

**Senate Counsel, Research,
and Fiscal Analysis**

G-17 STATE CAPITOL
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Senate

State of Minnesota

S.F. No. 908 - Dental Services

Author: Senator Becky Lourey

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: March 1, 2005

S.F. No. 908 changes the facilitator of the donated dental services program from the Board of Dentistry to the Commissioner of Health. **S.F. No. 908** also removes the \$500 annual benefit limit for adult dental services in the medical assistance program and restores the dental services to the services covered prior to 2003.

KC:ph



Minnesota Dental Association

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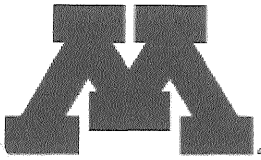
DATE: March 2, 2005
TO: SENATE HEALTH AND FAMILY SECURITY COMMITTEE
FROM: Dick Diercks, MDA Executive Director
RE: **Senate File 908**

Thank you for hearing our legislative bill, Senate File 908. The following information will provide you with background information about the "**Donated Dental Services Program.**"

This is a national program started by the American Dental Association's National Foundation of Dentistry for the Handicapped. Minnesota became the 34th state to provide funding for the "DDS Program" in 2002, with actual implementation in 2003. As with any new program, it took time to build momentum. Since its inception, there has been consistent, steady growth in dentists volunteering and in patients seeking necessary, comprehensive dental care. The program's focus is on the elderly, disabled, medically compromised who do not have insurance and have no way to pay for their care.

- Currently, there are 211 Minnesota dentists who have signed up as volunteers for the program.
- There are 58 dental laboratories signed up to donate services.
- Since the start of the program, \$257,891 worth of care has been donated to patients in need, with 128 patients having completed their care.
- The average value of treatment provided to each patient is about \$2,000.
- The goal for the current fiscal year is to provide \$250,000 worth of care to 130 patients...and the program is well on track to reaching that goal by June 30, 2005.
- There are 280 patients waiting to be assigned to a volunteer dentist, and fortunately, more dentists are signing up every week.

Perhaps the most compelling aspect of this program is the gratitude expressed by very thankful patients who would not otherwise be able to receive needed care. The coordinator of Minnesota's program has told of patients who literally have had their lives turned around for the better, one who is now a volunteer himself for a social service agency. One patient could not receive a badly needed kidney transplant until his dental treatment was completed, but he couldn't afford to get his teeth repaired...until he became a "DDS Program" patient. Another was suffering from malnutrition because his teeth were so badly decayed. These stories are the norm, not the exception for this wonderful, cost-effective program. We urge you to please **support S.F. 908 and authorize the very minimal state funding needed** to keep this important program going. Many needy Minnesotans are depending on it!



University of Minnesota School of Dentistry

Issues Briefing

Issue The U-M School of Dentistry (SOD) is Minnesota's largest provider of dental services to public program patients and is designated as a critical access provider by the Dept. of Human Services for Minnesota Health Care Programs (MHCP).

The unintended consequences of recent changes in the state's public dental programs have created limitations that de-link students from their educational experience and present unsustainable financial challenges to School of Dentistry clinics.

Program limitations endorse a student learning experience that 1) rationalizes and promotes a two-tier approach to treatment and a lower standard of care for low-income patients, 2) makes it difficult to engender a sense of public professional responsibility, and 3) compromises the student educational experience.

As a result of MHCP participation, SOD clinics on the Twin Cities' campus lost \$2.2 million last year. The impact of continued participation as a MHCP provider in 2005 is projected to increase. Over the next five years, the loss is projected to be \$11 million.

In an environment of decreasing state support and four years of double-digit tuition increases, the SOD is dependent upon clinic income to support its educational, research and service programs. Continued losses as a result of MHCP participation will force difficult and far-reaching decisions affecting quality of care and education.

Background The School of Dentistry historically has been a safety net for public program patients who are unable to access dental care. And the relationship has worked well: Patients in need are able to access care. Educationally reduced fees result in more patient services for the state's health care dollar. And dental and dental hygiene students benefit from an opportunity to 1) enhance their clinical skills; 2) treat a diversity of patients with a variety of oral health care needs; and 3) develop a broad understanding of the community responsibilities they will have as dental professionals.

In FY 2004, School of Dentistry students and faculty treated more than 10,000 public program patients. Facilities and programs include four floors of on-campus clinics, a Hibbing clinic that averages 5,250 patient visits per year (65% are public program patients), and portable and mobile dental clinics that travel the state to provide restorative and preventive care for underserved patient populations.

(please see other side)

UNINTENDED CONSEQUENCES OF CHANGES IN MINNESOTA'S PUBLIC DENTAL PROGRAMS

The \$500 cap jeopardizes patient health.

- Oral disease is preventable and economically treated. However, unlike some general health conditions, dental disease does not just go away. Left untreated, dental disease will worsen and require more extensive and expensive treatment as the disease progresses.
- Oral health is an integral part of overall health and wellness. Research links advanced periodontal disease to cardiovascular disease and low birth-weight babies, and documents transmission of oral bacteria from the infected mouths of parents to their children.
- The most vulnerable public program patients (medically and/or emotionally compromised) are unable to access operating dental room services. Because the average operating room patient requires almost triple the \$500 cap, many patients go without treatment.

The \$500 cap de-links students from their educational experience.

- Unlike physicians, dental and dental hygiene students graduate ready to be licensed and practice dentistry. Dental education must provide opportunities for students to learn, refine and master their professional skills. First and second year students practice skills on mechanical models. Third and fourth year students treat patients in the School of Dentistry's campus, community and portable/mobile clinics.
- Students rely on the School of Dentistry to provide patients – a lot of patients – with diverse oral health care needs (i.e. big and little fillings, moderate and advanced periodontal disease, oral surgery needs, crowns, single and multiple-root canals, partial and full dentures, bridges, etc.)
- Although public program patients often present with extensive oral health needs, the \$500 cap limits services to x-rays, an oral examination, and minimal restorative treatment.

The School of Dentistry cannot afford to absorb the financial and educational costs of participating in the state's public dental programs.

- High volume demand for services at U-M clinics results in excessive costs related to non-reimbursed and under-reimbursed services, lost student productivity, and administrative requirements that are cumbersome, time consuming, difficult to understand/implement/enforce, and that vary by major program, subprogram and administrator.
- Program limitations endorse a student learning experience that rationalizes and promotes two-tier treatment and a lower standard of care for low-income patients.
- Despite educationally reduced fees that provide more services for the state's dental dollar, program limitations result in an educational experience that makes it difficult to instill a sense of public professional responsibility and compromises the student educational experience.

Senators Lourey, Solon, Kiscaden and Koering introduced--

S.F. No. 908: Referred to the Committee on Health and Family Security.

1 A bill for an act
2 relating to health; modifying donated dental services
3 program; modifying covered services for medical
4 assistance; appropriating money; amending Minnesota
5 Statutes 2004, sections 150A.22; 256B.0625,
6 subdivision 9.

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

8 Section 1. Minnesota Statutes 2004, section 150A.22, is
9 amended to read:

10 150A.22 [DONATED DENTAL SERVICES.]

11 (a) The ~~Board of Dentistry~~ commissioner of health shall
12 contract with the Minnesota Dental Association, or another
13 appropriate and qualified organization to develop and operate a
14 donated dental services program to provide dental care to public
15 program recipients and the uninsured through dentists who
16 volunteer their services without compensation. As part of the
17 contract, the ~~board~~ commissioner shall include specific
18 performance and outcome measures that the contracting
19 organization must meet. The donated dental services program
20 shall:

21 (1) establish a network of volunteer dentists, including
22 dental specialties, to donate dental services to eligible
23 individuals;

24 (2) establish a system to refer eligible individuals to the
25 appropriate volunteer dentists; and

26 (3) develop and implement a public awareness campaign to

1 educate eligible individuals about the availability of the
2 program.

3 (b) Funding for the program may be used for administrative
4 or technical support. The organization contracting with the
5 board commissioner shall provide an annual report that accounts
6 for funding appropriated to the program by the state, documents
7 the number of individuals served by the program and the number
8 of dentists participating as program providers, and provides
9 data on meeting the specific performance and outcome measures
10 identified by the board commissioner.

11 Sec. 2. Minnesota Statutes 2004, section 256B.0625,
12 subdivision 9, is amended to read:

13 Subd. 9. [DENTAL SERVICES.] {a} Medical assistance covers
14 dental services. Dental services include, with prior
15 authorization, fixed bridges that are cost-effective for persons
16 who cannot use removable dentures because of their medical
17 condition.

18 ~~{b}-Coverage-of-dental-services-for-adults-age-21-and-over~~
19 ~~who-are-not-pregnant-is-subject-to-a-\$500-annual-benefit-limit~~
20 ~~and-covered-services-are-limited-to:~~

21 ~~{1}-diagnostic-and-preventative-services;~~

22 ~~{2}-restorative-services;-and~~

23 ~~{3}-emergency-services.~~

24 ~~Emergency-services,-dentures,-and-extractions-related-to~~
25 ~~dentures-are-not-included-in-the-\$500-annual-benefit-limit.~~

26 Sec. 3. [APPROPRIATION.]

27 \$70,000 in fiscal year 2006 and \$70,000 in fiscal year 2007
28 are appropriated from the health care access fund to the
29 commissioner of health to implement the donated dental services
30 program under Minnesota Statutes, section 150A.22.

Analysis of Minnesota Health Care Programs for Dental Administered by Delta Dental Plan of Minnesota

Current Enrolled Population of Managed Care Programs (as of December 1, 2004)

All MA, GAMC and MinnesotaCare	423,296	(not including DHS fee-for-service program)
Delta Dental Administration	249,590	(59% of total managed care enrollees)
PMAP	173,167	(41 % used services)
MinnesotaCare	76,423	(58 % used services)

There are nine managed care contracts for administration of Minnesota health care programs.

Delta Dental Plan of Minnesota administers the dental component of public programs for Blue Plus, First Plan Blue, Medica and Metropolitan Health Plan (MHP) through subcontracts.

Other administrators of public programs are HealthPartners, UCare, PrimeWest, Itasca Medical and South Country Health Alliance; combined, these other administrators have enrollment of 173,706 people.

In addition to these nine managed care contracts, the Department of Human Services has a fee-for-service program serving 189,020 people. The total number of people enrolled in Minnesota's public health programs is 612,316 (DHS plus managed care enrollment).

Delta Dental Administered Provider Network for Minnesota Public Dental Programs

Delta Dental Plan of Minnesota administers a network of dentists to serve public program patients -- Delta Community Dental Care (DCDC). Not all dentists in the state agree to participate in Delta Dental networks and not all dentists in the state agree to treat public program patients. Our data shows that this dental network actually grew in the period since the \$500 annual maximum went into effect. DCDC has 1,426 dentists, compared to Delta Dental's commercial networks, the largest of which has 2,711 dentists. There are 2,941 licensed practicing dentists in Minnesota according to the Board of Dentistry. Terminations include both voluntary business decisions by providers and involuntary terminations due to dentist license actions or provider fraud.

DCDC Dentists

	Terminations	Retirements	Deaths	Moved	Additions	Net Gain
2002	-42	-3	-2	-3	+87	+37
2003	-45	-16	0	-4	+87	+22
2004	-58	-12	-1	-8	+124	+45

**Delta Dental Administered Public Dental Programs and the \$500 Annual Cap
A Before and After Comparative Analysis**

**Prior to implementation of cap
12 month period ending 9/30/03**

	Patients	Paid	Portion Over \$500	Average Paid Per Patient
Under \$500	110,501 (90%)	\$16,001,779	---	\$145
Over \$500	12,623 (10%)	\$12,183,770	\$5,872,270	\$965
TOTALS	123,124 (100%)	\$28,185,549	\$5,872,270	\$229

**After implementation of \$500 cap
2004 (Entire Year)**

	Patients	Paid	Portion Over \$500	Average Paid Per Patient
Under \$500	113,755 (91%)	\$16,591,061	---	\$146
Over \$500	11,377 (9%)	\$10,243,205	\$4,554,705	\$900
TOTALS	125,132 (100%)	\$26,834,266	\$4,554,705	\$214

2004 Cost impact of \$500 Annual Cap on Dental Services

For 2004

Patients over \$500	11,377	(out of a total of 125,132 patients or 9% overall)
Patients denied due to cap	935	(8% of patients over \$500; less than 1% overall)
Total claims over \$500	\$4,554,705	(out of a total of \$26,824,266 in paid claims)
Total claims denied due to cap	\$ 336,749	

Notes:

1. Dollar figures do not include administration, which increased due to cap (most claims require manual work).
2. There are several exceptions to cap with reduce savings by \$4.2 million. These exceptions include services for children under 21, pregnant women, dentures and extractions related to dentures.
3. Orthodontia accounted for \$691,884 and denture-related claims totaled \$1,505,830 of claims paid over \$500 maximum.
4. Even if the 40% of enrollees not administered by Delta Dental had the same experience, total savings, given the several exceptions and current benefit design, is under \$700,000, not accounting for increased administrative costs on both the provider and payer side.

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S.F. No. 1000 - Offenders with Mental Illness

Author: Senator Linda Berglin

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) *KTC*

Date: March 17, 2005

S.F. No. 1000 modifies certain provisions involving offenders with mental illness.

Section 1 (241.01) authorizes the commissioner of corrections to contract with a separate entity to purchase prescription drugs for the inmates confined in correctional institutions. It also permits local governments to participate in the purchasing pool and states that if the commissioner convenes a committee to determine a drug formulary that a county representative is to be included in the committee.

Section 2, subdivision 1 (244.054), expands who may be eligible for a discharge plan.

Subdivision 2 requires an offender's designated agent to forward to the appropriate local entity any informed consent and releases needed for transition services. This section also requires the designated agent to determine whether the offender is eligible for medical assistance or general assistance medical care as part of the discharge plan and enroll the offender if eligible using special procedures established by process and a Department of Human Services bulletin.

