan area surrounding Minneapolis and St. Paul, and the other half are in greater Minnesota, comprising a good share of the rural and frontier areas. These implementers have service areas in 19 counties:

- Northwestern Mental Health Center: Kittson, Mahnomen, Marshall, Norman, Polk, Red Lake counties.
- Northern Pines Mental Health Center: Aitkin, Cass, Crow Wing, Morrison, Todd, and Wadena counties.
- People Incorporated: Hennepin and Ramsey counties.
- Ramsey County Mental Health Center: Ramsey County.
- Zumbro Valley Mental Health Center: Olmsted and Fillmore counties.

Together (and using unduplicated counts of the overlap in several agencies serving two of the same counties) the implementers serve a total estimated 2014 population of 3,143,633 residents. This includes Red Lake County – the third smallest county in the state with a population of 4,048 – and Hennepin County – the largest county in the state with a population of 1,210,720. Although Figure 12 below shows large portions of the state not covered by the implementers, they actually serve almost 57 percent of the total population of Minnesota (5,453,218.) Implementers also serve three Native American reservations: Leech Lake, Mille Lacs, and White Earth nation.

Three implementers are the legally designated mental health authority in their area, but the remaining three are committed to working closely with those authorities in their service areas. All implementers are existing mental health centers offering a wide array of mental and chemical health services to meet their communities’ needs. As longstanding community organizations committed to community benefit, all are well positioned to develop CCBHCs. All implementers enjoy existing relationships with the Minnesota Department of Human Services.

- Northwestern Mental Health Center, which had its beginnings in 1957, is a private, nonprofit corporation owned by the six counties it serves.
- Northern Pines Mental Health Center is a comprehensive community mental health center established in 1964. Serving a six-county area, it has offices in six cities.
- People Incorporated got its start in 1969 and has grown to provide services in nearly 40 locations in and around the Twin Cities metro area.
- Ramsey County Mental Health Center operates under the direction of its Board of Commissioners and the advice of a Mental Health Advisory Council that has been in operation since 1979.
Wilder Children and Family Services is a component of the Wilder Foundation, which was formed in 1906 and remains a community-based nonprofit mental health and social service provider.63

Zumbro Valley Mental Health Center is a component of the Zumbro Valley Health Center, which has worked to improve the health of under- and unserved people for over 50 years.64

**COMMON THEMES RELATED TO FIRST IMPLEMENTER SURVEY RESPONSES**

Each First Implementer organization completed a comprehensive survey related to needs in its service area. A representative(s) from each implementer was sent the same survey, but each implementer took a somewhat different approach to completing the survey. Some added much detail to their responses while others added none. In one section of the survey, some implementers focused their responses on unmet need (as requested) while others were more likely to discuss their current services. Most implementers responded to some but not all components of questions. Because of this situation, this summary will highlight common themes that were identified, but more themes or stronger conclusions could have been drawn if all implementers had shared more information.

**COMMON THEMES**

Four common themes focusing on unmet needs emerged: staffing, culturally-appropriate services, services for children, and reimbursement for travel time in greater Minnesota.

1. **Staffing.** All implementers expressed serious concerns with workforce issues. Some implementers spoke to the need for simply more staff – staff who could form strong teams be available 24/7 to best respond to crises.

   There were a number of types of staff are sorely needed to meet community demand – psychologists, neuropsychologists, LADCs, case managers, Certified Peer Specialists, nurses, child/adolescent therapists, and administrative staff – but the need for psychiatrists seemed to be mentioned most frequently. All implementers have access to at least one psychiatrist, but only four have a psychiatrist who functions as, serves as, or has a leadership role as medical director. Further, it appears that no implementer has a medically-trained behavioral health care provider who can prescribe both buprenorphine and naltrexone; four are in a situation of having no provider who can prescribe medication for either opioid or alcohol use disorders.
Both hiring and retention played a role in staffing issues. Some positions require highly specialized skills where there is a small pool to draw from. Low pay and compensation also contribute to the problem, particularly when implementers compete with private practice, for-profit, government or hospital-based settings which pay higher salaries and see less complex clients.

Hiring and retaining Certified Peer Specialists might be a special case. There was some mention that recruitment of peers who are far enough in recovery and have the computer skills and transportation required for the position is an additional barrier. Also, training people to become Certified Peer Specialists can be costly, and there is a need for ongoing training and supervision, which means additional time and oversight by the clinical supervisors.

It is apparent that staffing impacts SMI and SUD services in general, it also impacts ARMHS and CTSS certification and primary care screenings.

2. Cultural Competence. There is certainly overlap between this category and staffing issues. Most implementers mentioned a need for more staff training on cultural competence, more staff with lived experience from diverse cultural backgrounds, and staff, including peer specialists, who speak the language of the client populations. But cultural competence is core to person-centered planning, and it is worth putting this in context of what is at stake:

- All or almost all (five of six) implementers provide services to individuals across all age categories and diagnostic groups (EBD, SMI, and SUD) with limited English proficiency.
- At least four implementers provide services to American Indian adult age categories and all diagnostic groups.
- Four implementers provide services to all adult age categories from other racial and ethnic groups, and three provide services across all diagnostic groups to individuals from other racial and ethnic groups.

Overall, there is a need for culturally- and linguistically appropriate services for these populations mentioned by implementers: African American, Native American, Hispanic/Latino, Somali, Karen, Hmong, Cambodian, Vietnamese, Khmer, and Laotian.
American, Hispanic/Latino, Somali, Karen, Hmong, Cambodian, Vietnamese, Khmer, and Laotian.

3. **Services for Children.** When discussing their programs, implementers did not frequently distinguish between child/adolescent and adult services. However, there were a few mentions of the need for staff who could address adolescents’ and young adults’ concerns.

The distinction between adult and child/adolescent services is best seen in best practices that were implemented. Implementers were much more engaged in best practice services for adults than for children. Half the eight best practices listed on the survey for adults were implemented by at least five implementers. Of the five best practices listed for children under age 18, between zero and two implementers offered any of those services.

The survey also asked implementers to describe the special populations they serve by age group. Those special populations include those who are: members of the armed forces/ veterans/their families, incarcerated, homeless shelters, living on the streets, in foster care, living in other congregate settings, limited English proficiency, American Indian/tribal groups/nations, other specific racial and ethnic groups, individuals with physical/intellectual/sensory disabilities, and other cultural needs populations. Fewer implementers served children among all these populations except for: foster care where the same number of implementers served children and young adults, and American Indian/tribal groups/nations where the same number of implementers served children and adults age 22 and older.

Nonetheless, when asked specifically to describe their service model, all implementers reported that they had at least some involvement with schools, most had some involvement in child welfare and juvenile justice, half had some involvement with therapeutic foster care, but none were involved with Indian Health Service youth regional treatment centers often because there were none in their area.

4. **Reimbursement for Staff Travel Time in Greater Minnesota.** Travel time is a barrier for staff where the problem is serving individuals across a very large
geographic area. For example, one implementer serves an area of 6,808 square miles with a total population of 61,717 people: an average of 9 people per square mile. Its closest detoxification unit is between 40 and 180 miles, depending on where the trip begins. Two of the counties it serves are federally designated as Frontier and three as Rural Counties.

To deliver services outside four walls, lengthy distances need to be traveled to deliver services, for example, in children's home or school district. Travel time is also an issue for crisis services that need to reach individuals within a short time span, particularly when it is not feasible to station staff throughout the service area.

Reimbursement is a complicating factor. Non-reimbursement for “windshield time” limits ARMHS access for people who live more than 1/2 hour from a service provider. Difficulties also occur when staff travel long distances to meet with individuals who don’t show up for the appointment which means the provider can’t bill for those hours. In addition, due to limited transportation options in the area, staff often spend more time trying to find transportation or actually taking an individual to an essential appointment to make sure the person makes the appointment.

**Other Unmet Needs**

Screening, assessment, diagnosis, risk management, and patient-centered treatment planning are provided by all implementers, yet many believed they are not provided in sufficient capacity or geographic availability to meet all needs. Many implementers offer SMI group sessions for adults but, again, believe they don't meet all needs. Fewer offer family or individual group sessions. Few offer SMI day treatment or partial hospitalization.

