

June 2015

Region 7E Mental Health Assessment

OVERVIEW

With the closing of a major mental health provider in March 2014, the Region 7E Adult Mental Health Initiative (Chisago, Isanti, Kanabec, Mille Lacs, and Pine Counties) determined that there was a need to better understand the current strengths and gaps of the mental health system in the region and explore options and potential opportunities. The findings from the study will be used to inform future planning efforts of individual counties as well as potential regional collaboration as the initiative works towards the shared goal of serving community members with mental health needs. This report summarizes the findings from a needs assessment conducted between August 2014 and May 2015 and presents actionable recommendations and opportunities.

DEFINITIONS

Stakeholders: includes all individuals, groups, and organizations with a concern or interest in the topic of mental and behavioral health services and supports.

Key informant or informants: those participating in the interviews who have specific knowledge about the topic of mental and behavioral health services and supports and have an understanding of what is going on in the community.

Healthcare provider: hospital/clinic staff participating in the interviews with experience addressing emergency or ongoing care of patients presenting with a mental or behavioral health need.

Consumer: and individual over age 18 with mental or behavioral health needs or a caregiver of an individual of an individual (any age) with mental or behavioral health needs.

Why is this issue important?

There are serious consequences when someone cannot access needed services to support their mental health and other related health needs.

In 2013, 48% or 338,000 Minnesota adults experiencing any mental illness did not receive mental health treatment or counseling within the past year.ⁱ Similarly, 17,000 or 54% of adolescents ages 12-17 who experienced a major depressive episode in the past year also did not receive any treatment.

The quality of life outcomes for individuals unable to access needed services and supports can be very negative not only for the person needing help, but for their family and community as well. Adults may be unable to maintain employment or stable housing without appropriate supports. 71% of adults with mental health needs in Minnesota were not in the labor force.ⁱⁱ Adolescents' performance in school can suffer as a result of symptoms. Individuals can experience compromised functioning and ability to manage stress. Physical health and chronic conditions may also suffer without maintenance.

Frequent crisis situations can lead to family disruption and negative experiences with the resources available to help. In the most serious situations, unmanaged symptoms may lead to interactions with the criminal justice system when individuals may be at risk of harming themselves or others. Situations involving immediate threats to health and safety could also lead to costly hospitalizations and ER visits, taxing already limited resources for healthcare providers, law enforcement, prisons and jails, and schools.

Pathways to care for someone with mental health needs can be drawn out and complex depending on where they enter the system.

Traditionally, we may think the route to receiving mental health care is relatively linear with a clear roadmap for identification, referral, and access to services. **However, complicating factors may lead individuals with mental health concerns to delay or completely put off care.**

- Stigma and negative misconceptions about mental health can make it more difficult for individuals to make the decision to ask for help and participate fully in their communities.ⁱⁱⁱ
- Communication breakdowns between organizations serving those with mental health needs can lead to a lack of understanding of each other's roles and a more fragmented process for assisting an individual with the financial, legal, and medical components of their care.

In addition, a person’s mental health care journey may be further complicated if their entry point is with an organization whose primary function does not require specialized training or knowledge of mental health specific care. For example, law enforcement is often the first point of contact in situations where the safety of the individual in crisis or the people around them may be compromised. Because law enforcement officers lack specialized training in deescalating mental health crisis situations, they feel the only option is to bring the individual to a medical facility or jail. Individuals entering the legal system face additional barriers to accessing appropriate services.