Section 3, subdivision 14, paragraph (a) (256B.055), states that an inmate of a correctional facility who is conditionally released through work release and who is not housed in a detention facility but at a halfway house, community correctional center, or at home is eligible for medical assistance.

Paragraph (b) states that an individual who is involuntarily detained at a correctional or detention facility is not eligible for medical assistance. If the individual is detained for a period of less than 60 days and is awaiting other arrangements, the individual shall remain eligible for medical assistance.

KC:ph

Senators Berglin, Ranum, Neuville and Foley introduced--

S.F. No. 1000: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to human services; modifying discharge plans
3 for offenders with serious and persistent mental
4 illness; clarifying eligibility for medical assistance
5 for offenders released for work release; authorizing
6 commissioner of corrections to enter into a purchasing
7 pool for prescription drugs; allocating housing funds
8 for projects that provide employment support;
9 appropriating money; amending Minnesota Statutes 2004,
10 sections 241.01, by adding a subdivision; 244.054;
11 256B.055, by adding a subdivision.

12 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

13 Section 1. Minnesota Statutes 2004, section 241.01, is
14 amended by adding a subdivision to read:

15 Subd. 10. [PURCHASING FOR PRESCRIPTION DRUGS.] In
16 accordance with section 241.021, subdivision 4, the commissioner
17 may contract with a separate entity to purchase prescription
18 drugs for persons confined in institutions under the control of
19 the commissioner. Local governments may participate in this
20 purchasing pool in order to purchase prescription drugs for
21 those persons confined in local correctional facilities in which
22 the local government has responsibility for providing health
23 care. If any county participates, the commissioner shall
24 appoint a county representative to any committee convened by the
25 commissioner for the purpose of establishing a drug formulary to
26 be used for state and local correctional facilities.

27 Sec. 2. Minnesota Statutes 2004, section 244.054, is
28 amended to read:

1 244.054 [DISCHARGE PLANS; OFFENDERS WITH SERIOUS AND
2 PERSISTENT MENTAL ILLNESS.]

3 Subdivision 1. [OFFER TO DEVELOP PLAN.] The commissioner
4 of human services, in collaboration with the commissioner of
5 corrections, shall offer to develop a discharge plan for
6 community-based services for every offender with serious and
7 persistent mental illness, as defined in section 245.462,
8 subdivision 20, paragraph (c), and every offender who has had a
9 diagnosis of mental illness and would otherwise be eligible for
10 case management services under section 245.462, subdivision 20,
11 paragraph (c), but for the requirement that the offender be
12 hospitalized or in residential treatment, who is being released
13 from a correctional facility. If an offender is being released
14 pursuant to section 244.05, the offender may choose to have the
15 discharge plan made one of the conditions of the offender's
16 supervised release and shall follow the conditions to the extent
17 that services are available and offered to the offender.

18 Subd. 2. [CONTENT OF PLAN.] If an offender chooses to have
19 a discharge plan developed, the commissioner of human services
20 shall develop and implement a discharge plan, which must include
21 at least the following:

22 (1) at least 90 days before the offender is due to be
23 discharged, the commissioner of human services shall designate
24 ~~an-agent-of-the-Department-of-Human-Services~~ a discharge planner
25 with mental health training to serve as the primary person
26 responsible for carrying out discharge planning activities;

27 (2) at least 75 days before the offender is due to be
28 discharged, the offender's ~~designated-agent~~ discharge planner
29 shall:

30 (i) obtain informed consent and releases of information
31 from the offender that are needed for transition services, and
32 forward to the appropriate local entity; and

33 (ii) contact the county human services department in the
34 community where the offender expects to reside following
35 discharge, and inform the department of the offender's impending
36 discharge and the planned date of the offender's return to the

1 community; determine whether the county or a designated
2 contracted provider will provide case management services to the
3 offender; refer the offender to the case management services
4 provider; and confirm that the case management services provider
5 will have opened the offender's case prior to the offender's
6 discharge; and

7 ~~(iii)-refer-the-offender-to-appropriate-staff-in-the-county~~
8 ~~human-services-department-in-the-community-where-the-offender~~
9 ~~expects-to-reside-following-discharge,-for-enrollment-of-the~~
10 ~~offender-if-eligible-in-medical-assistance-or-general-assistance~~
11 ~~medical-care,-using-special-procedures-established-by-process~~
12 ~~and-Department-of-Human-Services-bulletin;~~

13 (3) at least 2-1/2 months before discharge, the offender's
14 ~~designated-agent~~ discharge planner shall secure timely
15 appointments for the offender with a psychiatrist no later than
16 30 days following discharge, and with other program staff at a
17 community mental health provider that is able to serve former
18 offenders with serious and persistent mental illness;

19 (4) at least 30 days before discharge, the offender's
20 ~~designated-agent~~ discharge planner shall convene a pre-discharge
21 assessment and planning meeting of key staff from the programs
22 in which the offender has participated while in the correctional
23 facility, the offender, the supervising agent, and the mental
24 health case management services provider assigned to the
25 offender. At the meeting, attendees shall provide background
26 information and continuing care recommendations for the
27 offender, including information on the offender's risk for
28 relapse; current medications, including dosage and frequency;
29 therapy and behavioral goals; diagnostic and assessment
30 information, including results of a chemical dependency
31 evaluation; confirmation of appointments with a psychiatrist and
32 other program staff in the community; a relapse prevention plan;
33 continuing care needs; needs for housing, employment, and
34 finance support and assistance; and recommendations for
35 successful community integration, including chemical dependency
36 treatment or support if chemical dependency is a risk factor.

1 Immediately following this meeting, the offender's designated
2 agent discharge planner shall summarize this background
3 information and continuing care recommendations in a written
4 report. The discharge planner shall determine whether the
5 offender is eligible for medical assistance, general assistance
6 medical care, or the MinnesotaCare program and shall enroll the
7 offender, if eligible, using special procedures established by
8 process and in accordance with a Department of Human Services
9 bulletin;

10 (5) immediately following the pre-discharge assessment and
11 planning meeting, the provider of mental health case management
12 services who will serve the offender following discharge shall
13 offer to make arrangements and referrals for housing, financial
14 support, benefits assistance, employment counseling, and other
15 services required in sections 245.461 to 245.486;

16 (6) at least ten days before the offender's first scheduled
17 postdischarge appointment with a mental health provider, the
18 offender's ~~designated-agent~~ discharge planner shall transfer the
19 following records to the offender's case management services
20 provider and psychiatrist: the pre-discharge assessment and
21 planning report, medical records, and pharmacy records. These
22 records may be transferred only if the offender provides
23 informed consent for their release;

24 (7) upon discharge, the offender's ~~designated-agent~~
25 discharge planner shall ensure that the offender leaves the
26 correctional facility with at least a ten-day supply of all
27 necessary medications; and

28 (8) upon discharge, the prescribing authority at the
29 offender's correctional facility shall telephone in
30 prescriptions for all necessary medications to a pharmacy in the
31 community where the offender plans to reside. The prescriptions
32 must provide at least a 30-day supply of all necessary
33 medications, and must be able to be refilled once for one
34 additional 30-day supply.

35 Sec. 3. Minnesota Statutes 2004, section 256B.055, is
36 amended by adding a subdivision to read:

1 Subd. 14. [PERSONS DETAINED BY LAW.] (a) An inmate of a
2 correctional facility who is conditionally released as
3 authorized under section 241.26, 244.065, or 631.425 is eligible
4 for medical assistance if the individual does not require the
5 security of a public detention facility and is housed in a
6 halfway house or community correction center, or under house
7 arrest and monitored by electronic surveillance in a residence
8 approved by the commissioner of corrections.

9 (b) An individual, regardless of age, who is involuntarily
10 detained by law in the custody of a correctional or detention
11 facility as an individual accused or convicted of a crime, is
12 not eligible for medical assistance. An individual is not
13 determined to be involuntarily detained for purposes of medical
14 assistance eligibility if the individual is placed in a
15 detention facility for a temporary period pending other
16 arrangements appropriate to the individual's needs, if the
17 period of time does not exceed 60 days.

18 Sec. 4. [APPROPRIATION.]

19 For the biennium ending June 30, 2007, the commissioner of
20 the Housing Finance Agency shall allocate \$..... from the
21 housing trust fund account in the housing development fund for
22 supportive housing projects that provide employment support.

1 Senator moves to amend S.F. No. 1000 as follows:
2 Page 2, line 32, delete "and"
3 Page 3, line 6, reinstate the stricken "and"
4 Page 3, line 7, reinstate the stricken "(iii)"
5 Page 3, line 12, after the stricken "bulletin" insert
6 "assist the offender in filling out an application for medical
7 assistance, general assistance medical care, or MinnesotaCare
8 and submit the application for eligibility determination to the
9 commissioner. The commissioner shall determine an offender's
10 eligibility no more than 45 days, or no more than 60 days if the
11 offender's disability status must be determined, from the date
12 that the application is received by the department. The
13 effective date of eligibility for the health care program shall
14 be no earlier than the date of the offender's release. If
15 eligibility is approved, the commissioner shall mail a Minnesota
16 health care program membership card to the facility in which the
17 offender resides and transfer the offender's case to
18 MinnesotaCare operations within the department or the
19 appropriate county human services agency in the county where the
20 offender expects to reside following release for ongoing case
21 management" and reinstate the stricken semicolon
22 Page 4, lines 4 to 9, delete the new language
23 Page 5, line 16, delete ", if the" and insert a period
24 Page 5, delete line 17

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March 17, 2004

**SOWING SELF-SUFFICIENCY
CULTIVATING COMMUNITY**

Dear Sen. Berglin, and members of the Committee:

Just a quick note to say that I am very much in favor of the reporting requirements for health care providers serving people with mental illness as outlined in S.F. 1000.

Please do not hesitate to contact me if you have further questions.

A handwritten signature in black ink that reads "John K. Trepp".

John K. Trepp
Executive Director

**Senate Counsel, Research,
and Fiscal Analysis**


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**S.F. No. 643 - Civil Commitment Chemically Dependent
Pregnant Women Early Intervention Treatment (First
Engrossment)**

Author: Senator Don Betzold

Prepared by: Joan White, Senate Counsel (651/296-3814) 

Date: March 11, 2005

S.F. No. 643 amends the Civil Commitment Act by expanding early intervention treatment. This bill allows the court to order early intervention treatment if the court finds that a pregnant woman is a chemically dependent person, as defined in this paragraph.

JW:rdt

1 A bill for an act

2 relating to civil commitment; expanding early
3 intervention services; amending Minnesota Statutes
4 2004, section 253B.065, subdivision 5.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

6 Section 1. Minnesota Statutes 2004, section 253B.065,
7 subdivision 5, is amended to read:

8 Subd. 5. [EARLY INTERVENTION CRITERIA.] (a) A court shall
9 order early intervention treatment of a proposed patient who
10 meets the criteria under paragraph (b) or (c). The early
11 intervention treatment must be less intrusive than long-term
12 inpatient commitment and must be the least restrictive treatment
13 program available that can meet the patient's treatment needs.

14 (b) The court shall order early intervention treatment if
15 the court finds all of the elements of the following factors by
16 clear and convincing evidence:

17 (1) the proposed patient is mentally ill;

18 (2) the proposed patient refuses to accept appropriate
19 mental health treatment; and

20 (3) the proposed patient's mental illness is manifested by
21 instances of grossly disturbed behavior or faulty perceptions
22 and either:

23 (i) the grossly disturbed behavior or faulty perceptions
24 significantly interfere with the proposed patient's ability to
25 care for self and the proposed patient, when competent, would

1 have chosen substantially similar treatment under the same
2 circumstances; or

3 (ii) due to the mental illness, the proposed patient
4 received court-ordered inpatient treatment under section 253B.09
5 at least two times in the previous three years; the patient is
6 exhibiting symptoms or behavior substantially similar to those
7 that precipitated one or more of the court-ordered treatments;
8 and the patient is reasonably expected to physically or mentally
9 deteriorate to the point of meeting the criteria for commitment
10 under section 253B.09 unless treated.

11 For purposes of this paragraph, a proposed patient who was
12 released under section 253B.095 and whose release was not
13 revoked is not considered to have received court-ordered
14 inpatient treatment under section 253B.09.

15 (c) The court may order early intervention treatment if the
16 court finds that a pregnant woman is a chemically dependent
17 person. A chemically dependent person for purposes of this
18 section is a woman who has been engaging during pregnancy in
19 excessive use, for a nonmedical purpose, of controlled
20 substances or their derivatives or noncontrolled substances,
21 which will pose a substantial risk of damage to a fetus' brain
22 development or physical development.

23 (d) For purposes of paragraph paragraphs (b) and (c), none
24 of the following constitute a refusal to accept appropriate
25 mental health treatment:

26 (1) a willingness to take medication but a reasonable
27 disagreement about type or dosage;

28 (2) a good-faith effort to follow a reasonable alternative
29 treatment plan, including treatment as specified in a valid
30 advance directive under chapter 145C or section 253B.03,
31 subdivision 6d;

32 (3) an inability to obtain access to appropriate treatment
33 because of inadequate health care coverage or an insurer's
34 refusal or delay in providing coverage for the treatment; or

35 (4) an inability to obtain access to needed mental health
36 services because the provider will only accept patients who are

1 under a court order or because the provider gives persons under
2 a court order a priority over voluntary patients in obtaining
3 treatment and services.

**Senate Counsel, Research,
and Fiscal Analysis**

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Senate

State of Minnesota

**S.F. No. 993 - Medical Assistance Coverage for Mental
Health Screening**

Author: Senator Linda Berglin

Prepared by: Joan White, Senate Counsel (651/296-3814) 

Date: March 10, 2005

S. F. No. 993 expands the services covered under medical assistance by expanding the definition of "screening services" to include mental health screening that uses a screening instrument approved by the commissioner according to criteria that are updated and issued annually and that is covered as a separately paid service.