Most implementers believe that withdrawal management and detoxification services are major issues. Half of the implementers offer SUD group sessions, and even fewer offer multifamily groups and individual therapy. Only a very few offer partial hospitalization or day treatment, but one noted that ARMHS generally replaces day treatment. Another barrier to service delivery is that a high percentage of individuals referred to a dual disorder program have significant trauma histories and those treatment needs are not completely met in a traditional IDDT program. There is also a treatment gap between detox and inpatient treatment due to waiting lists.

At least some type of primary care screening services are provided by most implementers but, with one exception, those services seem minimal but expected
given some stated need for nurses. About three implementers indicated that they do not monitor key health indicators and risks.

It appears there are many people are still left out of the service system, specifically targeted case management. The implementers identified many groups they believe need TCM services, but do not meet the state’s currently eligibility definition. Many of these include children and families: children who are at-risk of developing a behavioral mental health disorder and have environmental risk factors, children and adolescents with a parent who has a significant mental health issue yet are reluctant to pursue services on their own behalf, children of parents with developmental delays, and parents who have SUD issues. Other groups not served by TCM are excluded because of diagnosis issues: people experiencing a mental health crisis but who aren’t SPMI, individuals with depression and anxiety with high medical needs but do not quite meet the criteria for MH-TCM, individuals who are chronically chemically dependent, and individuals diagnosed with PTSD - Psychosis NOS but no hospitalizations. Still others are excluded for other systems issues: individuals with commercial insurance plans; individuals seen in acute services; and adults who are recent arrivals or refugees who do not meet the diagnostic categories for TCM services (especially if they do not speak English.)

**MODEL PRACTICES AND OTHER SERVICES PROVIDED**

Five model practices were used for all adult age categories by at least half the implementers: Motivational Interviewing, the Transtheoretical Model, Cognitive Behavioral Therapy, Integrated Dual Disorder Treatment, and Trauma-focused Cognitive Behavioral Therapy. There was much less use of model programs with children under age 18: two implementers used Managing and Adapting Practice, two used Trauma-focused Cognitive Behavioral Therapy, and two used Trauma-informed Child Parent Psychotherapy. Only one implementer used Parent-Child Interaction Therapy.

Implementers used a slightly greater number of model practices for the SMI population than the SUD population, but a much lower number of best practices for the EBD population.

Several other models are of particular significance.

**No Four Walls.** Five of the six implementers current provide at least some services in the community. The services typically include, for example, all ARMHS, case management, peer support, crisis services, homeless outreach, and therapy. These services have taken place in the client’s home, homeless shelters, schools, or any place of the individual’s choosing.

**Crisis Services Received within Three Hours.** It is difficult to determine how many implementers currently provide crisis services within three hours. At least two report they meet this standard. One meets this standard under
certain circumstances. One reported that if individuals present to any of three locations during business hours, crisis services are provided directly by the clinical staff at that location; this implementer provides crisis services to individuals served by another implementer. One did not respond to the survey question.

**FIRST IMPLEMENTER SURVEY RESPONSES**

Each First Implementer has completed a survey regarding their services, outreach methods, and potential associated gaps. The results are summarized below. Specific responses for each First Implementer can be found in Appendix A.

**UNMET NEEDS RELATED TO REQUIRED SERVICES:**

1. **Crisis mental health services: 24/7 mobile teams, Emergency intervention, Stabilization, Other crisis mental health services**

   **Limits to staffing:**
   Staffing is a significant unmet need. Most implementers mentioned a need for more staff training on cultural competence, more staff with lived experience from diverse cultural backgrounds, and staff who speak the language of the client population. Some mentioned a need for simply more staff (and not just on-call) to form strong teams operating 24/7 and meet crisis deliverables. The severe need for psychiatrists was mentioned throughout the survey. Psychologists, neuropsychologists, and administrative staff were also mentioned as a specific need, as were staff who could addresses the needs of adolescents and young adults.

   A related issue mentioned by one implementer was that their electronic health record is not robust enough to accurately track staff outcomes. Most implementers did not distinguish between child/adolescent and adult services.

   **Withdrawal management and detoxification services:**
   This is a significant unmet need. Two implementers said they had no formal withdrawal management and detoxification services,

   "Our closest detoxification unit is between 40 and 180 miles, depending where you start driving from... If a person presents at one of our regional hospitals, the person may stay in the emergency room until Blood Alcohol Levels drop to a reasonable level, or they may be admitted to the hospital for an overnight stay (if extremely impaired). Also, if there is erratic behavior, the impaired individual may be charged with a disorderly conduct and incarcerated. There is no case management or standard follow-up with any of these processes."

   *Northwestern MHC*

Page 63 of 96
one of whom serves six counties. One directly provides level 1-WM but contracts for all higher levels. Two provide some levels of care but would like to expand these services.

2. **Service Categories: Screening, Assessment, Diagnosis, and Risk Management**

   Minimally, all these service categories are provided by all implementers. Several said they provide all these services but not in sufficient capacity or geographic availability to meet all needs, particularly outside of traditional office hours. One mentioned the need to use tele-health services for these categories. Another said that services are provided mostly on a walk-in basis; at times, individuals may have to wait up to two hours to see a mental health professional but consistently decreasing wait time is important to them. The lack of culturally competent, bilingual staff was noted by one implementer. Another mentioned the short supply of providers with expertise in American Sign Language and deaf culture.

   "We have had difficulty recruiting prescribers due to both the shortage in the community and our compensation package not being competitive. In 2012, we had capacity to do up to 20 psychiatric intakes per week. Today we can do only 3-4 per week. There is often a 3-4 week wait for a psychiatry appointment."

3. **Patient-Centered Treatment Planning or Similar Processes Including Risk Assessment and Crisis Planning**

   Overall, the implementers reported that they have these planning and risk assessment services in place – often across a wide range of programs – but not always in sufficient capacity or geographic availability to meet all needs. One noted a need for culturally-specific SUD treatment services. Several shared details such as involving family members in children’s services, and inviting family members input in adult services, when appropriate. The need to use interpreters in these services was noted by one implementer. More staff training on these issues was mentioned by one implementer, who also noted that staff struggle to find the time to collaborate with a person’s natural supports and other providers because this is often not a reimbursable activity.

4. **Outpatient Mental Health Services: Group, Multifamily Group, Individual, Day Treatment, Partial Hospitalization, Other**

   **Mental Illness:**

   It seems that most implementers offer group sessions, but they are not always available throughout the service area. Several (three) say they offer family groups and individual sessions. One said few groups for children,
youth, older adults, and non-English speakers are available. Only one clearly stated that day treatment was provided and several offered partial hospitalization, but the latter noted that several times per year they have to put admissions on hold due to being at capacity. One has available a crisis stability unit where a person needing extra support (when medically necessary) can stay for up to 10 days.

There was a significant need for more qualified staff. Because of this there are outpatient waiting list for psychiatric and therapeutic services. Others mentioned the need for additional space to offer services and the need to be open more hours, especially over the lunch hour, evenings, and weekends.

Substance Use Disorders:
Three implementers offer group sessions, at least two of which were CBT. Less often offered were multifamily groups and individual therapy. Only a very few offer partial hospitalization or day treatment, but one noted that ARMHS generally replaces day treatment.

Many needs were noted, most of which were linked to an insufficient number of staff, particularly LADC, so the implementers were unable to meet the needs of the community. One mentioned that prospective staff were not hired because they were not trained in the Integrated Dual Disorder Model or Harm Reduction.

Another barrier to service delivery is that a high percentage of individuals referred to a dual disorder program have significant trauma histories and those treatment needs are not completely met in a traditional IDDT program. There is also a treatment gap between detox and inpatient treatment due to waiting lists. The longer the wait, the greater the possibility of disengagement.

The availability of services across large rural geographic service areas was mentioned frequently. One noted that Alanon and Adult Children of Alcoholic meetings, important informal supports, were not offered anywhere in their geographic service area. One implementer mentioned the need for home-based therapy services and another mentioned the need for programming specific to women.