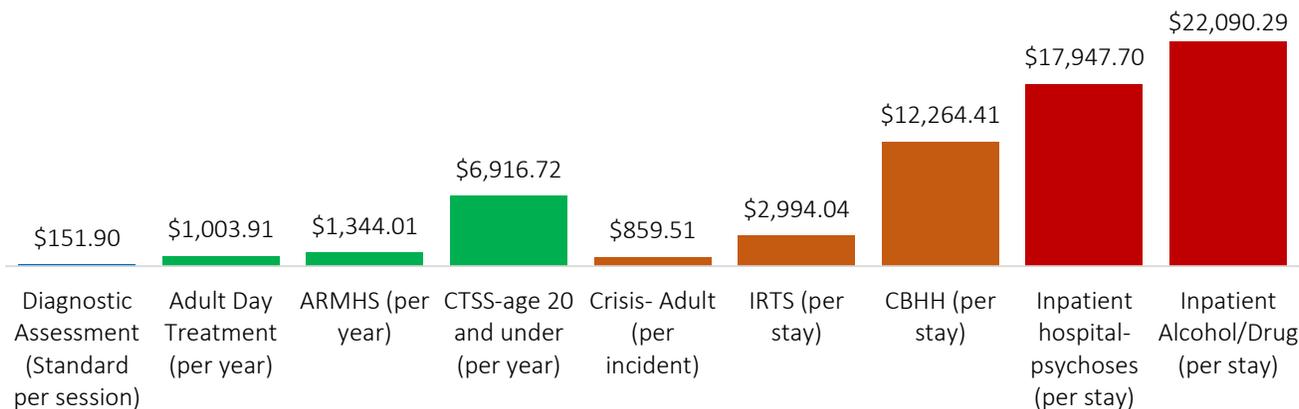
Mental health services contribute to avoiding costly hospitalizations related to mental and behavioral health.

Psychiatric hospitalization, residential placement, and emergency room visits are acute interventions that are more expensive than maintenance services focused on stabilizing symptoms. While these acute interventions are essential for serving individuals in crisis, they are an extreme on a continuum of care that could be available to the community (see Figure 1). Services on the most restrictive end of the continuum are reserved for a small number of people with a short-term need. However, when services that fall between rehabilitation and crisis on the continuum are not readily available, demand for acute, inpatient services may be unnecessarily elevated.

Figure 1: Continuum of care in mental health services



Figure 2: Approximate cost for an individual by service type for Region 7E Counties^{1iv}



¹ CY 2010 DHS mental health utilization tables for Region 7E counties Minnesota persons (both county-administered and additional state clients) provided through Minnesota Health Care Programs (MHCP). Average costs for services calculated using CY2010 average hours per client and [rates effective 1/1/2015](#) to illustrate general differences in cost of frequently used mental health services. Inpatient hospitalization average costs per stay for residents of 7E counties provided by the MN Hospital Association is for discharges from Cambridge Medical Center for CY 2013 and does not include professional fees. See end note iv for additional information about the data and rates. **Costs used for illustrative purposes only and do not reflect the full range of CPT/HCPC codes, services, and unit billing rates.**

What is the current state of things in Region 7E?

What are the strengths of the existing system of mental health services and supports in Region 7E?

Key informants identified the availability of certain critical mental health services as strengths. This includes in-home services such as ARMHS, children’s services such as dialectical behavior therapy (DBT), and outpatient psychology. The relationship between providers and the schools has improved through grants that bring providers into the school, leading to earlier identification of needs and better referrals. There have also been improvements to complementary services through regional service delivery models including supported employment and transportation in all counties. In addition, many providers and case managers have been in the region for most of their careers and have developed strong relationships that benefit consumers.

A variety of stakeholders meet regularly including provider groups, regional county case manager meetings, and collaborative meetings focused on children’s mental health. However, while small contingents meet independently, informants consistently noted the lack of coordination across the broader group, particularly communication with healthcare providers.

Mental health providers in the region have done a good job of stepping up to fill the void left by Riverwood by developing new services or expanding existing services to other parts of the region. The closure of Riverwood prompted collaboration between mental health providers and the counties to ensure consumers had access to needed services. In particular, several providers have worked to develop new services including services for children and bringing mobile crisis services back to the region. Open communication between stakeholders and the willingness of different players to collaborate are keys to the success of these efforts. Although some gaps remain, the perception is that access to services as well as the quality and selection of available services have improved since Riverwood closed. Regional providers and stakeholders are aware of the region’s needs and continue to be active in their efforts to bring new services and choice to the area.