JW:rdr

Senators Berglin, Solon and Rosen introduced--

S.F. No. 993: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to human services; modifying covered services
3 for medical assistance; amending Minnesota Statutes
4 2004, section 256B.0625, subdivision 14.

5 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

6 Section 1. Minnesota Statutes 2004, section 256B.0625,
7 subdivision 14, is amended to read:

8 Subd. 14. [DIAGNOSTIC, SCREENING, AND PREVENTIVE
9 SERVICES.] (a) Medical assistance covers diagnostic, screening,
10 and preventive services.

11 (b) "Preventive services" include services related to
12 pregnancy, including:

13 (1) services for those conditions which may complicate a
14 pregnancy and which may be available to a pregnant woman
15 determined to be at risk of poor pregnancy outcome;

16 (2) prenatal HIV risk assessment, education, counseling,
17 and testing; and

18 (3) alcohol abuse assessment, education, and counseling on
19 the effects of alcohol usage while pregnant. Preventive
20 services available to a woman at risk of poor pregnancy outcome
21 may differ in an amount, duration, or scope from those available
22 to other individuals eligible for medical assistance.

23 (c) "Screening services" include, but are not limited to:

24 (1) blood lead tests; and

25 (2) a mental health screening that uses a screening

- 1 instrument approved by the commissioner of human services
- 2 according to criteria that are updated and issued annually and
- 3 that is covered as a separately paid service.

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Director

MMHAG Evidence-Based Model Benefit Set

Treatments and Necessary Supports for Mental and Co-Existing Chemical Health Disorders

November 5, 2004
Final Version

Work Group

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Sharon Autio MS	Director, Adult Mental Health	MN Dept. of Human Services
Chris Bray MA, LP	Assistant Commissioner	MN Dept. of Corrections
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		The Storefront Group
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Candy Kragthorpe MSW	Mental Health Programs Coordinator	State Advisory Council on MH
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Jan Luker MST, Sp-CCC	Chief Operating Officer	Dakota County Public Health
Karen Lindberg PHN, MPH	Maternal/Child Health Program Coord.	Dakota Co. Collaborative
	Parent	Stearns County
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Cindy-Shevlin-Woodcock	Interagency/Mental Health Specialist	BHP
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The work group thanks others who contributed via phone/e-mail.

Charge to Model Benefit Set Work Group

March 22, 2004

Visionary Goal: Establish a sustainable and affordable financial framework that provides rational incentives to assure that the right care is delivered in the right setting and at the right time.

Problem: There is a **lack of insurance coverage and public sector funding for the full continuum of care**, including a lack of incentives for development of alternative programming that would prevent more costly acute care. For example, gaps include mobile crisis services, short term crisis shelter and community assistance teams. There is a **lack of continuity in care** (people lose coverage). Adequate supportive/social services that are necessary to meet treatment plans are not consistently paid for or provided. Services vary by geographic location.

Solution/Deliverable: Develop Model Mental Health Benefit set for children and adults and promote adoption by public and private payors (including self-funded employers).

- Outline current benefits (e.g. MA, health plans, insurance)
- Identify supportive services (educational, vocational, etc) necessary to treatment
- Review other existing benefit sets
- Review recommendations from the Continuum of Care Team
- Determine what benefits should be included from the continuum
- Review research for evidence of effectiveness
- Develop a model benefit set incorporating research on effectiveness and including both clinical services and necessary supports
- Develop a plan to finance model benefit set and identify payors
- Develop timeline for staged implementation
- Propose strategies to promote adoption by public and private payors
- Propose strategy/process for ongoing update as policy, technology, etc. change

Issues for Consideration:

- Individual rights to treatment access
- Incentives for innovative programs, especially prevention and early intervention.
- Addressing geographic disparities
- Equity in cost sharing and limiting cost shifting among payors
- How to determine what supportive services (education, vocational, housing, employment, etc) are necessary to treatment plan
- Development of full continuum to reduce acute care utilization

Guide to Proposed Minnesota Model Benefit Set

The proposed Model Benefit Set for mental health treatment was developed as a part of a broader effort to transform the system of care for children and adults in Minnesota into one that is consumer-centered and that provides quality care in the right place and at the right time. In addition to clinical services, the Model Benefit Set includes supportive services that are sometimes necessary to effective treatment. Both clinical and supportive services were selected based on documented and evidence-based mental health best practices. A broad base of Minnesota stakeholders (health plans, county, state, providers, parents, consumers, etc.) were involved in this effort.

The benefit set includes services that provide earlier help as well as services that offer alternatives that are just as effective as more costly acute care for some individuals. By offering a full continuum of care, it facilitates a system that has latitude and flexibility to meet consumer needs, which should lead to better outcomes and increased satisfaction. The intent is that **service provision should be based on medical necessity and in accordance with an individualized treatment plan approved by a physician or licensed practitioner**, excluding crisis services, for which a plan is not required.

The flexibility of the Model Benefit Set moves firmly in the direction of state-of-the-art research and understanding about how to facilitate quality care. As described in more detail below, benefits are intentionally not described as site- or provider-specific in order to allow the flexibility to provide the right care in the right place.

In addition, the Model Benefit Set provides a firm basis for a partnership between the public and private sectors to better meet consumers' needs. While it is silent as to who pays, it offers a framework for determining each sector's responsibility in providing the continuum of clinical services and community supports needed by those persons for whom it is responsible. Thus, the Model offers guidance for allocating limited resources to gain the best value for recipients, their families and society.

Finally, any Model Benefit Set is inevitably a work in progress. This is particularly true in the area of mental health where our knowledge of both mental health and effective treatments continues to evolve rapidly. It is important that this document be updated on an ongoing basis. In addition, a critical next step is to include chemical health treatments and necessary supports. Already Medicare, a key payor, makes no distinction between a chemical health diagnosis and any other mental health diagnosis. Creating two separate systems for funding billing and documentation further adds to the complexity of the system and is too often detrimental to consumers.

Grid

The complete Model Benefit Set is set forth in a grid on page 5. It is composed of:

- Standard Benefits—benefits that are currently covered now by most public and private payors;
- Recommended Benefits—to be added now;
- Recommended Benefits—to be added at the next implementation phase.

The following criteria guided decisions for selecting benefits recommended to be added now:

- Fills a critical service need or gap
- Promotes or enhances earlier intervention
- Was identified as priority by consumers or parents
- Promotes more efficient use of resources
- Supports or expands appropriate community-based care

It is important to note that some of these recommended benefits are already covered by many public and private sector payers, but they are less universally covered than the “Standard Benefits.”

In the “evidence” column of the grid, each benefit is labeled either “standard,” “logical,” or “evidence.”

- As noted above, standard benefits are those that are already widely accepted. The committee decided not to present evidence for these.
- Benefits which are less widely covered, but which the committee determined met the criteria for inclusion as part of an evidence-based model benefit set, are marked “evidence.” Evidence for the effectiveness of all but three of these benefits can be found in this document.
- The remaining benefits are marked “logical” because they were deemed obviously important components of quality care. The logical benefits include community health maintenance services such as transportation to treatment for selected consumers (If a person is unable to physically get to the provider, providing transportation is logical because without it the individual cannot get better), and outreach to targeted populations (e.g. homeless).

Evidence Packet

The “Evidence Packet” provides information on each of the Recommended Benefits, including: a description of the benefit, the target population, intensity, provider qualifications, evidence of effectiveness and in some cases, information on cost savings.

In reviewing the Grid and Evidence Packet, please keep the following points in mind:

- With the exception of targeted prevention, all benefits and supportive services in the Model Benefit Set are intended to be provided only when they are deemed necessary to an individual’s treatment plan. Not every consumer will get every service. Several benefits and supports are only appropriate for consumers with the most severe conditions.
- Benefits are intentionally not described as site-specific in order to allow the flexibility to provide the right care in the right place. Thus, the “right place” may be a home, school or community settings, depending on the consumer.
- Similarly, benefits are intentionally not described as provider-specific. For example, even though public health nurse home visiting is not specifically listed as a benefit, (because it is site- and provider-specific), it may be the very best

way to provide outreach to a severely depressed new mother. The Model Benefit Set provides for coverage of services provided by a public health nurse in the home or elsewhere when they are part of a plan of care or designed to promote earlier identification and intervention for at-risk populations.

- Benefits are not described in terms of how they are currently paid (e.g. Rule 79 Case management is not specifically listed because it defines a payment mechanism)
- Some benefits are recommended in the ‘add later’ group because the evidence about target population, key service components, etc. is still being gathered.
- Different systems have developed different ways of providing care coordination. This term is used to describe a wide range of care planning, service and payment coordination, and more. Some types of care coordination of more effective for specific target populations. To enhance clarity for the reader, care coordination evidence was separated into three categories – case management, wraparound, disease management.
- Chemical dependency benefits were only addressed when they involved co-occurring (co-morbid chemical dependency and mental disorder) disorders.
- The proposed Model Benefit Set is aligned with the President’s New Freedom Commission report and with the key recommendations of the Minnesota Mental Health Action Group, co-chaired by the Commissioner of Human Services, Kevin Goodno, and Gary Cunningham of the Citizen’s League.

MMHAG Evidence-Based Model Benefit Set

Treatments and Necessary Supports for Mental and Co-Occurring Chemical Health Disorders

Benefit	Covered Now		Add Now		Add Later		Evidence*
	Children	Adults	Children	Adults	Children	Adults	
ASSESSMENT							
Diagnostic and/or functional assessment, explanation of findings	X	X					Standard Practice
Biological testing	X	X					Standard Practice
PSYCHOTHERAPY (individual, family and group)							
	X	X					Standard Practice
CLINICAL CASE CONSULTATION - psychiatrist							
			X	X			Evidence
CLINICAL CASE CONSULTATION - other mental health professionals							
					X	X	Evidence
CARE COORDINATION							
Case management			X	X			Evidence
Wraparound					X	X	Evidence
Disease management & client education			X	X			Evidence
INTEGRATED TREATMENT MODEL - Assertive Community Treatment							
			X	X			Evidence
COMMUNITY OUTPATIENT/TREATMENT SERVICES AND SUPPORTS							
Family psychoeducation			X	X			Evidence
Respite			X	X			Evidence
Child and adolescent rehabilitative services			X	n/a			Evidence
Adult rehabilitative services (employment supports, ind. living skills/remediation training, etc.)			n/a	X			Evidence
Day treatment	X	X					Standard Practice
Partial hospitalization	X	X					Standard Practice
Community health maintenance (support. housing (for adults); transportation to treatment)			X	X			Logical/Evidence
Community health maintenance (supportive employment, partial hosp lodging)					n/a	X	Logical/Evidence
Therapeutic foster care					X	n/a	Evidence
INTEGRATED TREATMENT FOR CO-OCCURRING MH/SA DISORDERS							
				X	X		Evidence
MEDICAL SERVICES							
Medication management	X	X					Standard Practice
Services provided by or under supervision of physician	X	X					Standard Practice
PSYCHOTROPIC MEDICATION							
	X	X					Standard Practice
EMERGENCY/CRISIS CARE							
24 hr. crisis phone consultation	X	X					Standard Practice
Crisis response (mobile outreach, crisis intervention counseling, crisis stabilization (incl. residential))			X	X			Evidence
Urgent care	X	X					Standard Practice
PSYCHIATRIC HOSPITALIZATION							
	X	X					Standard Practice
RESIDENTIAL MH TREATMENT							
	X						Standard Practice
DIAGNOSTIC SCREENING							
Diagnostic MH screening (via multiple portals: primary care, public health, county ss, schools)			X	X			Evidence
SECONDARY PREVENTION							
Outreach					X	X	Logical
Targeted prevention (eg: primary care, public health, county soc. services, schools, incl. outreach)			X	X			Logical/Evidence
n/a = not applicable							
Comments: The benefits a client receives will vary based on diagnosis, age, income (e.g. transportation), site, provider, length of service, etc. This benefit set is intended to result in a system where a client receives the most effective intervention in an appropriate setting, from an appropriate provider, at the right time, and for the appropriate length of time.							

Pre-Diagnostic Screening

DEFINITION/SERVICES

Screening is a relatively brief process designed to identify persons who are at increased risk of having disorders that warrant immediate attention, intervention or comprehensive review. Identifying the need for further assessment is the primary purpose for screening. Mental health screening instruments are never used for diagnosis, but rather identify the need for further assessment.¹ Screens are typically a brief questionnaire which can be administered in person, over the phone, on a computer, over the Internet, etc. They can be administered in doctor's offices, schools, public health clinics, etc.

Screening tools often vary with the provider or setting. Screening instruments must accurately identify mental health needs. The tools should demonstrate effective use with the particular populations they screen. Good tools are easy to administer and score and require minimal expertise to use and have acceptable levels of:

- Sensitivity and specificity
- Reliability
- Validity
- Brevity

CONSUMERS

Anyone can be screened. Screening can either be done across the board for a broad population group or targeted at specific higher-risk subgroups

INTENSITY/DURATION OF SERVICE

Screens are designed to be brief, and may take as little as a few minutes. Screening may be done at regular intervals, such as yearly, or at times of high-risk, such as times of major transition or after experiencing trauma, etc.

TRAINING/CREDENTIALS REQUIRED TO PROVIDE

Most screening tools are designed to be self-administered or administered by someone with minimal training, such as a receptionist. They are *not* designed to require a mental health professional or someone with training at the master's or PhD level. More complicated screening instruments can be administered by staff such as social workers and case managers.

EVIDENCE OF EFFECTIVENESS

Screening can help catch mental disorders that would have otherwise gone unidentified and untreated.

- Studies indicate that fewer than thirty percent of children with substantial dysfunction are recognized by primary care clinicians. Nationally, referral rates of children seen by pediatricians to mental health services range from 1-4%.²

¹ Mental health diagnostic assessment is a comprehensive examination of the psychosocial needs and problems identified during a mental health screening. Assessments identify whether mental health disorders are present and recommend treatment interventions. Assessments routinely include individualized data collection, often psychological testing, clinical interviewing and reviewing past records. A mental health professional is needed to conduct the assessment and develop a comprehensive report.