5. Outpatient Clinic Primary Care Screening of Key Indicators and Health Risks
At least some type of primary care screening services are provided by most implementers. Only one implementer does not have any primary care screening at this point. One reported that primary care screening is currently done on a limited basis depending on the provider. To implement this in the future they will need to use a tool or tools to use consistently across the
population, identify staff who will perform the screenings, perhaps add staff such as a dietician to provide services related to physical health screening and monitoring, and train current staff.

Another implementer conducts health screenings, which include blood pressure and heart rate screening and pulse oximetry testing, and questions regarding diabetes, hypertension, COPD, and chemical use including nicotine. With two full-time RNs, abnormal vital sign results may be a red flag to contact the clients primary care provider or refer the individual to other resources.

6. **Outpatient Clinic Primary Health Care Monitoring of Key Health Indicators and Health Risks.**
Half of the implementers indicated that they do not monitor key health indicators and risks. Another implementer who conducts screenings spoke to the difficulty of monitoring health conditions when the lab is off-site and the implementer is not connected to the lab’s electronic medical record.

7. **Targeted Case Management (Requires SPMI and SED Eligibility)**
All implementers provide targeted case management, but all noted a limited capacity to meet the needs of their community. This is due to an insufficient number of qualified case managers to cover the geographic service area, poor staff retention due to low pay and compensation, the need for bilingual and bicultural staff, transportation problems, and limited service hours that don’t fit the individuals’ schedules. Several mentioned plans for partnering with DCOs to increase the level of TCM coverage. One mentioned the need for staff training on person-centered planning and staff who speak Karen, Hmong, and East African languages. Another barrier regards the rules and requirements of TCM under which dual case management isn’t allowed for clients with straight MA.
8. Psychiatric Rehabilitation Services:

a. **CTSS Certification:** Four implementers are CTSS certified, but one of those is certified in about three-fourths of their service area. One is not certified but contracts with organizations that are certified, and one has applied and is waiting for the final decision. Two implementers provided information on barriers. These include long waiting lists to receive services, recruitment of qualified mental health practitioners, clinical trainees and mental health professionals to deliver services particularly in the more rural/frontier areas; few qualified applicants who are bilingual and/or bi-cultural; provider fatigue and/or burn-out which occurs with non-traditional, evening work hours, and lengthy distances to deliver services in the children’s home or school district.

b. **ARMHS Certification:** At least five implementers are ARMHS certified, but one of those is certified certified in about three-fourths of their service area, one is certified but not currently providing ARMHS services, and another has only their peer specialists providing ARMHS services. One provides vocational rehabilitation services. Low reimbursement rates was noted as a barrier for service provision. There is a limited availability of clubhouse model services.

Very few options exist for persons who speak languages other than English. Culturally specific options are limited or nonexistent for most if not all age groups. In-depth information on barriers was provided by only one implementer. This implementer cited the difficulty in recruiting qualified rehabilitation workers, mental health practitioners, and mental health professionals to deliver services; maintaining staff because compensation is lower for these positions; recruiting bi-lingual and/or bi-cultural staff; and achieving sufficient reach with specialized ARMHS and Community Support Program groups.

Services are offered in each county, but depending on the topic and the availability of transportation, they can still be limited as to the population they are able to reach. Also noted are difficulties when staff travel long distances to meet with individuals who don’t show up for the appointment, resulting in fewer billings. Long travel times also mean that staff will assist clients to attend group sessions.

This implementer only has a means to provide ARMHS services to individuals with Medical Assistance or individuals who are on pre-paid Minnesota Health Care Programs; otherwise these individuals
can only receive outpatient services due to lack of a viable funding stream. Currently, Minnesota requires that providers bill ARMHS within 30 days of the date of the Diagnostic Assessment (to establish eligibility) which is a very short window of time especially when an individual may also be dealing with medical health issues, impeding their ability to meet with staff. In addition, if that timeline isn’t met, a Diagnostic Assessment Update needs to be completed. This results in the individuals and the insurance companies incurring additional costs for treatment, which can be a burden for an individual on a limited income already. Typically, these services are not covered during the weekend, although they are provided in the evenings if needed to best fit the individual’s schedule.

9. Peer Support and Counselor Services and Family Supports

a. Individual: At best, peer support is provided in only some services offered by each implementer. Current unmet needs include recruitment of Peers who are far enough in recovery and have the computer skills and transportation required for the position particularly in the more rural/frontier areas, and meet other job qualifications. Training people to become Certified Peer Specialists is costly. While these positions are often the lowest paid, they require the most training and supervision which means additional time and oversight by the clinical supervisors. Few multi-lingual peers are currently available.

Time to travel and no-shows present billable hour issues; this may limit options to engage in individual therapy as staff encourage people to attend group sessions. Many implementers need to hire more staff. Few peer supports are available for children’s services. This shortage of peer specialists is due in part to reluctance to self-disclose mental health conditions as a way to become certified as a peer specialist.

b. Group: One challenge is related to paying for training of peers and professionals to lead specialized types of groups. There is a need to hire more staff, including certified peer specialists. In particular, multilingual staff are desired who can support families with children and adolescents as well as families and caregivers of older adults living with SUD and/or MI.
### Figure 36: Model Practices

<table>
<thead>
<tr>
<th>Model Practices</th>
<th>Number of Implementers Providing Model Practice - by Age</th>
<th>Number of Implementers Providing Model Practice - by Diagnostic Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-17</td>
<td>18-21</td>
</tr>
<tr>
<td>Motivational Interviewing</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Stages of Change (Transtheoretical Model)</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Medication Assistance Therapies*</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Supported Employment – Individual Placement and Support</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Integrated Dual Disorder Treatment (IDDT)</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Trauma Treatment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Narrative Exposure Therapy</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>• Trauma-Focused Cognitive Behavioral Therapy</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Other evidence-based Trauma Treatment model (Cite evaluation)</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Evidence-Based Practices for Children:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Managing and Adapting Practice (MAP)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>• Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>• Parent-Child Interaction Therapy (PCIT)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>• Trauma Informed Child Parent Psychotherapy (TI-CPP)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>• Attachment Bio-Behavioral Catch-up (ABC)</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Implementers were asked to describe their model practices and include information on the percentage of staff who have been trained. Five focused almost exclusively on staff training with no further description. One described the model practices with...
less emphasis on reporting the percentage of staff trained. Overall, however, the pattern of breadth of model practices versus depth (in terms of number of staff trained) can best be described as highly variable.

- Two implementers provided a wide range of model practices for adults and reported that, among the model practices that were offered, a relatively high percentage of staff – often up to 50% to 80% had been trained in those practices.

- One implementer provided many model practices for adults, but only 1% to 15% of staff were trained in those practices.

- One implementer offered a moderate amount of model practices for adults, but between 50% and 100% of staff had been trained in those practices.

- Another offered a moderate amount of model practices for adults, but few staff were trained in those practices.

- One implementer provided all model practices to the adult population. This implementer noted that certain staff had less training than others; some model practices were offered with greater emphasis in some programs than others (e.g., Stages of Change in the dual diagnosis program); one model practice was contracted out (Supported Employment – Individual Placement and Support) although most agency staff understood its basic principles; and that there is a need for more training across the board.

- All but two implementers provided at least some form of best practice trauma treatment for adults.

- Three implementers provided no model practices for children, one implementer offered only one model practice, and the remaining two implementers offered three or four model practices for children. Among the three implementers who provided any model practices, the percentage of staff trained was much less than what was the case for adults.

**FIRST IMPLEMENTER’S SERVICE DELIVERY MODEL FOR BEHAVIORAL HEALTH SERVICES – INCLUDING DESIGNATED COLLABORATING ORGANIZATIONS**

This topic is addressed in the earlier section about common themes.