Healthcare providers and facilities lack capacity in terms of specialized staff and physical space to adequately serve individuals who present with higher mental health needs. Ninety-two percent (92%) of healthcare survey participants said that healthcare facilities are frequently a first point of contact for individuals seeking help during a crisis situation. However, staff noted challenges related to their facilities’ capacity to address immediate patient needs while finding appropriate care or placement.

The patient experience for those in crisis, as described by providers, is not ideal. While hospitals have varying protocols and guidelines for response, interviewees shared that an individual and their family presenting at the emergency room may wait for hours before receiving an assessment and may be admitted or put on emergency 72 hour hold while waiting for placement at a psychiatric hospital in Minnesota. With only seven Community Behavioral Health Hospitals (CBHHs) with 16 beds each shared across all Minnesota residents, options are limited when beds are full. Options such as Intensive Residential Treatment Services (IRTS) or partial hospitalization are not available in the five Region 7E counties. Cambridge Medical Center is the only hospital in the region with a mental health unit equipped to provide specialized care.

Healthcare providers expressed their concern about not being able to readily access specialized care. Besides being frustrating for the individual, family, and provider, admitting the person requires additional staffing, space, and financial resources. A “safe room” and staff trained to deal with extreme behaviors are not always available at smaller, rural facilities. Staff also must dedicate time to contact inpatient facilities across the state, even including sites in Wisconsin and Fargo, ND. If care cannot be secured, individuals often remain in a dangerous cycle by returning home without appropriate services, leading to continued decline of condition and eventual readmission.

WHAT IS A MENTAL HEALTH CRISIS?

A mental health crisis or emergency can occur as a result of a variety of factors including, but not limited to, mental illness symptoms, substance use, health complications, and victimization. In many cases, intervening resources or services like crisis intervention or drop-in centers can serve to deescalate the situation in the most positive way possible. Without these intervening supports, the person or their family may turn to less appropriate but more readily available resources like a hospital emergency department or law enforcement to assist.

Service gaps are similar throughout Region 7E. However, access to services is dependent on availability of transportation and proximity to facilities clustered in more highly populated areas and along the I-35 corridor.

Ease of access to services in the region is highly affected by where the consumer lives. Most of the providers in the region are located in larger population centers and along the I-35 corridor. Travel time and access to public transportation make getting to services easier for people who live close to these providers than people who live in rural areas. People who live in the most rural parts of the region, especially eastern Pine County, may have to travel an hour or more to get to a provider.

Some of these gaps are filled by providers who are willing to come to the area rather than requiring consumers to travel to them. Some services, such as ARMHS, are delivered in the consumer’s home, which increases access to care. However, individuals who need a higher level of care than is available in the region often have to travel to larger metro areas such as Duluth, St. Cloud, and Minneapolis-St. Paul. This presents a barrier to accessing care or continuing care for people who do not have access to reliable or affordable transportation.



What should the priorities be for mental health services?

Perspectives of which services and supports are most helpful for safety and stability vary based on roles in the mental health care system.

The framework for understanding service priorities is based on an understanding of available services and the needs expressed by key informants and healthcare providers. Healthcare providers, in particular, viewed short-term needs (e.g. crisis) as being especially helpful. Interviewees and survey respondents indicated that crisis services are an important intervening tool, preventing the use of emergency medical services. Consumers, on the other hand, appeared to be focused more on rehabilitation and recovery services like ARMHS and outpatient services as being most helpful. It is important to note that this does not indicate that consumers do not find crisis services helpful and necessary when needed. However, at the time of the survey, crisis interventions like a mobile team were not available.