² Jellinek, M. "Approach to the Behavior Problems of Children and Adolescents." In T.A. Stern, J.B. Herman, P.L. Slavin (Eds.) *The MGH Guide to Psychiatry in Primary Care*. 1998.

- Often recognition depends on parental complaint or school report of overt behavioral problems or less overt dysfunction (such as secondary and childhood depression, or family factors such as divorce).³
- Physicians who solely rely on clinical judgment fail to identify children with mental health problems. When the Child Behavior Checklist (an assessment tool)⁴ was used to identify the prevalence of psychiatric disorders in children ages 7 to 11 years visiting a primary care physician, 24% of the children were noted to have evidence of mental health problems. However, only 3.6% of the children had received a mental health referral from their primary care physician.⁵
- Compared with usual care, feedback on depression screening results to providers generally increased recognition of depressive illness in adults. Meta-analysis suggests that overall, screening and feedback reduced the risk for persistent depression (summary relative risk, 0.87 [95% CI, 0.79 to 0.95]). Compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up.⁶
- Studies have shown that usual care by primary care physicians fails to recognize 30% to 50% of depressed patients. Because patients in whom depression goes unrecognized cannot be appropriately treated, systematic screening has been advocated as a means of improving detection, treatment, and outcomes of depression.⁷
- Effectiveness data is available for individual screening tools. For example, The Pediatric Symptom Checklist (PSC) is a one-page questionnaire a parent of a child age 4-16 can complete in the waiting room in 2-5 minutes. The PSC has proven validity with low-income and middle-income kids, and with both Caucasians and populations of color. The cutoff score of 28 has sensitivity of 95% for middle income and 88% for lower income children, and a specificity of 68% for middle income and 100% for lower income children. Children "incorrectly" identified usually have at least mild impairment, and can still benefit from services and closer supervision. Use of the PSC has been shown to improve recognition rates for psychosocial problems in pediatric primary care settings.⁸

COST/COST SAVINGS

Screening tools can often be self-administered and self-/automatically scored on paper or online, therefore costing little or nothing.

³ Jellinek, M. "Approach to the Behavior Problems of Children and Adolescents." In T.A. Stern, J.B. Herman, P.L. Slavin (Eds.) *The MGH Guide to Psychiatry in Primary Care*. 1998.

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⁵ "Why do we wait? A mental health report," Minnesota Office of the Ombudsman for Mental Health and Mental Retardation. 1999.

⁶ Screening for Depression in Adults: A Summary of the Evidence for the U.S. Preventive Services Task Force Michael P. Pignone, MD, MPH; Bradley N. Gaynes, MD, MPH; Jerry L. Rushton, MD, MPH; Catherine Mills Burchell, MA; C. Tracy Orleans, PhD; Cynthia D. Mulrow, MD, MSc; and Kathleen N. Lohr, PhD

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⁸ http://psc.partners.org/psc_home.htm

The cost benefit of screening comes from identifying problems early, before they become more severe, and require more costly treatment, and while better outcomes are more likely. Potential cost savings to the system are significant.

- Research indicates that the appropriate identification and treatment of mental disorders in childhood can reduce symptoms of child psychopathology, improve adaptive functioning, and sometimes serve as a buffer to long-term impairment.⁹
- In 2001, mental disorders were the leading cause of hospitalization for 5-14 year-olds (2,172 children and youth) in Minnesota. Another 2,051 children and youth ages 5 - 14 were treated (not admitted) in emergency departments for a mental disorder. For Minnesotans age 15-44, mental disorders were the second leading cause of hospitalization.¹⁰
- Individuals with untreated mental illness often consume excessive amounts of general health care services. They make multiple trips to their primary care physician with complaints of an upset stomach, headache, difficulty sleeping, and general aches and pains, when the real problem is an undiagnosed mental disorder. The American Psychological Association estimates that 50-70% of usual visits to primary care physicians are for medical complaints that stem from psychological factors.¹¹
- Annual health care costs for consumers with untreated depression are nearly twice that of consumers who do not have depression.¹²
- Mental disorders ranked among the top ten leading causes of hospitalization for Minnesotans in every age group.¹³
- The decreased disability payments in the first 30 days following initial treatment for major depression results in employer savings totaling \$93 per consumer, which can exceed the cost of treatment for a similar period of time. The workplace benefits from improved functioning are substantial and may, in fact, exceed the usual costs of depression treatment. Thus, purely on economic rather than clinical or quality-of-life grounds, this argues in favor of more aggressive outreach to employees with symptomatic disease that results in initiation of treatment before their symptoms are allowed to persist and result in a disability claim.¹⁴

RESOURCES

http://www.ncmhjj.com/pdfs/publications/Screening_And_Assessing_MHSUD.pdf

<http://www.teenscreen.org/>

<http://www.mentalhealthscreening.org/>

http://www.healthyplace.com/Communities/Eating_Disorders/concernedcounseling/eat/EATtest.htm

www.brightfutures.org/mentalhealth/index.html

www.aap.org/policy/re0062.html

Carter AS, Child Psychol Psychiatry. 2004 Jan;45(1):109-34. Assessment of young children's social-emotional development and psychopathology: recent advances and recommendations for practice.

Example obsessive-compulsive disorder screen http://www.zoloft.com/index.asp?pageid=15&PFW_jump2

Example post-traumatic stress disorder screen http://www.zoloft.com/index.asp?pageid=20&PFW_jump2

⁹ Ringeisen H., Oliver KA., and Menvielle E. in *Pediatric Drugs. Vol 4(11) (pp 697-703), 2002.*

¹⁰ Minnesota Department of Health, 2001

¹¹ "The Costs of Failing to Provide Appropriate Mental Health Care," *American Psychological Association, 2003.*

¹² Agency for Healthcare Research and Quality (HS09397)

¹³ Minnesota Dept. of Health, 2003.

¹⁴ "Management of Major Depression in the Workplace: Impact on Employee Work Loss" Howard G. Birnbaum, Pierre Y. Cremieux, Paul E. Greenberg and Ronald C. Kessler

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RESOURCES

http://www.ncmhjj.com/pdfs/publications/Screening_And_Assessing_MHSUD.pdf

<http://www.teenscreen.org/>

<http://www.mentalhealthscreening.org/>

http://www.healthyplace.com/Communities/Eating_Disorders/concernedcounseling/eat/EATtest.htm

www.brightfutures.org/mentalhealth/index.html

www.aap.org/policy/re0062.html

Carter AS, Child Psychol Psychiatry. 2004 Jan;45(1):109-34. Assessment of young children's social-emotional development and psychopathology: recent advances and recommendations for practice.

Example obsessive-compulsive disorder screen http://www.zoloft.com/index.asp?pageid=15&PFW_jump2

Example post-traumatic stress disorder screen http://www.zoloft.com/index.asp?pageid=20&PFW_jump2

⁹ Ringeisen H., Oliver KA., and Menvielle E. in *Pediatric Drugs. Vol 4(11) (pp 697-703), 2002.*

¹⁰ Minnesota Department of Health, 2001

¹¹ "The Costs of Failing to Provide Appropriate Mental Health Care," *American Psychological Association, 2003.*

¹² Agency for Healthcare Research and Quality (HS09397)

¹³ Minnesota Dept. of Health, 2003.

¹⁴ "Management of Major Depression in the Workplace: Impact on Employee Work Loss" Howard G. Birnbaum, Pierre Y. Cremieux, Paul E. Greenberg and Ronald C. Kessler



Volunteers of America®

Minnesota

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March 16, 2005

Dear Senator Lourey and members of the Senate Committee:

I am a mental health professional with over 30 years experience, currently working as Director of Senior Mental Health Services, Volunteers of America - Minnesota. I am also a member of the State Advisory Council on Mental Health, representing family members of persons with mental illness – in my case, an elderly spouse. Speaking from the confluence of my professional experience with older adults and personal struggles to access mental health care on behalf of my spouse, I strongly urge you to approve SF 993 that would allow mental health screening to be a separate billable service under Medical Assistance.

Persons aged 65 and above are in the fastest growing age group that is likely to grow to 20% of the total population by year 2030. National data from CDC indicates that nearly 20% of the population aged 55 and above is experiencing some form of mental disorder. Suicide rate is highest among this group. Research suggests that 80% or more of these acts of self-harm are related to underlying depression and other mental health disorders.

According to American Association of Geriatric Psychiatry Fact sheet, the most common disorders among the elderly in order of prevalence are: Anxiety disorders (11% - most commonly, phobias), Cognitive impairments (10% - Higher in the older age groups), Depression and other mood disorders (6% overall, 8-20% in community, up to 37% in primary care settings), and Schizophrenia (0.6% - economic burden of late life Schizophrenia is high). Much of that goes untreated. Yet, **mental illness is not part of the normal aging process** and can be successfully treated by knowledgeable professionals.

Then, why do we not provide that much-needed treatment early on and save lives, support caregiving family members, markedly improve the quality of life of those afflicted, and save a significant portion of health care dollars that go to support nursing home placements, repeated hospitalizations, and ER visits? The explanation lies in systemic gaps and problems that do not support early identification and intervention of seniors at risk.

The dual stigma of aging and mental illness and absence of effective early identification and screening process often get in the way of seniors accessing much needed mental health care. Unlike many medical conditions and diseases such as cancer and hypertension, mental health screening is not a reimbursable service. Research has shown that 80% of persons who committed suicide had seen their primary physicians with one month – 40% within one week. How many of these lives might have been saved if the primary physicians had screened for presence of mental illness and addressed the need for treatment?

We have an opportunity in this bill to provide incentive for that kind of screening to happen. Please lend your support to this bill. I appreciate your efforts on behalf of older adults like myself who have felt the need in their lives.

Respectfully,

Atashi Acharya



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In my work with Senior Citizens who reside in a Minneapolis Public Housing High-rise we often encounter instances where mental health assessments would prove useful. Seniors who are suffering from Depression, Anxiety Disorders, and other mental illnesses may exhibit behaviors such as:

- a) isolation
- b) fear
- c) phobias
- d) somatic symptoms
- e) panic attacks
- f) paranoia
- g) irritability
- h) alcohol use or other substance use (self medication)
- i) violent behaviors including suicide

Such behaviors can be very harmful to the person's quality of life and could affect their ability to continue living independently. Such behaviors may result in:

- a) Nursing Home Placement
- b) Hospitalization
- c) Loss of familial support
- d) Loss of community support.

It is easy to recognize the positive impact assessment and intervention would play in reduced nursing home placement and hospitalization. Let us not ignore the very important role familial and community supports play in bolstering our scarce resources. Keeping these ties strong is essential to assisting older adults to remain independent.

The pain of severe depression is quite unimaginable to those who have not suffered it and it kills in many instances because its anguish can no longer be borne. (William Styron)

Mental Illness often co-occurs with other serious illness. Here I will address Depression as most people are familiar with this diagnosis. **Depressive symptoms are not a normal part of aging!** In a report released by the National Institute of Mental Health in April of 2004 addressing Depression and Suicide facts, the author states **Depression often co-occurs with serious illness such as Heart disease, Stroke, Diabetes, Cancer, and Parkinson's disease.** Because older adults face these illnesses and other social and economic challenges it is assumed that Depression is a normal occurrence among this group. The same report speaks of studies that have found that among the many older adults who die by suicide (18 percent of all suicide deaths) 75% had seen their primary care physician within a month of their death. Additionally **when Depression co-occurs with other illnesses, if left untreated, it can lengthen recovery time and worsen outcomes.** Clearly early assessment and intervention could alleviate much grief and loss in prevention of suicide and better health outcomes. In addition it could reduce the burden on an already stretched healthcare system in terms of time and costs associated with un-treated or under-treated mental health issues.

Ms. Natalie Boisvert
Graduate Student
College of St. Catherine and University of St. Thomas

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Myths and Facts Regarding Mental Health Screening Programs and Psychiatric Drug Treatment for Children

Karen R. Effrem, MD

Ed/Watch/EdAction – www.EdWatch.org/www.EdAction.org

International Center for the Study of Psychiatry and psychology – www.icspp.org

Alliance for Human Research Protection – www.ahrp.org

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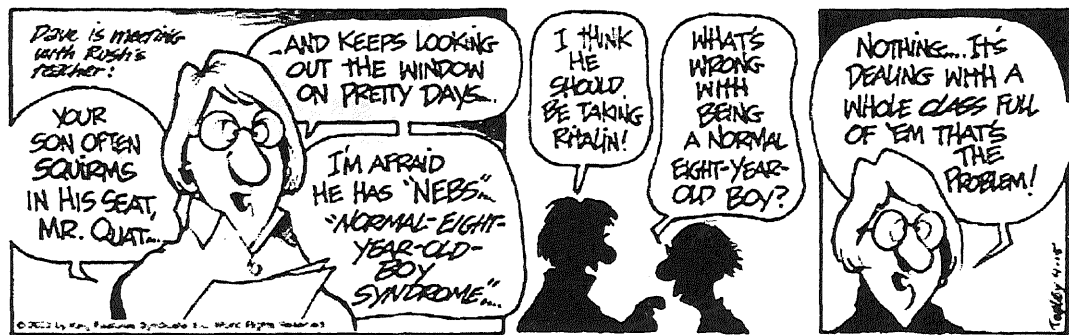
kreffrem@pro-ns.net

Myth: The President's New Freedom Commission on Mental Health is not advocating widespread mental health screening. "... The commission proposed broad screening only in settings where many children are known to have untreated behavioral problems." (Michael Hogan – NFC chairman, Washington Times, 10/21/04)

Fact: The New Freedom Commission report frequently recommended universal mental health screening and treatment for children.