**SPECIAL POPULATIONS SERVED BY FIRST IMPLEMENTER – INCLUDING DESIGNATED COLLABORATING ORGANIZATIONS**

Special populations are addressed by implementers in Figure 37, as follows:
Figure 37: Special Populations

<table>
<thead>
<tr>
<th>Special Populations</th>
<th>Number of First Implementers Serving Populations - by Age</th>
<th>Number of FI - by Diagnostic Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-17</td>
<td>18-21</td>
</tr>
<tr>
<td>Members of the armed forces and veterans and their families</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Homeless shelters</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Living on the streets</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Foster care</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Other congregate living</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Limited English proficiency</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>American Indians, tribal groups, and nations</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other specific racial and ethnic groups</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Individuals with physical, intellectual, and sensory disabilities</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Other cultural needs populations</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Although some commonalities were found among implementers, most responses were specific to each agency. However, the theme to emerge most clearly is that in most cases special populations are integrated into the mainstream service system rather than being served in separate programs tailored to their needs.

- Members of armed forces, veterans, and their families: Although all implementers served veterans, several didn’t track veteran status. Several estimated the (relatively) low numbers of veterans served. Several seemed to have made a concerted effort to actively engage veterans and possibly their families. One partners with the National Guard and the Beyond the Yellow Ribbon project. One mentioned a connection with a TriCare agency but also the severe limitations on the types of mental health providers TriCare will reimburse; as a result, the implementer provides many services to veterans and their families without compensation. Another implementer serves this population through an outreach and housing contract with their local County.

- Incarcerated: Two implementers do not provide services for people who are currently incarcerated, although they stated that some current clients have been previously incarcerated. One implementer provides a large number of services: crisis assessments and Rule 25 assessments at the jail; participates with the DWI court; and provides assessments, individual therapy, and crisis services at the juvenile center. Two provide a few traditional services such as
competency evaluations, mobile crisis outreach, and some services to people in jails. Another mentioned about one-third of the children and youth they serve have parents who are currently or previously incarcerated or involved with the justice center.

- Homeless shelters: Although all implementers provided services to the homeless, two implementers did not mention any special descriptions of those services. Two implementers provide outreach to homeless shelters, and one may provide case management, too. One provides crisis services to the homeless, and another sees homeless people in all of their programs and also has a contract with a local social service agency to provide transitional beds.

- Living on the streets: All implementers provide some type of services to people living on the streets, but two of them did not mention any special services for this population. Three other implementers provided or contracted for outreach services to them. One mentioned that street people are typically served only by crisis services.

- Foster care: One implementer said no services were provided, but it is unclear if the question was interpreted as “people living in foster care” or “foster care settings.” Three implementers did not mention any special services in or for people living in foster care. One mentioned that case management was provided to adults, children, and ARMHS. One mentioned referring individuals in foster care to existing mental health services, and another served them in case management and clinical services.

- Other congregate setting: Three implementers did not mention any special services in or for people living in other congregate settings. While one said that they (without naming those settings) were offered crisis services. Other settings mentioned included board and care services, nursing homes, ACFs, and customized living environments.

- Limited English proficiency: All implementers served people with limited English proficiency. Among the four implementers who mentioned specific languages, Spanish (n=4) was most frequently mentioned, followed by Somali (n=3), Hmong and Vietnamese (n=2 for each language), and once each for Karen, Khmer, Laotian, Amharic, Chinese, and Cambodian. (See also “sensory disabilities” below.

- American Indians, tribal groups, and nations: One implementer’s response seemed to indicate that services were not provided to American Indians, or tribal groups or nations. Three implementers did not provide detail on the types of services or said that no special services were provided to this population. One implementer mentioned that this population is served
typically by crisis services or in regular programs. Another mentioned that 3-5% of their client population is Native American or from tribal groups or nations.

- Other specific racial and ethnic groups: Two implementers mentioned no other racial and ethnic groups, another said they were serviced but provided no additional description. One mentioned that 1,330 of their 3,623 clients are American Indian or people of color; another mentioned an unspecified range of ethnically and racially diverse clientele, and another said that 10 to 35% of clients in various programs are African American.

- Individuals with physical, intellectual, and sensory disabilities: All implementers seemed to indicate that they provide services to at least some of these populations. Of the five implementers who responded to this item with additional detail, one said that this population is served in regular programs: 291 of clients receiving mental health services were also receiving DD services; one said that they have services geared specifically to the deaf and hearing impaired; one provides free office space and telemedicine to VOA staff trained in deaf and hard of hearing services and ASL; one implementer has a therapist who specializes in treatment for people with TBI and DD; and one said that approximately 20-25% of children it serves have some form of PDD or ASD.

- Other cultural needs populations: No additional populations were mentioned.

**RESPONSES TO ADDITIONAL SURVEY QUESTIONS**

1. **Is your organization the mental health authority in the CCBHC service area?**
   
   a. **Yes:** (Northwestern, Ramsey County, and People Inc. selected this response.)
   
   b. **No, but a designated collaborating organization is the mental health authority:** (No implementers chose this response.)
   
   c. **No, and we do not plan to partner with the mental health authority.** (No implementers chose this response.)
   
   d. **No, but we work closely with the counties who are the legally designated mental health authority.** (Wilder, Northern Pines, and Zumbro Valley selected this response.)
2. **Is there other information you would like to provide about SMI diagnostic subgroups of individuals you currently serve?**

One implementer commented that they provide case management to clients who are civilly committed as chemically dependent. Their IDDT program specializes in serving individuals who have not found traditional treatment helpful. The implementer commented that they provide mental health services to clients who have SUD issues, but are not providing specific SUD treatment other than to clients in ACT. In ACT, they provide IDDT services.

3. **Is there other information you would like to provide about EBD diagnostic subgroups of individuals you currently serve?**

Implementers who responded spoke of serving individuals regardless of ability to pay in all of their programs. Most of their clients face multiple, complex problems including poverty.

4. **Is there other information you would like to provide about SUD diagnostic subgroups of individuals you currently serve?**

Most implementers did not address this question. Wilder discussed their cultural competence regarding children and families.

5. **Is there other information you would like to provide about SUD diagnostic subgroups of individuals in your area who need services but are currently not served?**

Implementers reported that both adolescents and adults need early intervention through withdrawal, detoxification, and treatments. A lack of resources and licensed/trained staff were mentioned as one of the major barriers. Transportation is also a barrier for staff and individuals. Implementers cited opioid addictions with MAT services as an issue, and noted that there are long waiting lists for these services. There is a gap in service for individuals leaving detox and waiting for inpatient treatment, during which time they are at risk of relapse.

There are a growing number of persons living with serious mental illness and chronic physical health conditions who are also using street drugs as well as alcohol and tobacco. A significant percentage of these persons are parents or caregivers with young children in the household. Therefore, implementers seek to employ and implement models that use a family centered approach to chemical health treatment.

6. **Is there other information you would like to provide about SMI diagnostic subgroups of individuals in your area who need services but are currently not served?**

One implementer said they are under-serving the Karen community. Another said they are underservicing individuals with dual diagnoses.
7. Is there other information you would like to provide about EBD diagnostic subgroups of individuals in your area who need services but are currently not served?

One implementer has seen an increase in behaviorally aggressive and assaultative clients in all service areas over the last several years. Another said they have assessment services for autism spectrum children and their families, but are limited in mental health treatment and other supports they are able to offer due to resource constraints.

8. Have you recently surveyed (survey, focus group, etc.) your clients and/or your service area regarding their stated needs?

Three implementers mentioned client surveys and two mentioned focus groups conducted in partnership with other organizations. One conducted a survey with immigrant and refugee populations. Another conducted a Native American Needs Assessment and is in process of several other assessments with frequent detox visitors and correctional inmates.

9. Does the agency experience workforce issues in recruiting and retaining qualified staff in the required CCBHC service areas?

All implementers expressed serious concerns with workforce issues. Primary among these are with recruiting and retaining qualified staff, particularly psychiatrists and advanced practice nurses who can prescribe medications for adults and children, but also LADCs and RNs. There is also a need for experienced child/adolescent therapists trained in evidence based practices, and in hiring culturally- and linguistically-specific staff in all areas: adult, youth and children. Private practice, for-profit, government or hospital-based settings pay higher salaries and see less complex clients, and it is difficult to compete with them for staff. People tend to stay in the area where they were trained and those programs are in the Twin Cities metro area or online.

10. What screenings (other than those currently required by Minnesota for diagnostics and Rule 25) are being done routinely when someone presents for services? SUD? Brain Injury? History of Trauma? Depression/Anxiety? Other? Are these screenings repeated routinely?