Table 1: Services ranked as most helpful for maintaining consumer health and safety

Respondent	Key informants (n=146)	Healthcare providers (n=52)	Consumers (n=182)
ARMHS	73%	46%	32%
Case management	37%	31%	37%
Crisis services	38%	56%	4%
CTSS	66%	27%	6%
Dual or Integrated MI/CD	80%	35%	4%
Outpatient Psychiatric	32%	31%	30%
Psychology	66%	13%	50%

*Selected up to 3 for key informants and healthcare; selected up to 2 for consumers

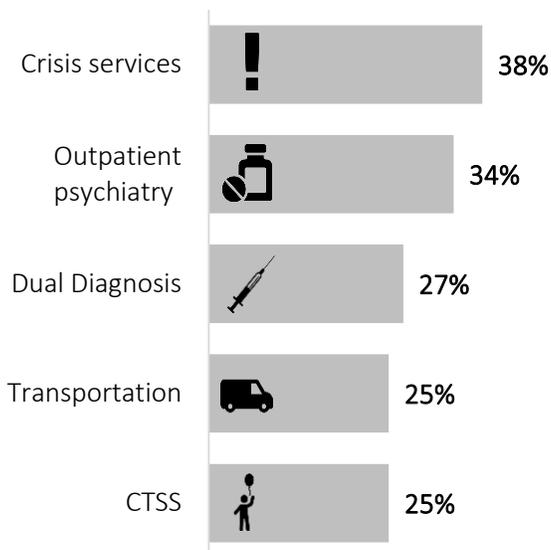
Differences in services identified as most helpful for safety and stability existed across key informant groups as well. Law enforcement emphasized the need for services impacting the population they interact with most frequently like crisis (50%) and mental illness/chemical dependency (50%), while service providers identified maintenance services like ARMHS (39%), CTSS (48%), and psychology (46%) as top services.

Across the board, interviewees acknowledged that acute services like crisis assessment and intervention are important, but it is better to keep people out of crisis in the first place. Interviewees talked about need for early intervention and maintenance services to fill this gap.

Meeting immediate needs through crisis services and psychiatric services (outpatient and hospitalization for crisis) were identified as the highest priority gaps to address.

Despite varying opinions on what services are most helpful, key informants and healthcare providers were in strong alignment in identifying service gaps.

Figure 3: Percent of key informants responding that the service gap is a priority to address



Crisis services. Interviewees referenced the closing of Riverwood and loss of mobile crisis and crisis beds as a loss of a key option in the continuum of mental health services. Although a crisis phone line is still available, it was not viewed as a sufficient alternative for more intensive intervention resources to ensure the safety of individuals and their families in a crisis situation. In particular, the lack of shorter term crisis services is viewed as a significant contributing factor to an overreliance on law enforcement and general hospitals to respond to mental health crises.

Adult and children’s psychiatry. Outpatient psychiatrists play an important role in helping individuals with a psychiatric illness maintain stability through medication management. However, the provider base is limited in the region. Children’s psychiatry, in particular, has limited openings and long waitlists. As a result, patients have to travel significant distances to access care. Mental health providers said the rural setting of the 7E counties makes it difficult to attract and retain psychiatrists.

Dual diagnosis and chemical dependency treatment. Chemical dependency and mental illness are often interdependent and closely linked in complex ways. However, there are a lack of treatment options for adults and children and limited coordination between the two worlds. Consumers with chemical dependency needs are often placed outside of the region for detox or substance abuse treatment, which disrupts any current mental health services and locates the person far away from positive support systems. After treatment, many people come back to the area to be closer to family or work. When they return, they have to start over with a new program, which may or may not address ongoing chemical dependency needs. Interviewees said that in order to avoid a cycle of recidivism, more local treatment options are necessary.

“There are a lot of people falling through the cracks because they don’t fit into the current system. (We have) acute care, but nothing in the middle.”

-Key informant

Limited public transit. Many consumers do not have access to reliable transportation or do not drive for reasons related to their condition. Those that do drive cannot always afford gas to travel to appointments. Although alternatives such as public transportation and medical transit are available in the region, the options are limited for people living in rural settings. Buses typically do not run on evenings or weekends, and transportation often needs to be arranged 24 hours in advance. In addition, public transit and medical transit may not be appropriate for people with mental health needs such as anxiety or paranoia. Such transportation difficulties mean that families are often not always able to fully participate in treatment even though family participation is a key determinant of success.