(<http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf>)

- "For consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding..." (p. 19)
- "Since children develop rapidly, delivering mental health services and supports early and swiftly is necessary to avoid permanent consequences and to ensure that children are ready for school." (p. 65)
- "Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports." (p. 65)
- "Because of this important interplay between emotional health and school success, schools must be partners in the mental health care of our children" (p. 66)



Myth: Informed parental consent is an important component of programs recommended by the NFC.

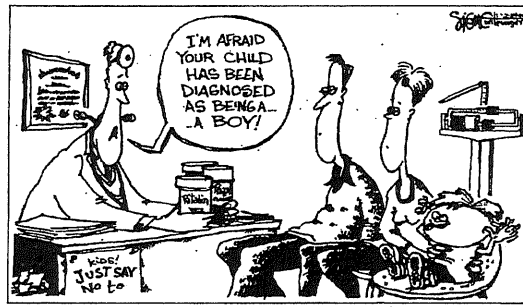
Fact: The NFC report never uses the word "voluntary" in the context of screening and treatment and uses the phrase "parental consent" just once to describe a program that uses passive, opt-out parental consent.

- "Parents at Penn and other schools could withhold their children from the screening by returning a form mailed to their houses. Parents who did not sign the form and return it were considered to have given permission for TeenScreen... 'We would probably see the level of participation drop way off (if active consent were required),' he said." (Rumbach, South Bend Tribune, 1/19/2005)

Myth: Psychiatric diagnostic criteria are scientifically validated and non-controversial among experts in the field.

Fact: Mental health diagnostic criteria are very vague and subjective. The very studies and reports cited by proponents of universal screening are full of contradictions. These experts admit the lack of science underlying psychiatric labels.

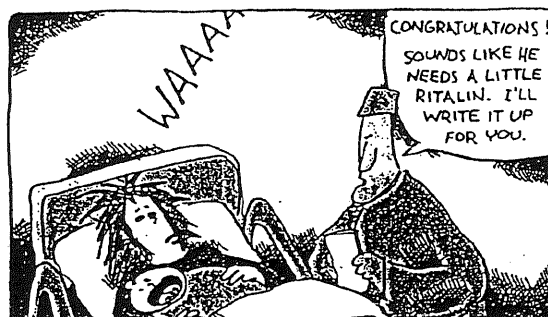
- “In other words, what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures.” (Surgeon General Report on Mental Health. 1999. p. 1-5 <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c1.pdf>)
- “The diagnosis of mental disorders is often believed to be more difficult than diagnosis of somatic or general medical disorders since there is no definitive lesion, laboratory test or abnormality in brain tissue that can identify the illness.” (Surgeon General, p. 2-18, <http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf>)
- “No consistent structural, functional, or chemical neurological marker is found in children with the ADHD diagnosis as currently formulated.” (Attention Deficit Hyperactivity Disorder State of the Science - Best Practices, Peter S. Jensen and James R. Cooper, Eds, Civic Research Institute, Kingston, N.J. 2000, p. 3-7)
- “DSM-IV criteria remain a consensus without clear empirical data supporting the number of items required for the diagnosis . . . Furthermore, the behavioral characteristics specified in DSM-IV, despite efforts to standardize them, remain subjective . . .” (American Psychiatric Association Committee on the Diagnostic and Statistical Manual (DSM IV- 1994), pp.1162-1163)



Myth: It is possible to accurately diagnose mental illness in young children, even infants. “Even before their first birthday, babies can suffer from clinical depression, traumatic stress disorder, and a variety of other mental health problems.” (Florida Strategic Plan for Infant Mental Health)

Fact: Due to rapid developmental changes, it is very difficult to accurately diagnose young children.

- “Childhood and adolescence being developmental phases, it is difficult to draw clear boundaries between phenomena that are part of normal development and others that are abnormal.” (World Health Organization, World Health Report, 2001)
- “The science is challenging because of the ongoing process of development. The normally developing child hardly stays the same long enough to make stable measurements. Adult criteria for illness can be difficult to apply to children and adolescents, when the signs and symptoms of mental disorders are often also the characteristics of normal development.” (Surgeon General, 1999)



Myth: Children would never be labeled potentially violent or mentally based on their worldview or politics.

Fact: Federally funded school violence prevention programs do label children based on their beliefs. A federally funded study held that people of a particular political philosophy had hallmarks of mental illness.

- A school violence prevention program funded by the federal government called Early Warning, Timely Response lists “intolerance for others and prejudicial attitudes” as an early warning sign for violence and mental instability, saying, “All children have likes and dislikes. However, an intense prejudice toward others based on racial, ethnic, religious, language, gender, sexual orientation, ability, and physical appearance when coupled with other factors may lead to violent assaults against those who are perceived to be different.”(U.S. Department of Education - Early Warning, Timely Response Action Guide http://www.ed.gov/admins/lead/safety/actguide/action_guide.txt)
- “In August 2003, the National Institute of Mental Health and the National Science Foundation announced the results of their \$1.2 million taxpayer-funded study. It stated, essentially, that traditionalists are mentally disturbed. Scholars from the Universities of Maryland, California at Berkeley, and Stanford had determined that social conservatives, in particular, suffer from ‘mental rigidity,’ ‘dogmatism,’ and ‘uncertainty avoidance,’ together with associated indicators for mental illness.” (Eakman, Chronicles, 10/04. See full study at [http://facultygsb.stanford.edu/Jost/private/Political Conservatism as Motivated Social Cognition.pdf](http://facultygsb.stanford.edu/Jost/private/Political%20Conservatism%20as%20Motivated%20Social%20Cognition.pdf))

Myth: Mental health screening instruments are scientifically validated and screening programs are effective at preventing suicide.

Fact: Screening instruments are not validated or effective and fail to prevent suicide.

- “[TeenScreen has] reasonable specificity identifying students at risk for suicide. A second-stage evaluation would be needed to reduce the burden of low specificity.... As with other suicide risk instruments, the CSS has the potential of having high (0.88) sensitivity at the expense of specificity [false positives]...” (Journal of the American Academy of Child & Adolescent Psychiatry, 2004, v. 42, 71-79)
- “USPSTF found no evidence that screening for suicide risk reduces suicide attempts or mortality. There is limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk.”(US Preventative Services Task Force <http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm#clinical>)

Myth: Children are not adequately treated for mental illness.

Fact: Children are over diagnosed and over treated with psychiatric medications and both problems will increase with wide spread screening programs.

- 300% increase in psychotropic drug use in 2-4 year old children between 1991-1995
- 300% increase in psychotropic drug use in children between 1987 and 1996
- More spent on psychiatric medications for children than on antibiotics or asthma medication in 2003



Myth: The decision to treat a child with psychotropic medications is always between a parent and their physician.

Fact: Parent all over the country have been coerced with threats of child abuse or to place their children on or continue psychiatric medications prompting over 20 state legislatures and the US Congress to introduce or pass legislation prohibiting coercion.

- Both Matthew Smith and Shaina Dunkle died of medication toxicity after their parents were coerced to place their children on drugs by the schools.
(<http://ritalindeath.com/homepage.htm>)
- Paul Johnston was institutionalized with drug-induced psychosis after his parents were coerced to put him on 16 different psychiatric medications over seven years.
(<http://www.eagleforum.org/educate/2002/june02/drug-induced.shtml>)

Myth: Psychiatric drug treatments are effective in children.

Fact: Neither antidepressants like Prozac nor stimulants like Ritalin are effective in children, but pharmaceutical companies, with the approval of the FDA, only published positive studies despite having evidence for years of their ineffectiveness.

- “More than two-thirds of studies of antidepressants given to depressed children, for instance, found the medications were no better than sugar pills, but companies published only the positive trials” (Vedatam, Washington Post, 9/9/04, p. A02)
- “No antidepressants have demonstrated greater efficacy than placebo in alleviating depressive symptoms in children and adolescents” (Baker (1995) as quoted in Breggin, P. and Cohen, D. (1999) Your Drug May Be Your Problem: How and Why to Stop Taking Psychiatric Medications, Perseus Books, Reading, MA)
- “However, psychostimulants do not appear to achieve long-term changes in outcomes such as peer relationships, social or academic skills, or school achievement.” (Pelham, et. al. as quoted in Surgeon General, 1999)

Myth: Psychiatric drugs are safe for children.

Fact: Evidence of dangerous and sometimes deadly side effects of psychiatric medication has been covered up for years by the pharmaceutical manufacturers, sometimes with the help of the FDA.

- “Dr. Robert Temple, director of the FDA's office of medical policy, said after an emotional public hearing here that analyses of 15 clinical trials, some of which were hidden for years from the public by the drug companies that sponsored them, showed a consistent link with suicidal behavior.” (Harris, New York Times, 9/14/04, p. A01)
- “TCAs [tricyclic antidepressants] have been linked to cardiac arrhythmias, and “sudden death.” (Wilens TE, et al, 1996. Cardiovascular effects of therapeutic doses of tricyclic antidepressants in children and adolescents. Journal of The Association Of American Child & Adolescent Psychiatry. 35: 1491-501)
- “These drugs also impair flexible problem-solving and divergent thinking. James Swanson, a researcher for the U.S. Department of Education and leading Ritalin advocate, stated in a 1992 review of the medical literature that this type of ‘cognitive toxicity’ may occur at commonly prescribed clinical doses of stimulants, and in up to 40% of patients.” (Breggin, P., (2001) Talking Back to Ritalin, Cambridge, Massachusetts, Perseus, pp. 49-50)
- Zyprexa linked to Diabetes (Eli Lilly's Big Seller, Zyprexa, Can Help Schizophrenics; Is It Linked to Diabetes? --- Warnings Abroad, Not in U.S. – Wall Street Journal, 4/11/03, <http://www.ahrp.org/infomail/0403/11.php>)

Myth: The pharmaceutical industry has no vested interest in the treatment recommendations made by the NFC.

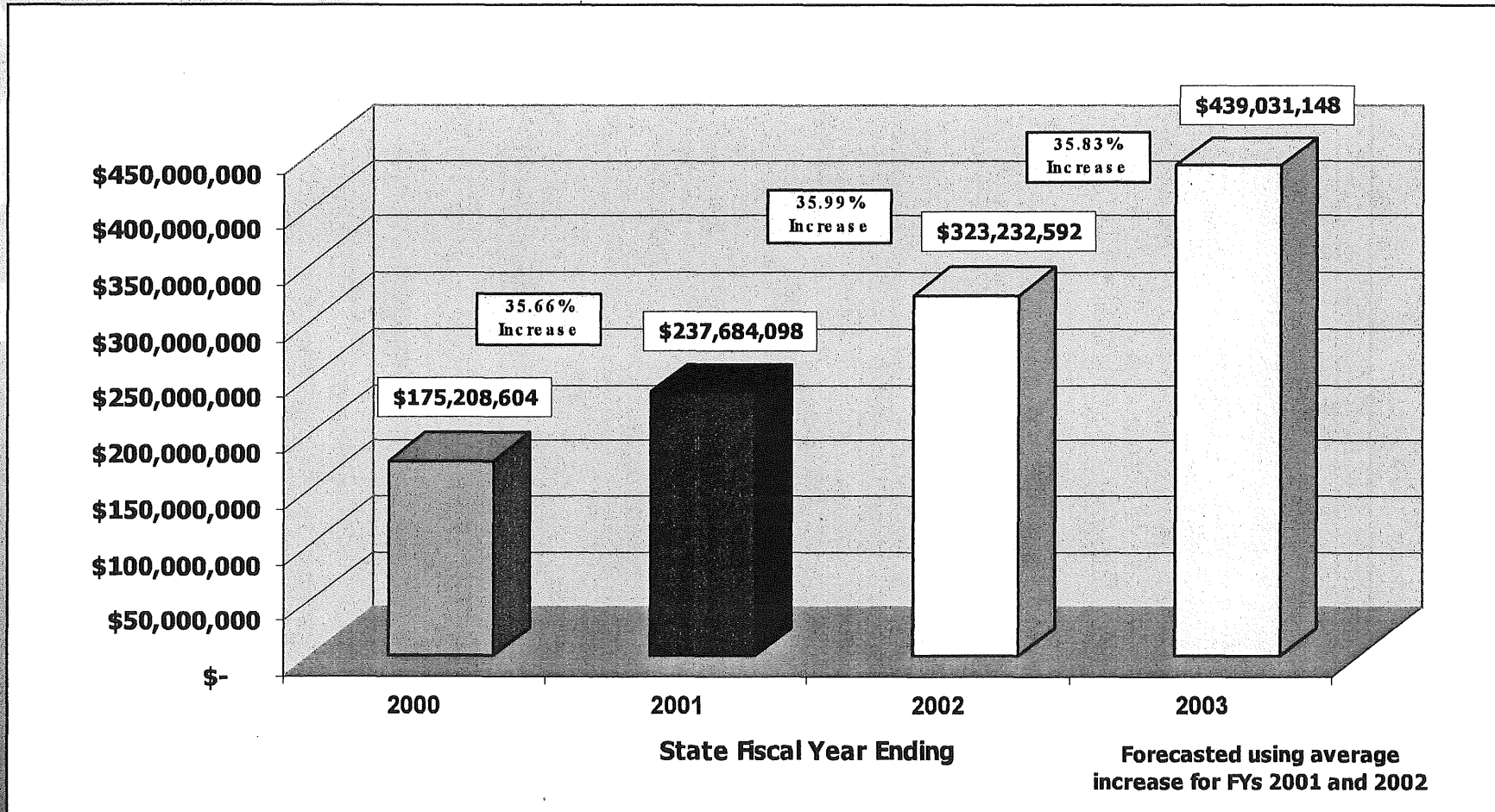
Fact: The pharmaceutical industry steered TMAP treatment recommendations toward their products and have profited mightily from those recommendations, despite the fact that the drugs are more expensive, less effective and have severe side effects.