All implementers conduct at least some assessments of mental health disorders, suicide risk, and chemical health disorders, but the list is quite varied and includes: UCLA/North Shore and Trauma Symptom Checklist; MMPI, TOVA, PHQ-9 and PHQ-9A, Standard Diagnostic Assessment, GAINS-SS, GAD-7; WAIS, WISC; CAGE-AID, AUDIT-C; WHOQOL; AIMS; and WHODAS-12. One implementer screens for housing stability and tobacco use. There was no mention of how frequently the assessments were repeated.
11. What primary care screening and monitoring of key health indicators and health risks is occurring currently?

One implementer is planning to use the USPSTF screening services selector with adults in its behavioral health home starting July, 2016; their screenings for children will be based off the Minnesota Child and Teen Checkup schedules. One screens for diabetes, BMI, blood Pressure, cholesterol, cancer, vision, and hearing. Several implementers cited ACT’s requirements as their screening and monitoring activity for that population. Several screen for weight, temperature, and blood pressure, and one of these noted a prescriber may order labs to monitor for diabetes and heart disease, and it also has staff who will assist individuals in obtaining primary care. One asks questions of individuals about their health as part of their diagnostic assessments.

12. Please list populations that you identify as needing TCM services, but do not meet the state’s currently eligibility definition.

Responses include: individuals with commercial insurance plans; children who are at-risk of developing a behavioral mental health disorder and have environmental risk factors such as a history of trauma or a witness to domestic violence; people experiencing a mental health crisis, but who aren’t SPMI; individuals seen in acute services; individuals diagnosed with PTSD, Psychosis NOS but no hospitalizations; individuals with depression and anxiety with high medical needs but do not quite meet the criteria for MH-TCM; individuals who are chronically chemically dependent; children and adolescents with a parent with significant mental health issues who are reluctant to pursue services on their own behalf; children of parents with developmental delays; parents who have SUD issues; adults who are recent arrivals or refugees who do not meet the diagnostic categories for TCM services, especially if they do not speak English; adults who have learned to be wary of the system that requires them to have a specific diagnosis of mental illness in order to receive help; adults who have young children in the home who would like help but experience case management as intrusive.

13. Have you recently surveyed (survey, focus group, etc.) your service area regarding their needs?

Three implementers have not surveyed their service area regarding needs. One conducted focus groups with Native American community and another surveyed immigrant and refugee communities. One responded that they completed satisfaction surveys and focus groups with clients.

14. Does the agency have a psychiatrist who functions as the medical director?

Please describe their role.

Four implementers have a psychiatrist who functions as, serves as, or has a leadership role as medical director. It seems that all psychiatrists are either part time or also have duties in addition to medical director. The other two
implementers have psychiatrists on board, but these individuals do not act in the medical director role.

15. Does the agency have a medically-trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications under state law, including buprenorphine and other medications used to treat opioid and alcohol use disorders?
It appears that no implementer has a medically-trained behavioral health care provider who can prescribe both buprenorphine and naltrexone. One implementer has a psychiatrist who can prescribe naltrexone. Another has a psychiatrist who can prescribe buprenorphine, but this implementer didn’t mention naltrexone. The other four implementers had no provider who could prescribe medications to treat opioid and alcohol use disorders.

FIRST IMPLEMENTERS READINESS ASSESSMENT RESULTS
A feasibility study was performed by all organizations seeking to become a First Implementer. The study, I-CCRFT (Assessment of Feasibility and Readiness to Become a CCBHC), was developed by the National Council for Behavioral Health. Responses from organizations who were selected as First Implementers are summarized below in Figure 38.

Figure 38: Readiness Assessment Results

<table>
<thead>
<tr>
<th>Item</th>
<th>First Implementer Scores*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
<td>1</td>
</tr>
<tr>
<td>A. Non-Four-Walls System Design Readiness Assessment</td>
<td>26</td>
</tr>
<tr>
<td>B. Trauma-Informed Care Readiness Assessment</td>
<td>96</td>
</tr>
<tr>
<td>C. Prospective Payment System Rate Support Requirements</td>
<td>41</td>
</tr>
<tr>
<td>D. Other Considerations Related to CCBHC Feasibility and Readiness</td>
<td>4</td>
</tr>
<tr>
<td>E. Service Delivery Operational Feasibility Assessment</td>
<td>75</td>
</tr>
<tr>
<td>Total Score</td>
<td>242</td>
</tr>
</tbody>
</table>

Minimum: 61. Maximum: 305. Average: 183. According to the National Council, a score less than 160 will require significant organizational changes.

*Key: 1: Northwestern Mental Health Center; 2: Northern Pines Mental Health Center; 3: People Incorporated; 4: Ramsey County Mental Health Center; 5: Wilder Children and Family Services; 6: Zumbro Valley Mental Health Center
LEVELS OF NEED IN SERVICE AREAS

Each service area as defined by the First Implementers was reviewed related to a number of data sources to help understand the levels of need. One such data source was found in Medicaid data from fiscal year 2015, as summarized below.

The purpose of using Medicaid data is to better understand what services are currently being delivered in the county, and for which populations. It should be noted that levels of service may not reflect actual demand, if there is insufficient capacity among providers to meet the need. Other cultural factors may also affect the utilization of services, particularly for populations or individuals for whom mental health services are not socially acceptable.

MEDICAID DATA BY COUNTY

Medicaid data from fiscal year 2015 was analyzed related to targeted mental health services by county. Results are found in Figure 16.

As can be seen in the data, Mahnomen County has a very large proportion (68%) of non-white clients accessing targeted mental health services through Medicaid (Hispanic individuals are considered white for this purpose). Ramsey (43%) and Hennepin (40%) had the next highest levels, followed by Crow Wing at 33%.

The county with the largest Hispanic population accessing Medicaid mental health services was Polk (14%).

The proportion of services for individuals under age 18 was highest in Norman county (44%), followed by Mahnomen (39%), Cass (39%), and Morrison (38%) counties.

The grid shows the number of individuals for whom targeted mental health services were reimbursed through Medicaid for each county. The bottom set of numbers reflect the percent of overall services that were utilized non-Whites, Hispanics, and children under age 18.
### Figure 39: Medicaid Data by County

#### Sum of Clients Served in CY 2015

<table>
<thead>
<tr>
<th>Client Type</th>
<th>North</th>
<th>East</th>
<th>Central</th>
<th>West</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Clients Served</td>
<td>617</td>
<td>1,501</td>
<td>3,396</td>
<td>1,492</td>
<td>6,706</td>
</tr>
<tr>
<td>- Percent Non-White (does not include Hispanic)</td>
<td>11%</td>
<td>3%</td>
<td>7%</td>
<td>5%</td>
<td>13%</td>
</tr>
<tr>
<td>- Percent Hispanic</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>- Percent Age Under 18</td>
<td>35%</td>
<td>32%</td>
<td>38%</td>
<td>32%</td>
<td>36%</td>
</tr>
</tbody>
</table>

#### Color Key to Fast Implementer Service Area

- Northern Plains: Atkin, Cass, Crow Wing, Morrison, Todd, Wadena
- Zumbro Valley: Fillmore, Olmsted
- Anoka, Dakota, Washington
- Hennepin
- Ramsey
- Kittson, Mahnomen, Marshall, Norman, Polk, Red Lake

#### Medicaid Data by County (Example)

<table>
<thead>
<tr>
<th>County</th>
<th>Clients Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aitkin</td>
<td>12</td>
</tr>
<tr>
<td>Cass</td>
<td>28</td>
</tr>
<tr>
<td>Crow Wing</td>
<td>10</td>
</tr>
<tr>
<td>Morrison</td>
<td>2</td>
</tr>
<tr>
<td>Todd</td>
<td>8</td>
</tr>
<tr>
<td>Wadena</td>
<td>9</td>
</tr>
<tr>
<td>Fillmore</td>
<td>2</td>
</tr>
<tr>
<td>Olmsted</td>
<td>14</td>
</tr>
<tr>
<td>Anoka</td>
<td>225</td>
</tr>
<tr>
<td>Dakota</td>
<td>97</td>
</tr>
<tr>
<td>Washington</td>
<td>850</td>
</tr>
<tr>
<td>Minnetonka</td>
<td>20</td>
</tr>
<tr>
<td>Ramsey</td>
<td>2</td>
</tr>
<tr>
<td>Kittson</td>
<td>1</td>
</tr>
<tr>
<td>Mahnomen</td>
<td>2</td>
</tr>
<tr>
<td>Marshall</td>
<td>1</td>
</tr>
<tr>
<td>Norman</td>
<td>3</td>
</tr>
<tr>
<td>Polk</td>
<td>4</td>
</tr>
<tr>
<td>Red Lake</td>
<td>4</td>
</tr>
</tbody>
</table>

*Note: The table continues with similar data for other counties.*
Staffing, Linguistic, Cultural Competence, and Evidence-Based Practice Needs of First Implementer Service Areas

Northern Pines Mental Health Center defines its service area as six central Minnesota counties: Aitkin, Cass, Crow Wing, Morrison, Todd, and Wadena.