Children’s services. Specialized services such as children’s psychiatry, DBT, and CTSS are not readily available in all parts of the region. These services are key to improving outcomes for adults through early identification activities and supporting children and their families. Interviewees emphasized that children’s services need to be flexible, accommodating a full-family approach and provided through a variety of settings like in-home, school, in office, and day treatment.

Where are things headed?

Insurance access has increased, but it is currently unclear what this means for access to mental health services.

Table 2: Uninsurance rates for Region 7E Counties

County	2013	2015
Chisago	9%	8%
Kanabec	12%	10%
Isanti	11%	9%
Mille Lacs	13%	11%
Pine	13%	11%

Source: County Health Rankings

Between 2013 and 2014, the uninsurance rates for Minnesotans ages 18 to 64 fell from 10.7% to 6.7% with the addition of MNSure, the health insurance enrollment marketplace.^v Region 7E counties also saw a similar downward trend in estimated uninsurance rates from 2013 to 2015.^{vi}

Although more people have access to insurance, including adults and children, it is yet to be explored how having insurance translates to better access to mental health services. Current research indicates that individuals and families still face challenges

to actually receiving care.^{vii} The key informant interviews support this claim. The insurance application process can be difficult and burdensome. Furthermore, some people are still unable to afford premiums or deductibles and forgo care by choice. Interview participants noted there is limited access to certain services like in-home for private insured individuals.

Over the next 10 years, age of first diagnosis will continue to trend younger while complexity of diagnosis will continue to increase, and services will need to evolve to meet the changing needs of the community.

According to key informants, growing awareness of mental health issues has resulted in more people being diagnosed with mental illness and earlier identification of mental health needs, particularly in children and adolescents. At the same time, mental health providers report seeing more people with more complex needs or co-occurring disorders such as substance abuse or chronic physical illness that require active coordination between providers. Most key informants felt that these trends will continue over time and will require changes to the way mental health services are provided in the region.

Dealing with these demographic and diagnosis trends will require developing services that meet the specialized needs of children and individuals with complex medical histories and improvements to the existing behavioral health infrastructure. In particular, informants identified a need for earlier intervention and prevention programs for children, residential treatment options for people with intensive mental health needs, and increased involvement of primary care providers in treating consumers.

What happens next?

The recommendations presented take into consideration the current available resources and parameters set by State and Federal requirements.

Recommendations and potential implementation steps are given with the understanding that the Region 7E counties are faced with limited funding to dedicate to additional programs or services. In addition, options were crafted with the assumption that staff resources will remain unchanged and time dedicated to implementation is considered reasonable and within the scope of the current AMHI group. It is also assumed that resources such as housing and market conditions will not significantly change. In addition to being driven by availability of resources, policy changes at the state and federal levels create boundaries for the possible actions that can be taken and the types of services that can be developed.

The foundations of relationships exist to build a stronger, more integrated health care system.

While relationships exist between the different players in the mental health care system, they have become more difficult to maintain over time. Demanding schedules and lack of funding for non-reimbursed staff time are challenges to sustaining consistent communications across all groups. In addition, there is a lack of trust related to the closure of Riverwood and the communication around the problems with the center. In order to be successful, the region must focus on strengthening these relationships with a goal of continuing to expand services and finding creative solutions to filling service gaps.

1

Develop a strategy to compile and disseminate information about mental health and complementary services region wide.

Informants and healthcare providers participating in the assessment requested more regular communication about local mental and behavioral health resources so they are better prepared to refer clients to appropriate services. Growing reliance on emergency medical services has made it even more important for different organizations to more closely coordinate to ensure individuals have help navigating and accessing mental health resources. Consumers, primary care providers, mental health providers, county agencies, and complementary service providers would all benefit from easily accessible information about the services in the region.

The Region 7E AMHI is in a position to facilitate the process of exploring options for compiling this information and disseminating it to the broad range of stakeholders. County case managers are experienced in connecting with providers and navigating the system, and they can provide guidance in how to best share knowledge. Pamphlets and online resources like a website, and existing meetings are potential strategies for ongoing sharing of information. The proposed timeline for acting on this recommendation can be found in Figure 4 on the next page.