- "...Dr. Peter J Weiden, who was a member of the project's [TMAP] expert consensus panel, charges that the guidelines are based on 'opinions, not data' and that bias due to funding sources undermines the credibility of the guidelines since 'most of the guideline's authors have received support from the pharmaceutical industry.'" (Lenzer, Jeanne (5/15/04) British Medical Journal, <http://bmj.bmjournals.com/cgi/content/full/bmj;328/7449/1153>)
- KEYE Investigation (Wilson N. KEYE News Investigates. Psychiatric drugs (July 23, 2004); Drugs and your tax dollars (September 30, 2004). <http://keyetv.com/investigativevideo>)

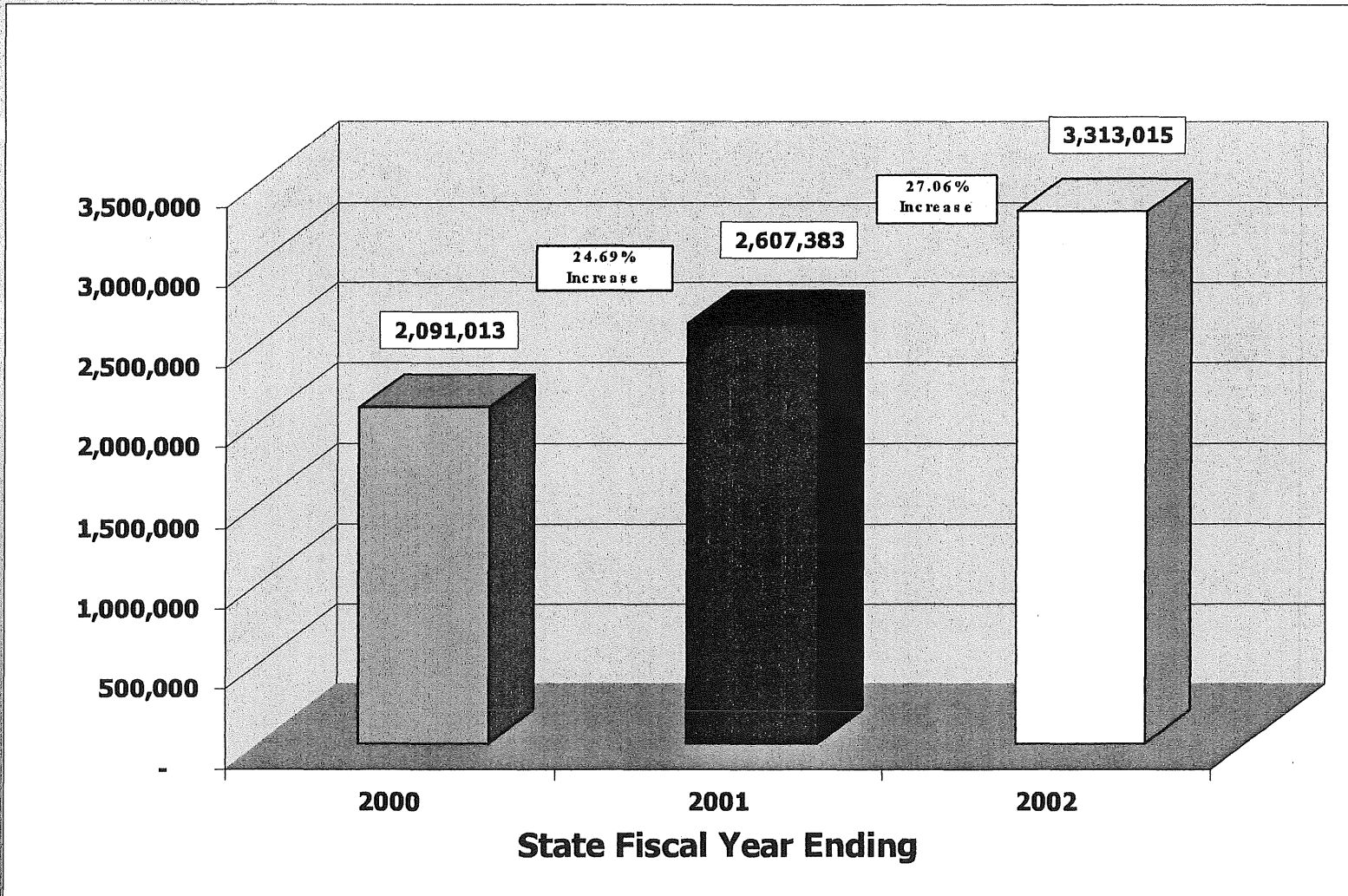
Drug Company	Expenditures on the Texas Medication Algorithm Project	Profits from Texas Medicaid involving that Company's Psychiatric Drugs
Pfizer	\$232 thousand	\$ 233 MILLION
Janssen	\$224 thousand	\$ 272 MILLION
Eli Lilly	\$109 thousand	\$ 328 MILLION



Total Medicaid Expenditures (Mental Health Drugs Only)



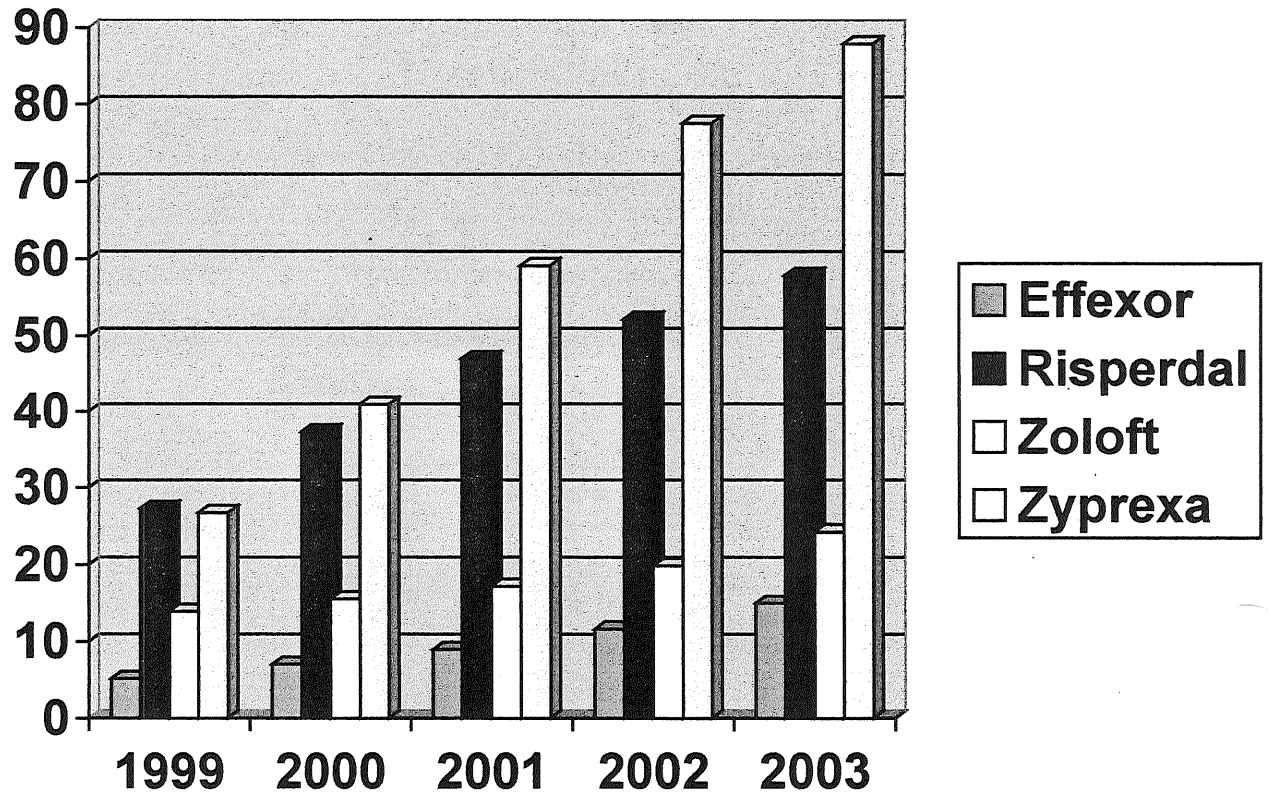
Total Prescription Claims (Mental Health Only)



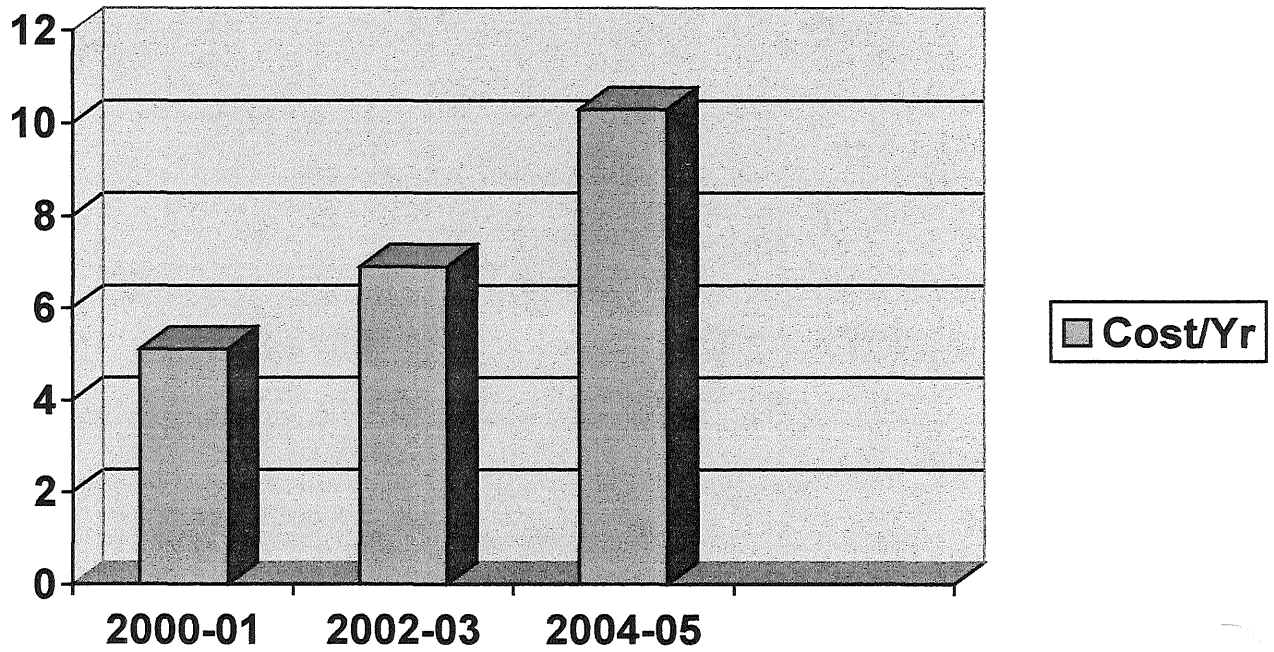
Mental Health Drugs Compared to Total Drugs Florida Medicaid - FYs 2000-2003

State Fiscal Year Ending	2000	2001	2002	2003
Prescribed Drug Budget	\$1,313,358,605	\$1,448,643,280	\$1,667,995,770	\$1,979,817,431
Mental Health Drugs - Total Expenditures	\$175,208,604	\$237,684,098	\$323,232,592	\$439,031,148
Prescribed Drug Budget Without Mental Health	\$1,138,150,001	\$1,210,959,182	\$1,344,763,178	\$1,540,786,283
Mental Health Drugs as Percent of Total Drugs	13.34%	16.41%	19.38%	22.18%
Rate of Increase				
Prescribed Drug Budget		10.30%	15.14%	18.69%
Mental Health Drugs - Total Expenditures		35.66%	35.99%	35.83%
Prescribed Drug Budget Without Mental Health		6.40%	11.05%	14.58%
Claims Count				
Total Prescribed Drug Claims	22,128,389	24,798,686	27,250,693	31,232,517
Mental Health Drug Claims	2,091,013	2,607,383	3,313,015	4,163,890
Mental Health Drug Claims as Percent of Total Prescribed Drug Claims	9.45%	10.51%	12.16%	13.33%
Rate of Increase				
Total Prescribed Drugs Claims		12.07%	9.89%	14.61%
Mental Health Drug Claims		24.69%	27.06%	25.68%

Texas Medicaid Expenditures by Year on Selected
New Generation Mental Health Drugs in Millions of
Dollars



Texas Medicaid Expenditures by Year on New Generation Mental Health Drugs for Hospitalized Patients in Millions of Dollars



Cost and Consequence: drug "cocktails" deplete Medicaid_Globe
(<http://www.ahrp.org/infomail/0603/24a.php>)

Tue, 24 Jun 2003

The escalating cost of healthcare is in large measure due to the spiraling expenditure on drugs--many of which are misprescribed. The Boston Globe reports about one Medicaid patient who is prescribed 18 medications at a cost of roughly \$16,000 a year-- "all at the expense of the financially struggling Massachusetts Medicaid program."

The woman (who was alcoholic) is a pharmaceutical company's dream consumer. Thanks to psychiatrists' poly-pharmacy prescribing practices she is taking multiple costly drugs of the same class. Such prescribing practices are more likely to generate drug-induced new pathologies than to cure the condition for which they are prescribed. What some would call malpractice, is an incredibly lucrative marketing strategy.

According to Massachusetts Medicaid, the 10 most prescribed drugs under the Medicaid program are:

1. Zyprexa (antipsychotic) costs Massachusetts taxpayers \$4.2 million,
2. Protonix (heartburn) costs \$3.6 million
3. Risperdal (antipsychotic) costs \$3.1 million
4. Lipitor (anti-cholesterol) costs \$2.8 million
5. Seroquel (antipsychotic) costs \$2.8 million
6. Neurontin (neuropathic pain...) \$2 mill
7. Depakote (antidepressant) \$1.7 million
8. OxyContin (narcotic) \$1.6 million
9. Zoloft (antidepressant)\$1.5 million
10. Paxil (antidepressant) \$1.2 million

7 of the 10 drugs are expensive psychiatric drugs that are eating up the Medicaid budget. The Boston Globe (Kowalczyk, Globe Staff, 6/22/2003, p. E1) reports that about 40,000 patients in the Massachusetts Medicaid program take eight or more medications.