Staffing Needs:
- Medicaid data show that children under age 18 utilize services in this region at a higher rate than is found for most other areas.
- Survey responses indicate that more FTEs are needed in every category to cover all crisis services demand.
- Treatment facilities report higher than average levels of admission for methamphetamine use in Todd, Morrison, and Crow Counties, and for alcohol use in Cass and Crow Wing Counties.

Linguistic and Cultural Competence Needs:
- Medicaid data show relatively low numbers of targeted services utilized by persons of color overall in the region. However, individual counties show unique populations at higher than average rates, as described below.
  - Cass County has a higher than average (12%) population of American Indians.
  - Todd County has a higher than average rate (8.2%) of language other than English spoken at home. Its Hispanic population is 5.3% of the total population in the county.
- Survey responses:
  - Specific training, as well as lived cultural experience, is lacking for current staff. Training programs include all the cultural competency areas listed.
  - The Native American population lives throughout the region off-reservation, but also reside on-reservation including Leech Lake and Mille Lacs.
  - There is a small enclave of Hispanic families in the Long Prairie area.

Evidence-Based Practice Needs:
- Crisis Mental Health:
  - The crisis team has enough FTEs, but lacks distribution in parts of the service area, particularly Northern Cass County and Eastern Aitkin County.
  - In most areas, staff are able to respond within ½ hour of a call.
  - Withdrawal Management and Detox: Will provide 1WM and contract for higher levels.
• **Service Categories:** These are all available but not in sufficient capacity or geographic availability to meet all need.
• **Patient Centered Treatment Planning:** These are all available but not in sufficient capacity or geographic availability to meet all need.
• **Outpatient Mental Health Services:** Group and individual, but not multi-family group, day treatment, or partial hospitalization. These are available but not in sufficient capacity or geographic availability to meet all need.
• **Outpatient Substance Use Services:** Licensed Rule 31 sites in Crow Wing, Morrison, and Wadena counties. Need to increase capacity and geographic spread.
• **Outpatient Clinic Primary Care Screening:** Not at this time, but will when Behavioral Health Home is up and running.
• **Outpatient Clinic Primary Care Monitoring:** No.
• **Targeted Case Management:** Some capacity, but will need to quadruple this.
• **Psychiatric Rehabilitation:**
  o **CTSS:** Certified in ¾ of region.
  o **ARMHS:** Certified in all 6 counties.
• **Peer Support:** Currently have a fairly large complement, but will need to increase and develop it to meet need.

**Consumer Voice:**
In “The Health of Morrison County” – a comprehensive community health needs assessment undertaken in 2013, the following feedback was given regarding access to mental health providers: 25% answered “yes,” there were sufficient mental health services in Morrison County; 18% responded “no,” while 57% said “they don’t know.” For the question about whether the respondent would be comfortable seeing a mental health provider in Morrison County, 35% said “yes,” 29% said “maybe,” 14% said “no,” and 22% said “they don’t know.”
Northwestern Mental Health Center defines its service area as: Kittson, Mahnomen, Marshall, Norman, Polk, Red Lake counties.

**Staffing Needs:**
- Medicaid data show that children under age 18 utilize services in this region at a higher rate than is found for most other areas.
- Survey responses indicate that more trauma-informed training would be beneficial for staff. Many in the region are from single-parent homes. Poverty, limited access to informal support because of geographical distance is often a major factor. Chemical health issues, as well as mental health issues, cause crisis situations for adolescents/young adults.
- There is need for a psychologist and neuropsychologist to properly differentially diagnosis complex individuals, as well as assess for diagnosis such as dementia and ADD/ADHD. There is currently one psychologist who will be retiring within the calendar year.
- Treatment facilities report higher than average levels of admission for methamphetamine use in Mahnomen and Marshall Counties, and for alcohol and marijuana use in Norman Counties.

**Linguistic and Cultural Competence Needs:**
- Medicaid data show a higher than average utilization of targeted services by non-white persons in several counties in the service area, as described below.
  - Very high (68%) non-white service levels in targeted services are found in Mahnomen County.
    - Census data show 41.7% of the county is American Indian, with 9% of the population two or more races.
    - The DWI arrest rate in Mahnomen County is approximately three times the national average.66
  - Norman, Polk, and Red Lake each show 14% non-white service levels.
    - Census data show that Norman, Polk, and Red Lake Counties have 4.9, 5.9, and 3.9% Hispanic populations.
    - Census data show that a language other than English is spoken at home in counties at these rates: Kittson (3.8%), Mahnomen (5.5%), Marshall (5.6%), Norman (5.4%), Polk (7.3%), and Red Lake (3.7%).
    - Polk County has a growing Somali culture.
- Survey responses:
  - There are areas of improvement necessary in providing culturally-competent training services, specifically to customers in the White Earth Nation area of Mahnomen County and the Hispanic/Somalian population.
    - There is currently one professional bi-lingual in Somali.
• There is currently one professional bi-lingual in Spanish.
• There is one American Indian Mental Health Therapist.

**Evidence-Based Practice Needs:**

- **Crisis Mental Health:**
  - There is a 24/7 warmline for crisis services, by the name of Txt4LIFE. The new mobile crisis team initiated services in April 2016 and appears to be appropriately staffed currently.
  - There is no formal withdrawal management and detoxification in the service area. The closest detoxification unit is between 40 and 180 miles away. Regional hospitals may admit intoxicated individuals for an ER Visit or overnight stay until their blood alcohol level drops. If there is erratic behavior, the individual may be incarcerated. There is no case management or standard follow-up. Opportunities exist to partner with area emergency departments to address this need.

- **Service Categories:** Because of the large geographic area, work continues with partners in the schools and clinics to provide screening and assessment using tele-health services.

- **Patient Centered Treatment Planning:** Patient-centered care is the focus of treatment. Children’s programming often includes family members in treatment planning, risk assessment, and crisis planning. Adult and outpatient services currently include treatment planning, with the goal of inviting family members opinions where appropriate.

- **Outpatient Mental Health Services:** There is a day treatment program, but no partial hospitalization. A Crisis Unit is available for up to 10 days for people needing extra support. At one location, DBT adult group, DBT coping skills for adolescents, and peer-facilitated group are offered. Individual therapy is offered full-time at Crookston campus and at 4 physical health clinics on a weekly basis, but waiting lists are often 3-6 weeks. More qualified staff and space are needed to meet the demand for service.

- **Outpatient Substance Use Services:** The CHANGE Outpatient program is offered for adolescents on a limited basis. Three clinicians offer individual therapy for co-occurring disorders, but are not able to keep up with the need. The agency is licensed as Rule 29 and Rule 31, and offers Rule 25 assessments. There are no Ala-non or Adult Children of Alcoholics meetings offered in the service area.

- **Outpatient Clinic Primary Care Screening:** Screening for chronic health conditions is performed for clients who see the psychiatrist and/or psychiatric nurse practitioner. Referrals are typically back to primary care, but with no follow-up. Two RNs are on staff; one working with the psychiatric practitioners, and one with community visits. Another RN is desired, as well as clinic space, to perform the chronic health assessments.