The costs associated with taking action include the time to put together resources and materials, and labor for the ongoing upkeep of resources and contact information. However, the benefits include the opportunity to connect more regularly with key stakeholders to build a more cohesive system and improve processes for efficient and appropriate referrals.

Figure 4: Timeline for Recommendation 1.



2

Continue to identify opportunities to build upon successful efforts and partnerships to meet immediate and future needs.

Since the closure of Riverwood, the region has built positive momentum in service development through strong collaboration with local providers. The region should continue to convene regularly with a network of providers to be deliberate about service planning and finding ways to more efficiently share resources to provide the best quality services to consumers.

Collaboration should not end once a project has been completed; maintaining relationships with providers can help the system better anticipate and react to service needs. It is important to extend invitations to all providers including both mental health, complementary, and other community supports.

3

Facilitate community collaborations and partnerships across all stakeholders who have a vested interest in the health and well-being of individuals with mental health needs.

The Region 7E AMHI is in a position to lead efforts to bring a variety of groups together to communicate shared goals and build awareness of each group's role in the mental health system. Sharing information at regular intervals is a starting point to collaborative planning for individual care as well as larger system improvements by establishing formal linkages between organizations. One pathway for sharing information is to initiate an open meeting at regular intervals (e.g., twice per year or quarterly) to share updates from the AMHI, and solicit agenda items from organizations around mental health service development and opportunities for collaboration.

While intentional collaboration requires an investment of time up front, the potential reduction in coordination time and improve the consumers' experience with accessing mental health resources. Paired with action on recommendations 1 and 2, the aggregate impact could foster greater collaboration and a better experience for community members who seek out these services from different entry points.

4

Communicate needs to providers, DHS, and potential funders to invest in longer term solutions particularly related to identification, preventative, maintenance services.

While communicating needs to Region 7E providers is a priority for meeting immediate gaps, this assessment revealed that less intensive services and supports for prevention and ongoing recovery will be a long-term issue. The reduction and elimination of intensive state operated services has left stakeholders with a general feeling of lack of support from DHS for dealing with the highest need, highest cost individuals. Although the number of residents using these services is much smaller, the resources to serve them in the community are limited.

The conversation about the long-term sustainability of mental health services begins with the dissemination of results and opening communication channels with those who impact policy and funding. This assessment does not dive into the potential savings and financial trade-offs or examine how supply and demand of

intensive services is impacted by large statewide policies around rates and service development. However, region-specific information is vital to share with a diverse group of stakeholders to consider in their conversations about delivery models for mental health services. Region 7E should identify ongoing opportunities to share with the stakeholders in Table 3.

Table 3: Primary external stakeholder communication and suggested methods of outreach

STAKEHOLDER	INTEREST/PERCEPTION/CONCERN	METHOD
Minnesota Department of Human Services	Maintaining health and safety of Minnesotans; financial sustainability of programs; supporting people to live in communities in least restrictive setting possible	AMHI Liaison, sharing report, ongoing updates through AMHI meetings
County Boards	Oversight of county activities including responsible use of county assets and creation of policy for the administration of programs	Sharing report, brief presentation of findings, ongoing updates from County Directors
Local provider meetings	Providing quality services and supports for consumers; developing strong relationships with consumers; positive outcomes for consumers	Sharing report, presentation of findings, ongoing updates through regular meetings
Healthcare systems	Well-being of patients; availability of appropriate services to lessen burden (staff time and financial) on emergency departments	Sharing report, ongoing updates through regular communication
Managed Care Organizations	Reduce costs for providing health benefits; improve quality of care	Sharing report, updates sat annual meeting
Regional AMH and CMH meetings (county)	Providing care coordination and ease of navigation of the system for consumers; effective delivery of needed services	Sharing report, presentation of findings
Public/Community Health partners	Assure quality of and access to health services; protect overall health of community through partnerships	Sharing report, collaboration on funding opportunities
Consumers (LACs)	Maintaining health, safety, and stability in preferred setting	Sharing report, brief presentation of findings
National Alliance on Mental Illness (NAMI) Minnesota	Advocacy; improving quality of life for individuals with mental illness and their families through development and access to services, reduced stigma, and public outreach.	Sharing report

5

Provide mental health crisis intervention and de-escalation training for law enforcement, especially for areas with limited access to crisis services.