"Thousands of other patients take five or more psychiatric drugs, more than one newer antidepressant, or more than one newer antipsychotic."

Furthermore, "For patients on eight or more drugs or five or more psychiatric drugs, Medicaid officials will try to educate doctors about why this could be a health problem."



A MATTER OF LIFE OR DEATH

"Shaina looked into my eyes as her life ended and I could do nothing to save her. It's been two years and I relive those last few minutes every day. Believe me, it is a nightmare no parent should ever have to live with."

Mrs. Vicky Dunkle, whose daughter, Shaina, died of toxic levels of a prescribed psychotropic drug

The Citizens Commission on Human Rights (CCHR) acknowledges the problems and needs of young individuals and their need for excellent care. These things are self-evident.

However, it seems that many in our mental health system are unaware that parents looking for help do not expect their children to be harmed during the course of psychiatric "treatment," let alone killed.

Today, the mental health treatment of our young is a life or death gamble and, given the growing number of fatalities, a roll of the dice not to be taken lightly. No longer is it a question of whether children die from psychiatric treatments, but rather whose child will be next. It's a question of whether parents are willing to bet their child's life on subjective psychiatric diagnoses and dangerous mind-altering drugs and treatments.

The horror stories of parents who unwittingly gambled by trusting the mental health system with the lives of their children are tragic—and parents are devastated by the fact that they never even knew the level of risks involved.

As the following shocking summary reveals, far too many parents have

unwittingly taken the bet and suffered the ultimate loss. Too late they learned that when children are subjected to psychiatric drugs and "treatments," it's literally a game of Russian Roulette. At stake was the life of their child.

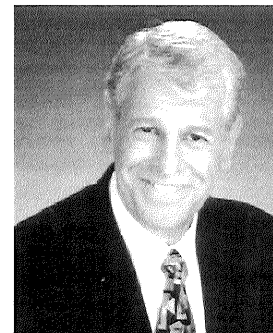
It is absolutely vital that any assessment of the effectiveness of our mental health system or its funding, consider the atrocious record of abuse, fraud and death that now characterizes the expanding mental treatment of our children, and others.

Sincerely,

Jan Eastgate
President CCHR
International



Bruce Wiseman
National U.S.
President, CCHR





IN MEMORY OF...

"I cannot go back and change things for us at this point. However, I hope to God my story and information will reach the hearts and minds of many families, so they can make an educated decision."

Mr. Lawrence Smith, whose son died from heart failure caused by a prescribed stimulant

Child Death By Drugs

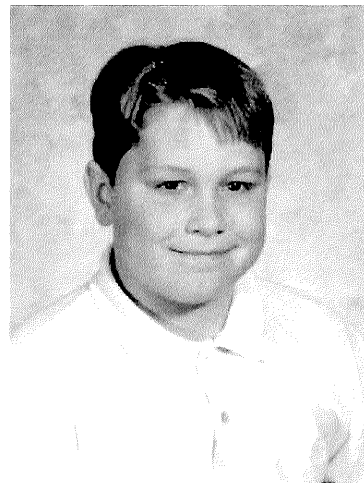
Millions of school-age children are diagnosed with alleged mental disorders such as Attention Deficit Hyperactivity Disorder (ADHD). By talking out of turn, being distracted, not following directions and fidgeting, a child can be labeled and subsequently drugged. The same subjective "criteria" are used to diagnose toddlers who are then put on powerful mind-altering drugs—often before they are able to form a complete sentence.

While the term "medication" is euphemistically used in the mental health system, the truth is that millions of children are simply being heavily drugged. One of the most common drugs used to treat "ADHD" is listed as a Schedule II controlled substance—in the same category as opium, morphine, heroin and cocaine.

Parents are typically told that the drugs prescribed to treat their children are modern, safe and effective, contradicting numerous studies and reports documenting their known dangers and side effects. Such side effects include stunted growth, weight loss, manic behavior, future drug dependence, heart palpitations, cardiac arrhythmia, anxiety, agitation, insomnia, bizarre dreams, suicidal thoughts, violent behavior, and even death.

Long after the utmost tragedy has struck, more and more parents are left desperately grasping for answers. And the one question that continues to haunt them is "Why wasn't I warned?"

MATTHEW SMITH, 1986 - 2000



Matthew Smith liked riding his bike, playing softball, and had a particular passion for building forts. According to his father, Mr. Lawrence Smith, "The trouble all started for

Matthew in the first grade, when the school social worker kept calling us in for meetings, complaining that Matthew was 'fidgeting' and 'easily distracted.'" They were told Matthew had ADHD. "She told my wife and I that if we wouldn't consider drugging our son, we could be charged for neglecting his educational and emotional needs." After also being told that the stimulant was safe and effective and that it could help, the Smiths acceded to the



pressure. On March 21, 2000, while skateboarding, Matthew died suddenly from a heart attack. He was 14 years old. The coroner determined that Matthew's heart showed clear signs of the small blood vessel damage caused by stimulant drugs like amphetamines, and concluded that he had died from the long-term use of the prescribed stimulant. "If we hadn't been pressured by the school system, Matthew would still be alive today," says Mr. Smith. "I cannot go back and change things for us at this point. However, I hope to God my story and information will reach the hearts and minds of many families, so they can make an educated decision."

SHAINA DUNKLE, 1991 - 2001

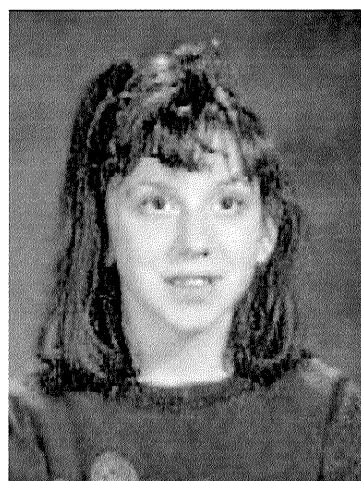


Shaina Dunkle from Pennsylvania was a little girl whose life was filled with dance classes, girl scouts, piano lessons and softball games. However, in 1999, when Shaina was in second

grade, teachers believed she was "too active" and "talked out of turn." Her mother, Mrs. Vicky Dunkle, was pressured by the school psychologist to have Shaina evaluated for ADHD. The psychologist referred Shaina to a psychiatrist who, after a 30-minute evaluation—with no tests or physical exams—diagnosed her with ADHD and prescribed a psychiatric drug, then later two more. On February 26, 2001,

the school nurse phoned Mrs. Dunkle to report that Shaina had suffered a slight seizure and had fallen out of her seat. Mrs. Dunkle took her to the doctor but while there, Shaina began convulsing. Her mother rushed to hold her in her arms, where, minutes later, she died. Shaina was 10 years old. "As I held her in my arms, she looked into my eyes as her life ended and I could do nothing to save her....If I had followed my heart instead of the advice of 'professionals' who thought they knew my daughter better than I did, my precious Shaina would be alive now."

STEPHANIE HALL, 1984 - 1996



When Stephanie Hall was in first grade in Ohio, she was a quiet, shy girl, who had a great love of books and school. However, her teacher said that Stephanie had a hard time "staying

on task" and suggested the girl be tested for Attention Deficit Disorder (ADD). A doctor subsequently diagnosed this and prescribed her a stimulant. Over the next five years, she increasingly complained of stomachaches and nausea, and displayed mood swings and bizarre behavior. On January 5, 1996, at age 11, Stephanie died in her sleep from cardiac arrhythmia. The coroner ruled the death to be of natural causes, but her parents disagree, blaming the drug. Mrs. Hall remembers the last



words exchanged with her daughter before she went to bed: "I said, 'It's 9 o'clock Steph, get to bed,' and she replied 'OK Mom, I love you.'" The next morning when her dad went to wake her for school, she didn't respond. "We called paramedics and the police," her mother recalls. "Stephanie was so cold. I kept saying to them, 'She is supposed to bury me, not me bury her'....No other family should know the agony of burying their child."

SAMUEL GROSSMAN, 1973 - 1986



Riding bicycles and horses was one of Sammy Grossman's favorite hobbies. He was also fast at jigsaw puzzles and had an uncanny sense of direction. Sammy was

never wrong with his directions. For the first eight years of his life, he was one of the healthiest members of his family of six, rarely suffering any of the usual childhood illnesses. But then he was put on a stimulant. He became forgetful about dressing himself, was constantly thirsty and lost weight, becoming pathetically thin, recalls his mother, Georgia Grossman. He began experiencing a racing and irregular heart beat and collapsed in the school playground. The doctor told Mrs. Grossman, "Don't worry about this, this is

only the [stimulant]." Shortly afterwards, Sammy collapsed again, falling off his bike along a roadside in Austin, Texas—and died, at age 13. The autopsy revealed an enlarged heart—a consequence of the long-term use of the stimulant—had contributed to the heart attack.

"Giving this drug to a child is like playing Russian Roulette. No one knows which child will get the brain damage and/or those who will die. I played the game and I lost," said Mrs. Grossman. "If the cause of Sammy's death is made public...and it can save other children, then maybe Sammy will not have died in vain."

CECIL REED, 1984 - 2000

"Daddy, I don't want to take medicine anymore. They are just using me as a guinea pig."

On April 7, 2000, 16-year-old Cecil Reed suffered a massive, fatal heart attack while swimming in a pool at the state-run Bronx Children's Psychiatric Center in New York. A cocktail of four prescribed psychiatric drugs triggered the attack. Cecil's father had repeatedly tried to get the hospital to stop drugging his son, but experts said Cecil had schizoaffective disorder and post-traumatic stress disorder. His father, however, believed his son was just a strong-willed kid who, like any youngster, would lash out after being separated from family and friends. The autopsy report noted that Cecil's body contained "potentially toxic" levels of pindolol, a heart medication used to treat high blood pressure, which was also combined with Selective Serotonin Reuptake Inhibitor antidepressants. Pindolol had not been tested in or recommended for children.

CHILD SUICIDES

"What did the psychological and psychiatric profession do for this boy? They killed him! When the money trail ran out on this boy, they turned their back on him and wouldn't even return a phone call. They absolutely killed him."

Mr. Fred Ehrlich whose son Daniel hanged himself after being on psychiatric drugs known to cause suicide

According to psychiatrists themselves, "suicide is the major complication" of withdrawal from the stimulant used to treat Attention Deficit Hyperactivity Disorder and similar amphetamine-like drugs. The U.S. Drug Enforcement Administration's 1995 Report on Methylphenidate states, "The high percentage of attempted suicide is consistent with the high frequency of depression associated with stimulant abuse."

Suicidal ideation has also been associated with antidepressant use: Between 1988 and 1992, the Food and Drug Administration (FDA) Drug Adverse Reaction (ADR) reporting system showed 90 children and adolescents who had suffered suicidal or violent self-destructive behavior while on one newer Selective Serotonin Reuptake Inhibitor antidepressant.

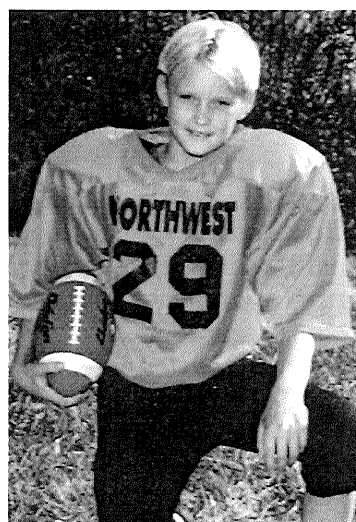
MATTHEW MILLER, 1984 - 1997

According to his father, Matt Miller had "a warm sense of humor, a love of friendship and a heart of solid gold that friends who knew him well loved in him." But at age 13, all that changed. Mr. Miller said the family "began a brief, but tragic journey with Matt into a world we didn't understand—the world of professional psychiatry and legalized mind-altering medications. An unfamiliar world with its

own rules. Its own accepted procedures. And its own arrogance."

After moving to a new neighborhood, Matt was trying to make new friends and, while his parents noticed he was a bit sullen, they felt this was not unusual for a teenager. However, his teachers thought that his withdrawn demeanor might have a more deep-seated cause, and recommended that Matt get "professional help." A psychiatrist gave him a free sample of an antidepressant. There was no printed information. His parents were told that he might experience a bellyache or have trouble sleeping. Seven days later, Matt's mother went to collect the laundry from her son's room and found him

hanging inside his closet. "Our son didn't want to die," said Mr. Miller. "I can't believe our son wanted to die. I never will. For a bright, healthy and loved young man, Matt had every reason to live. Yet

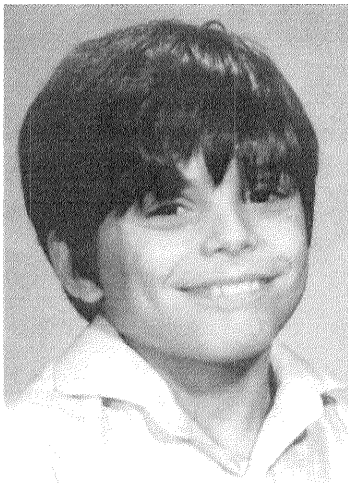




under the power of this debilitating drug, he found a way to die. We know it was not our Matt who took his own life. This was a Matt 'high' on a legalized pill."

RAYMOND PERRONE, 1975 - 1985

Ten-year-old Raymond was "a bright, intelligent child, who loved life and lived each moment to the fullest," according to his mother, Mrs. Linda Perrone. "It took quite some cleverness to keep up with him, let alone keep ahead of him," she said.