- **Outpatient Clinic Primary Care Monitoring:** There is no on-site lab; follow-up of physical tests done at partner organizations does not typically occur.

- **Targeted Case Management:** TCM provider for adults and children. More qualified case managers are needed, particularly for rural/frontier areas.
Dual case management isn’t currently allowed for clients with straight MA, but sometimes would be of benefit to clients, given the language/cultural needs of the clients. There are concerns about the inability to bill for travel time when clients at a distance do not keep their appointments. Services are provided in the evenings, but not on weekends.

- **Psychiatric Rehabilitation:**
  - CTSS: Current CTSS certified provider.
  - ARMHS: Current ARMHS provider, and assist a partner agency who provides the employment specialist. Only individuals with MA or on pre-paid MHCP are provided these services. There are timing issues with the ARMHS billing. Individual and Placement and Support Services are offered in Polk County only due to funding limitations.

- **Peer Support:** Currently provide Certified Peer Specialists in the Adult Community Services program only. The availability of training sessions within the service area would greatly support this program. Currently, only one bi-lingual (Dacotah American Indian language) peer is on staff. There are plans to train staff to lead groups such as WRAP. The large geographic area and limited transportation has placed more responsibility on peers to assist clients in getting to groups.

**Consumer Voice:**
In the 2013 Polk-Norman-Mahoman county community health assessment, the following themes were recorded related to mental illness: Distance to services; Inappropriate/Lack of Access; Prison population mental health issues; Stigma; Cultural needs; Elderly – Depression.
People Inc. defines its service area as:
Ramsey and Hennepin counties.

**Staffing Needs:**
- Medicaid data show somewhat lower targeted service utilization by children under age 18 in Ramsey and Hennepin Counties.
- Survey responses do not highlight specific staffing needs.
- Treatment facilities report higher than average levels of admission for crack/cocaine use in Ramsey and Hennepin Counties, and for opioids use in Hennepin County.

**Linguistic and Cultural Competence Needs:**
- Medicaid data show high targeted service use by non-white populations in Ramsey (43%) and Hennepin (40%) counties.
- The 2 counties in this service area all fall within the top 3 counties in the state regarding non-White populations.
  - Ramsey: American Indian (1.0%); Asian (13.8%); Black (11.7%); Hispanic (7.3%)
  - Hennepin: (American Indian (1.2%); Asian (7.2%); Black (12.6%); Hispanic (6.8%)
- Survey responses:
  - Survey responses do not highlight specific linguistic and cultural competence needs.

**Evidence-Based Practice Needs:**
- **Crisis Mental Health:**
  - Capacity can be built for 24/7 teams for intervention or stabilization in-house. The organization has 3 residential 24/7 crisis facilities, and will be opening additional mental health satellites.
  - Withdrawal management could be offered through DCO relationships.
- **Service Categories:** Currently offered.
- **Patient Centered Treatment Planning:** Currently offered.
- **Outpatient Mental Health Services:** Currently offered except for adult MH day treatment and partial hospitalization. There is a waiting list for outpatient therapeutic services.
- **Outpatient Substance Use Services:** Currently offered, will need to increase service levels at one location.
- **Outpatient Clinic Primary Care Screening:** Currently offered.
- **Outpatient Clinic Primary Care Monitoring:** Not offered consistently.
- **Targeted Case Management:** Offered in-house. Can offer outpatient through a DCO.
- **Psychiatric Rehabilitation:**
- CTSS: Offered in-house.
- ARMHS: Certified but not currently providing.
- Other: ACT, IRTS Crisis services in system, but not in demonstration group.
  - **Peer Support**: Have peers, but none are in service cohort.

**Consumer Voice:**
The East Metro Mental Health Roundtable published a report on Community Metrics in 2015. The following statistics are drawn from this report.⁶⁸
- Since 2010, ED behavioral health visits have increased, as well as ED wait times.
- Service utilization at Urgent Care has remained relatively stable from 2012 to 2015.
Staffing Needs:
- Medicaid data show somewhat lower targeted service utilization by children under age 18 in Ramsey County.
- Survey responses indicate a desire for 24/7 coverage that is not staffed by on-call personnel. Psychiatry services are in short supply, as psychiatrists are difficult to recruit. LADC staff are challenging to recruit and retain. The organization currently has one LADC and are trying to recruit another. They would like to add more peers but don't have the staff capacity.
- Treatment facilities report higher than average levels of admission for crack/cocaine use in Ramsey County.

Linguistic and Cultural Competence Needs:
- Medicaid data show that 43% of targeted services are utilized by non-white persons, and 6% of targeted services by Latino/Hispanic persons.
- Ramsey County has the second lowest proportion (66.2%) of White residents of all counties in Minnesota, second to Nobles County (65.2%). In Ramsey County, 12.3% of residents are Asian, 11% are Black, 6.9% are Hispanic, 3% are of mixed race/ethnicity, and .7% fall into an “other” category. Only 43.5% of children under age 4 are White.
- Survey responses:
  - Language capacity beyond Hmong and Spanish is desired by the organization. Karen and East African populations, in particular, have unmet linguistic needs.

Evidence-Based Practice Needs:
- Crisis Mental Health:
  - On-call personnel staff the 24/7 function, which is not ideal. Tracking of the 3 hour window is challenging. Stabilization services are contracted to People, Inc., and have significant turnover. High out-of-pocket costs for these services deter use. Withdrawal management is provided for levels 3.2 and 3.7, but not yet for levels 1 and 2.
- Service Categories: Provided on a walk-in basis, with wait times up to 2 hours. Staff cannot meet demand for new referrals.
- Patient Centered Treatment Planning: This has been implemented in partial hospitalization program, day treatment, dual disorder program, and for most individual and group therapy recipients. Targeted case management and psychiatry teams have room to grow. Collaboration with natural supports and other providers is not currently reimbursable.
- Outpatient Mental Health Services: The shortage of psychiatrists has significantly decreased capacity for psychiatric intakes, resulting in long wait
times. Family support is not well attended, but individual therapy tends to have long wait times. The partial hospitalization program will be reduced due to an upcoming retirement of a prescriber.

- **Outpatient Substance Use Services:** LADCs are difficult to recruit. There is a desire to add female-specific programming. The traditional IDDT program does not adequately address the needs of individuals with significant trauma histories. The treatment gap between detox and inpatient treatment contributes to the risk of disengagement.
- **Outpatient Clinic Primary Care Screening:** This is currently done on a limited basis depending on the provider. Standardization and tools are needed.
- **Outpatient Clinic Primary Care Monitoring:** Additional training is needed in this area.
- **Targeted Case Management:** Additional staff training on person-centered planning is needed. Two Spanish-speaking case managers are on staff, but language capacity is needed for Karen, Hmong, and East African populations.
- **Psychiatric Rehabilitation:**
  - CTSS: Contract with 3 agencies to provide CTSS.
  - ARMHS: The peer specialist provides ARMHS services.
- **Peer Support:** Three peers work at crisis; 3 work at Rule 29 clinic. A peer is embedded into all clinic programs. Two peers do a weekly social skills group in the community. More peers are desired.

**Consumer Voice:**
According to the Ramsey County IRTS Needs Assessment in 2015, IRTS providers consistently have a full census and lengthy waits for admissions. One provider states, “Emergency and crisis services are overflowing. It is a challenge to keep up with the need. The needs of clients continue to change, clients appear to be experiencing higher levels of acuity, and there is a heightened sense of desperation. While more treatment options are useful, it is apparent that more housing resources are required.”
The Amherst H. Wilder Foundation defines its service area as Anoka, Dakota, Ramsey, Washington, and possibly portions of Hennepin County.

Staffing Needs:
- Medicaid data show somewhat lower targeted service utilization by children under age 18 in Ramsey and Hennepin Counties, but higher levels in Anoka, Dakota, and Washington Counties.
- Survey responses did not detail specific staffing needs other than cultural/linguistic competence.
- Treatment facilities report higher than average levels of admission for crack/cocaine use in Ramsey and Hennepin Counties, and for opioids use in Hennepin County.