Law enforcement officers are often the first contact for individuals experiencing a mental health crisis, in rural areas. However, officers often lack appropriate training for intervening in mental health crisis situations. Individuals in crisis who encounter law enforcement are often brought to the emergency room or jail rather than a being referred to a more appropriate mental health setting.

The Region 7E AMHI should select training providers and seek out funding opportunities to help defray staffing costs associated with the trainings, with each county working individually to develop a training plan in conjunction with city and county law enforcement agencies. The trainings should be aimed at better preparing officers to identify mental health components in law enforcement contacts, de-escalating crisis situations, and referring individuals to appropriate services. The proposed timeline for acting on this recommendation can be found in Figure 5 on the next page.

The costs associated with law enforcement trainings include overtime rates attached to training time and shift coverage, as well as training fees and materials. However, the benefits include decreased jail and emergency room usage, avoiding crisis situations, and improved relationship between consumers and law enforcement.

Figure 5: Timeline for Recommendation 5.



6

Provide training and education for community members and complementary service providers about early intervention and mental health management. Tap into community partnerships to improve outreach about mental health services in the region.

Stakeholders participating in the assessment did not feel like there was enough community knowledge about mental health and the services available. Survey participants in particular said this lack of knowledge was a barrier to accessing care for individuals with mental health needs.

As the gatekeepers for information about providers and resources in the region, the Region 7E AMHI is in an ideal position to lead outreach and education efforts. These efforts should include targeted efforts to create informed consumers of mental health services.

The primary costs to the counties for these efforts are staff time for outreach and training. However, the benefits include improved knowledge of community resources and supports, decreased stigma around mental health diagnoses, and potential early diagnosis and intervention.

Looking to the future

The region has made great strides in adapting to the ever changing landscape of available resources and evolving needs of individuals seeking mental and behavioral health services. Success will depend on building a core set of relationships and networks to actively address underlying challenges facing the mental health system. Action to consider for the future include

Build infrastructure for a regional Local Advisory Council (LAC) with active members from all five counties. While each county is responsible for recruiting participants for the LAC, counties with established groups should share suggestions for boosting attendance and engagement. Strong consumer groups can help guide priorities for service development and can provide a foundation for peer delivered service models like drop-in centers or peer-support groups.

Develop relationships with institutions and programs targeting rural healthcare. Academic programs, particularly those through the University of Minnesota, focus on rural healthcare infrastructure including initiatives for mental and behavioral health. For example, the Center for Rural Mental Health Studies works on projects that include partnerships with counties and healthcare providers and support regional efforts to student mental health problems in rural areas. Currently, FirstLight Clinic in Mora is part of the Center's telemental health network.^{viii} To address issues in recruiting qualified mental health professionals to rural areas, the University also has a community-based education program^{ix} with the intention of matching individuals interested in rural medicine with underserved communities. Opportunities to communicate future needs, direct research focus, and partner on service delivery projects are a valuable resource for future exploration.

Explore models that incorporate evidenced-based or best practices for mental health service delivery.

Peer support includes emotional and instrumental support provided by someone with a mental health condition to others with similar mental health conditions with the goal of social or personal change. Peer support systems rely on principles of respect, shared responsibility, and mutual agreement. Peer delivered services have been found to be as effective or more effective than non-peer services. The services also have positive impact on peer providers, who report increased confidence, self-esteem, and coping abilities, and mental health service providers, who report changed attitudes toward people with mental illness.^x

Peer Crisis Services provide calming environments with supports for people in crisis. The services are provided in community settings with medical supports, and generally last less than 24 hours.^{xi} There is evidence that peer service group participants have better outcomes than people who receive crisis care in hospital settings including more improvement in psychiatric symptoms, higher treatment satisfaction, and higher social functioning.^{xii}

Warm Lines are peer-run crisis lines for situations that are not emergencies but could escalate if not addressed. The lines are staffed by people in recovery and trained mental health service consumers. Peer counselors support callers by offering a message of hope, and may talk about loneliness, anxiety, sleeplessness, and other concerns of callers in crisis.^{xiii} A study of a peer-run warm line in a primarily rural state found that respondents credited the warm line with helping with personal recovery and an increase in security and empowerment.^{xiv}

Mental Health First Aid is a 12-hour course that trains participants in mental health and related issues, including responding to acute mental health crises. Started in Australia, Mental Health First Aid has been used in the U.S. since 2007 and is appropriate for a range of populations and regions, including rural areas.^{xv} The training has been linked to improved outcomes for individuals with mental health needs due to better community knowledge of mental health disorders. Members of the public who participate in the training are also shown to have experienced positive changes in knowledge, attitude, and behavior related to mental health issues.^{xvi}

About the Region 7E Mental Health Initiative

Region 7E Adult Mental Health Initiative (AMHI) includes Chisago, Kanabec, Isanti, Mille Lacs, and Pine Counties. The AMHI Governing Board includes supervisors from each of the five counties, one social services director, a case manager representative, and a DHS representative.

Funding for the assessment was provided by the Region 7E Adult Mental Health Initiative.

Methodology

The assessment drew on the expertise of practitioners in the field and engaged people who receive services. The counties have contracted with the Improve Group to gather information through multiple sources including:

- A survey for people with mental health needs
- A survey for providers, county staff, mental health professionals, and other community stakeholders
- A survey of hospital/clinic staff including ER and primary care physicians
- Interviews with key informants (providers, county staff, etc.)
- Review of existing research and assessments

Limitations

While we were able to reach about 380 individuals to share their input for the assessment, the following limitations should be noted when interpreting the results presented in this report.

- Consumers were reached through formal services including case management and service providers which may limit the perspective to those already accessing the mental health system. In addition, a limited number of caregivers of children completed the survey which may bias results towards adult services.
- Two major regional healthcare providers did not participate in the assessment.
- Law enforcement and service providers in the smallest communities were more difficult to reach, and efforts to encourage participation was less successful than with larger communities and organizations in the region.
- Perspectives from Mille Lacs Band Behavioral Health were not included in the assessment.
- The implementation of the regional SHIP surveillance survey was delayed, and data from this general assessment about health topics was not available to be included in this report.

Author Information

The Improve Group conducts rigorous studies to help organizations make the most of information, navigate complexity, and ensure their investments of time and money lead to meaningful, sustained impact. The Improve Group is based in St. Paul, Minnesota, and provides research, evaluation, capacity-building and strategic planning services to organizations locally, nationally, and internationally.

ⁱ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: United States, 2014. HHS Publication No. SMA-15-4895. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

ⁱⁱ 2013 CMHS Uniform Reporting System (URS) Output Tables.

ⁱⁱⁱ Corrigan, P., & Watson, A. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 16-20. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/pmc1489832/>

^{iv} Minnesota Hospital Association inpatient claims (January-December 2013). Mental Health Management Report Service Utilization Tables for Adults and Children during Calendar Year 2010. (Procedure codes to calculate rates: H2017HM, S9484HN, H2012, 90791, H0019, 90837, S9484 UAHN)

^v Health Reform Monitoring Survey (HRMS-MN)

^{vi} County Health Rankings

<http://www.countyhealthrankings.org/app/minnesota/2015/measure/factors/85/data>

^{vii} Minnesota Department of Health (2014). Assessing the Affordable Care Act in Minnesota.

^{viii} Center for Rural Mental Health Services

<http://www.med.umn.edu/duluth-internal-resources/center-for-rural-mental-health-studies/about-the-crmhs/index.htm>

^{ix} Rural Physician Associate Program

<http://www.rpap.umn.edu/about/home.html>

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^{xi} Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MN: Substance Abuse and Mental Health Administration, 2014.

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