Linguistic and Cultural Competence Needs:
- Medicaid data show high targeted service use by non-white populations in Ramsey (43%) and Hennepin (40%) counties, with somewhat lower levels in Dakota (18%), Anoka (17%), and Washington (14%) counties.
- The 5 counties in this service area all fall within the top 13 counties in the state regarding non-White populations.
  - Anoka: American Indian (.8%); Asian (4.3%); Black (5.4%); Hispanic (4.0%)
  - Dakota: American Indian (0.5%); Asian (4.9%); Black (5.7%); Hispanic (6.6%)
  - Ramsey: American Indian (1.0%); Asian (13.8%); Black (11.7%); Hispanic (7.3%)
  - Washington: American Indian (0.5%); Asian (5.5%); Black (4.3%); Hispanic (3.8%)
  - Hennepin: American Indian (1.2%); Asian (7.2%); Black (12.6%); Hispanic (6.8%)
- Survey responses:
  - Culturally-competent match is very limited; there is a shortage of providers. No providers who speak Karen (Burma), limited Somali providers, Spanish – a few adult providers and almost no children. Russian language is in short supply. American Sign Language and deaf culture – culturally competent providers are in short supply for all age groups.

Evidence-Based Practice Needs:
Note: Responses reflect availability in service area, but services are not necessarily provided by the First Implementer.
- Crisis Mental Health:
• Service area counties offer children and adult 24/7 mobile teams, emergency intervention. Adult crisis does stabilization; children’s stabilization is unclear. Withdrawal management is primarily available via detox centers.

- **Service Categories:** Provided by primary care settings and mental health providers in service area.
- **Patient Centered Treatment Planning:** Provided by Rule 29 clinics in service area.
- **Outpatient Mental Health Services:** Provided within service area.
- **Outpatient Substance Use Services:** Provided within service area.
- **Outpatient Clinic Primary Care Screening:** Provided within service area. Wilder has the ability to do all these screenings in-house.
- **Outpatient Clinic Primary Care Monitoring:** Provided within service area. Wilder has the ability to do all these monitorings in-house.
- **Targeted Case Management:** Provided within service area.
- **Psychiatric Rehabilitation:**
  - **CTSS:** Provided within service area. 2-3 week wait.
  - **ARMHS:** Limited within all counties due to low reimbursement rates.
- **Peer Support:** Unmet need for family peer support certification. Limited peers who can speak languages other than English. Very limited peer groups for non-English speakers, families with children and adolescents, and caregivers of older adults living with SUD/MI.

**Consumer Voice:**
The Wilder Research study - *Speaking for Ourselves – Perceptions of Health, Mental Health, and Health Care Access Among Immigrants and Refugees in the Twin Cities* - offers a number of insights on these populations.70

- Stigma associated with mental health issues was particularly salient within the Latino, Karen, and Somali communities that participated in the study, although all participating communities expresses some degree of stigma or embarrassment associated with mental illness.
- Strategies used to reduce stigma around seeking treatment for mental health concerns could include things like using plain language and more acceptable terms when discussing mental illness.
- It appears that a substantial percentage of participants may be experiencing some symptoms of depression, stress, isolation, or other situations that can lead to mental illness. Further the life experiences of many of these participants includes trauma and extreme poverty, which can cause and/or exacerbate mental health issues.
ZUMBRO VALLEY MENTAL HEALTH CENTER

Zumbro Valley Mental Health Center defines its service area as Olmsted and Fillmore Counties.

Staffing Needs:
- Medicaid data show somewhat higher targeted service utilization by children under age 18 in Fillmore and Olmsted Counties.
- Survey responses indicate administrative staffing needs, and note a provider shortage in psychiatric care.
- Treatment facilities report somewhat higher admissions for marijuana and methamphetamine use in Fillmore County.

Linguistic and Cultural Competence Needs:
- Medicaid data show somewhat higher targeted service use by non-white (19%) and Hispanic (4%) populations in Olmsted County.
- Survey responses:
  - No specific linguistic or cultural competence needs were noted in the survey response.
- Of the two counties, Olmsted has higher non-White populations.
  - Olmsted: American Indian (.2%); Asian (5.4%); Black (4.7%); Hispanic (4.2%)
  - Fillmore: Asian (0.3%); Black (0.2%); Hispanic (1.0%)

Evidence-Based Practice Needs:
- Crisis Mental Health:
  - Staffing levels for clinical service delivery are adequate, but administrative staffing support is insufficient. Working to add community stabilization services.
  - WM1 and 2 not met. WM 3.2 met through in-patient detox program. WM 3.7 would require DCO agreement.
- Service Categories: Services met.
- Patient Centered Treatment Planning: Services met.
- Outpatient Mental Health Services: Day treatment and partial hospitalization services not met. No mention of other outpatient MH services in this response.
- Outpatient Substance Use Services: Services provided.
- Outpatient Clinic Primary Care Screening: Services provided.
- Outpatient Clinic Primary Care Monitoring: Services provided.
- Targeted Case Management: Services provided.
- Psychiatric Rehabilitation:
  - CTSS: Awaiting DHS approval.
  - ARMHS: Services provided.
  - Other: Vocational rehab provided.
• **Peer Support:** Minimal services provided due to shortage of qualified applicants.

**Consumer Voice:**
According to the Olmsted County Community Health Needs Assessment 2013 survey, mental health issues (illness and depression) were cited as one of the most pressing community health issues impacting Olmsted County. Mental health was listed as a major community health concern during the community listening session. Mental illness was also discussed in the context of children being diagnosed with autism and ADD/ADHD. Several residents discussed the issues of addiction, depression, and stress management.
LOOKING FORWARD

During the summer of 2016, much preparation will be undertaken by the First Implementers in order to plan for their state certification application as CCBHCs in August. In January of 2017, the demonstration states will be selected, and if Minnesota is one of them, the Minnesota demonstration will begin in July 2017.

Regardless of the outcome of all of these milestones, Minnesota has begun an important journey toward developing a collaborative process of community mental and mental health care that will result in significant changes to the way care is delivered in the state.

ENDNOTES

1 Attributed to Julius Richmond, former Surgeon General of the United States.
7 Minnesota State Demographic Center. http://mn.gov/admin/demography/map-viz-gallery/map-percent-limited-english.jsp
8 Minnesota State Demographic Center.
11 Minnesota Hospital Association – Mental and Behavioral Health: Options and Opportunities for Minnesota.
16 Minnesota Hospital Association – Mental and Behavioral Health: Options and Opportunities for Minnesota.
17 DHS 2010 #1 co-occurring
18 Minnesota Behavioral Health Home Planning and Community Engagement Final Report - By the Minnesota Department of Human Services In partnership with National Alliance on Mental Illness (NAMI) Minnesota April 2015
20 DHS 2010 #1 co-occurring
21 DHS 2010 #1 co-occurring
26 DHS 2010 Survey #2 findings
30 ALCOHOL AND DRUG ABUSE DIVISION - 2015 LISTENING SESSIONS SUMMARY REPORT - Minnesota Department of Human Services March 2016
32 Gearing Up for Action: Mental Health Workforce Plan for Minnesota.
33 Gearing Up for Action: Mental Health Workforce Plan for Minnesota.
34 Legislative Report: DHS ADAD. https://www.leg.state.mn.us/docs/2013/mandated/130622.pdf
37 2015 Minnesota Laws Chapter 71, Article 2, sections 1-2
38 Minnesota Department of Human Services, School-Linked Mental Health Services
Provider adequacy was determined by the number of available providers divided by the number of individuals with serious mental illness and multiplied by 10,000.
44 HIS, 2015.

Page 94 of 96
49 Hmong mental health - An assessment of mental health needs and services for the Hmong community in Ramsey County - Wilder Research - 2010
52 Minnesota Hospital Association – Mental and Behavioral Health: Options and Opportunities for Minnesota.
54 Jaeger, Kristopher. Addressing Mental Health with the Somali Population in the Twin Cities Area. [http://sophia.stkat.edu/cgi/viewcontent.cgi?article=1334&context=msw_papers]
Mental Health, Care Access among Immigrants and Refugees in the Twin Cities.pdf
Olmsted County Community Needs Assessment – 2013.