Being intellectual, able to quickly grasp things, then having to wait for the rest of the class to catch up, he felt bored with school. This led to poor performance in class and, in approximately February 1985, Raymond was diagnosed as "hyperactive" and prescribed stimulant drugs. Four months later on June 9, during a house warming party, Mrs. Perrone was sitting at the picnic table with a friend. "My sister-in-law suddenly ran screaming into the back yard for someone to call an ambulance. I stood up in complete shock. She started screaming, 'Ray, Ray has hung himself.' I remember running towards the garage to see what had happened, but everyone was surrounding my son. They wouldn't let me go near him. When I finally saw him laying on the ground, I saw his face all purple, a sight that will remain in my memory forever." Raymond had been two days into withdrawal from the stimulant

prescribed by a psychiatrist. His mother was never warned about the withdrawal effects of the drug.



DANIEL EHRLICH, 1970 - 1984

Ten-year-old Daniel Ehrlich from Pennsylvania liked to "monkey around and climb trees," according to his father, Mr. Fred Ehrlich. In 1979, a school nurse diagnosed Daniel as "hyperactive." His father thought his son was just acting like a regular kid, but the consensus of school personnel was that there was a "serious problem" with him. He was placed on a stimulant and a major tranquilizer. When his parents' health insurance ran out, the only "help" they could get from the psychiatrist was a repeat prescription. Four years later, Mr. Ehrlich read that behavioral problems could be caused by sugar and the wrong diet and saw the chance for Daniel to live drug-free and be returned to a normal life. He eliminated sugar from Daniel's diet. Within two weeks Mr. Ehrlich saw a remarkable change, so he stopped getting the drug prescriptions and withdrew Daniel suddenly from the drugs. Two months later, Daniel, who was then 14 years old, hanged himself. Mr. Ehrlich wasn't warned that suicide was a major complication of withdrawal from amphetamine-like drugs.



DEADLY RESTRAINT

"He was held down. Someone just held him down until he stopped breathing....How could people be so cruel to harm an 11-year-old....You've got to love kids, not kill them."

Mother of 11-year-old Andrew McClain,
killed during physical restraint

In 1998 and 1999, working with legislators and the media, CCHR exposed the grisly truth that up to 150 restraint deaths occur each year in the United States. Thirteen of the deaths over a two-year period were of teenagers and children who had been placed under psychiatric "care."

Horror stories emerged of children dying strapped to beds and chairs, others pinned to floors by hospital staff, crying out that they couldn't breathe. One six-year-old boy died alone, of asphyxiation, while strapped to a wheelchair. Family members were frequently not told the circumstances under which their children died, and incredibly some were told that "natural causes," or "accidents" were the cause of death.

While federal regulations were subsequently passed in 1999, since then at least nine more children and teens have died from suffocation or cardiac arrest during violent restraint procedures. The youngest was nine years old.

On October 14, 2002, 17-year-old Charles Chase Moody suffocated during a restraint procedure at a Mason County, Texas, behavioral treatment facility—the fifth death in this chain of facilities since 1988.

The fact is that in spite of legislative safeguards, child restraint deaths continue today.



Since federal regulations were passed in 1999 to curb abusive restraint procedures, nine more youths have died, the youngest was nine.



A CONTINUING LITANY OF DEATH

The death of a child is devastating by any measure. But when a child is killed under the guise of "help," by uncaring mental health professionals and an impassive system, it is unspeakably tragic.

The following list is a damning indictment of what amounts to legalized child abuse dressed up as mental health treatment.

Jeffrey Bogrett, 9

Died December 1, 1995 while being violently restrained at the New England Center for Autism.

Chris Campbell, 13

Died November 2, 1997 from intense, repeated restraints at the Iowa Juvenile Home.

Edith Campos, 15

Died February 2, 1998 while being restrained for not giving staff her family photo at the Desert Hills Center, Arizona.

Paul Choy, 16

Died February 4, 1992 from suffocation while being restrained at Rite of Passage in Nevada.

Casey Collier, 17

Died December 21, 1993 of asphyxiation after being forcibly restrained at the Cleo Wallace Center in Colorado.

Sabrina E. Day, 15

Died February 10, 2000 after being restrained at the North Carolina Group Home.

Sakena Dorsey, 18

Died June 10, 1997 from suffocation during a face down

restraint, with a staff member laying across her back at Foundations Behavioral Health in Pennsylvania. She had a medical history of asthma and swollen tonsils that hindered her breathing.

Mark Draheim, 14

Died December 1998 of asphyxiation while being forcibly restrained by three staff members at Kids Peace in Pennsylvania.

Kara Fuller-Otter, 12

Died June 7, 2001, killing herself while suffering withdrawal from an antidepressant.

Anthony Green, 15

Died May 12, 1991 while being restrained face down on the floor for 15 minutes at the Brookhaven Youth Ranch in Texas.

Jamar Griffiths, 15

Died October 18, 1994 of heart and lung failure while being restrained at the Allen Residential Center in New York.

Diane Harris, 17

Died April 11, 1990 after being violently restrained at the Seguin Community Living Center in Texas.

Tony Haynes, 14

Died July 1, 2001 after being restrained at America's Buffalo Soldiers in Arizona.

Charlotte Holliman, 14

Died July 31, 1992 from hanging herself while on an antidepressant at Truckee Meadows Hospital, Nevada.

Demetrius Jeffries, 17

Died August 26, 1997 from strangulation while in a restraint hold at the Crockett State School in Texas.

Jimmy Kanda, 6

Died September 20, 1997 from strangulation while in a restraint hold at Crow's Next Family Care Home in California.

William "Eddie" Lee, 15

Died September 18, 2000 after being restrained at Obsidian Trails Wilderness Camp in Oregon.

John McCloskey, 18

Died February 24, 1996 from a ruptured liver and a torn colon and small intestine after being sodomized with a broom-like handle while at Western State Hospital in Virginia.

Shinaul McGraw, 12

Died June 5, 1994 of extremely high body temperature after being wrapped in a bed sheet with gauze over her mouth and being restrained to a bed at New Directions, Second Chance in Washington.

Caitlin McIntosh, 12

Died January 5, 2000 in Texas from hanging herself after being on a cocktail of four psychiatric drugs.

Kristal Mayon-Ceniceros, 16

Died February 5, 1999 of respiratory arrest after being restrained face down on the floor by four staff members at New Alternatives in Chula Vista, California.



Thomas Mapes, 17

Died July 8, 1994 of asphyxiation after being handcuffed and pushed face down on the floor at the Youth Center at Topeka in Kansas.

Amanda Mead, 18

Died 1991 from two undiagnosed brain tumors. A California school counselor and psychiatrist had wrongly labeled her as "manic-depressive."

Travis Neal, 13

Died November 24, 1997, in Michigan, collapsing from a heart attack after taking a psychiatric stimulant for years.

Candace Newmaker, 10

Died April 2000 after being wrapped in a sheet and pushed by adults for 70 minutes in a Colorado therapy session.

Cameron Pettus, 12

Died August 2, 1993 in Austin, Texas, from toxic levels of an antidepressant.

Dustin E. Phelps, 14

Died March 1, 1998 after being strapped in a blanket and mattress at a Lancaster foster home in Ohio.

Bobby Jo Randolph, 17

Died September 26, 1996 from asphyxia due to compression of the neck after being restrained by two aides at the Progressive Youth Center in Texas.

Kevin Neil Rider, 14

Died June 3, 2000 in Utah from shooting himself during antidepressant withdrawal.

Eric Roberts, 16

Died February 2, 1996 after being wrapped in a plastic and

foam blanket with Velcro for one hour at Odyssey Harbor in Texas.

Robert Rollins, 12

Died April 21, 1997 from asphyxiation while being restrained face down with arms crossed over his chest after a dispute over his missing teddy bear at Devereaux School in Massachusetts.

Joshua Sharpe, 17

Died December 28, 1999 while being restrained at the Wisconsin Treatment Center.

Macauley Showalter, 7

Died September 30, 2000, in Hutchinson, Minnesota, of cardiac arrest while taking a psychiatric stimulant and three other psychiatric drugs.

Earl Smith, 9

Died January 1, 1995 from asphyxiation due to chest compression while being restrained face down by a Children's Village staff member in Michigan.

Mark Soares, 16

Died April 29, 1998 of cardiac arrest from physical restraint when aides at Wayside Union Academy in Massachusetts thought he was "faking" unconsciousness.

Randy Steele, 9

Died February 6, 2000 of a heart attack while being restrained at Laurel Ridge Hospital in San Antonio. He had an enlarged heart and had been on a stimulant and several other psychiatric drugs.

Jason Tallman, 12

Died May 12, 1993 from suffocation while being

restrained facedown on a pillow at Kids Peace in Pennsylvania.

Bobby Sue Thomas, 17

Died August 16, 1996 from acute cardiac arrhythmia while being restrained face down at Northwood Children's Home in Minnesota.

Timothy Thomas, 9

Died March 11, 1999 while being restrained at the Grandfather Home for Children in North Carolina.

Tanner Wilson, 11

Died February 9, 2001 from a heart attack while being physically restrained at the Gerard of Iowa facility.

Michael Wiltsie, 12

Died February 5, 2000 of asphyxiation while being restrained at Eckherd Youth Alternatives in Florida.

Willy Wright, 14

Died March 4, 2000 from suffocation while being restrained by staff at Southwest Mental Health Center in San Antonio, Texas.

Jaimie Young, 13

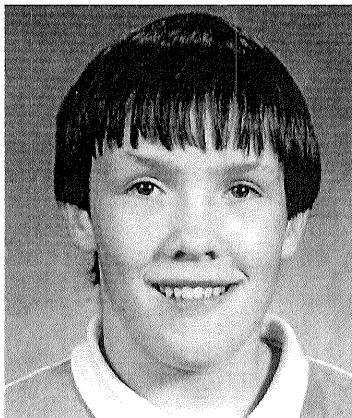
Died June 5, 1993 while on a hike at Ramsey Canyon Hospital & Treatment Center in Arizona. Autopsy found that death was caused by heat stroke with dehydration triggered by 10 times the lethal levels of an antidepressant in her system.

Kelly Young, 17

Died March 4, 1998 of asphyxiation while being restrained on the floor at Brisbane Child Treatment Center in New Jersey.



TRISTAN SOVERN, 1982 - 1998



Sixteen-year-old Tristan Sovern of North Carolina died at the Charter Behavioral Health System's hospital in Greensboro, North Carolina during physical

restraint. He was held face-down, with his arms crossed under his body by at least two mental health assistants when he screamed, "You're choking me...I can't breathe." The assistants knew he was having trouble breathing but neither responded. Tristan had been admitted on February 26, 1998, and less than a week later, he died of asphyxiation during restraint, in which staff shoved a large towel over his mouth and then tied a bed sheet around his head.

ANDREW MCCLAIN, 1987 - 1998

On March 22, 1998, Andrew McClain, 11, a patient at Elmcrest Behavior Network, a psychiatric hospital in Portland, Connecticut, died of traumatic asphyxia and chest compression. Two staff restrained Andrew by lying on top of him in a padded "time out" room. "They thought he was trying to get up, but he was trying to get air," his mother, Lucinda McClain, said. "He was held down. Someone just held him down until he stopped breathing....How could people be so cruel to harm an 11-year-old....You've

got to love kids, not kill them." Andrew had been in the custody of the state Department of Children and Families, and had been a patient at Elmcrest psychiatric hospital for just four days when he died.

ROSHELLE CLAYBORNE, 1981 - 1997



On August 18, 1997, 16-year-old Roshelle Clayborne died during restraint at the Laurel Ridge Residential Treatment Center, a psychiatric facility in San Antonio, Texas.

Roshelle was slammed facedown on the floor; her arms were yanked across her chest, her wrists gripped from behind by a mental health aide. "I can't breathe," she gasped. Her last words were ignored. A syringe delivered 50 milligrams of Thorazine into her body and with eight staffers watching, Roshelle became suddenly still. Blood trickled from the corner of her mouth as she lost control of her bodily functions. Her limp body was rolled into a blanket and dumped in an 8-by 10-foot room used to seclude dangerous patients. After she was restrained, she lay in her own waste and vomit for five minutes before anyone noticed she hadn't moved. Three staff tried in vain to find a pulse. Two went looking for a ventilation mask and oxygen bag, emergency equipment they never found. By the time a registered nurse arrived and began CPR, it was too late. Roshelle never revived.



SUMMARY

"Any child, particularly a boy, in America could be considered to have ADD. The children are normal; they are just not performing."

Mrs. Sue Parry, from Honolulu, whose son stopped taking an ADHD stimulant after developing heart problems

Parents and children's rights are compromised when it comes to psychiatric diagnoses, labels and treatments. The idea of full "informed consent," as it applies to mental health, simply doesn't exist.

Unsuspecting parents typically rely on the professionals, trusting them for an accurate medical diagnosis, unaware that there are no medical diagnoses in psychiatry—only subjective criteria. There are no blood tests, brain scans or any scientific means by which to diagnose a mental disorder.

In 1999, the former U.S. Surgeon General, David Satcher, admitted, "...the diagnosis of mental disorders is often believed to be more difficult than diagnosis of general medical disorders since *there is no definitive lesion, laboratory test or abnormality in brain tissue that can identify the illness.*" [Emphasis added]

Today, it is estimated that between six and eight million American children take psychiatric drugs for ADHD and other so-called learning and behavioral disorders. Some 1.5 million children and teenagers are now prescribed antidepressants. The potential side effects of these newer antidepressants include anxiety, agitation, insomnia, bizarre dreams, suicidal thoughts, hostility and violent behavior.

Frequently, children who are started on mind-altering drugs end up incarcerated in

psychiatric institutions, warehoused and brutally abused to the point of permanent damage.

Parents are being coerced and threatened with charges of medical or educational neglect if they reject a questionable psychiatric diagnosis and refuse to put their child on mind-altering drugs. Children have been wrenched from their family's care simply because their parents favored an alternative, drug-free approach to addressing educational and behavioral problems.

The bottom line is that rather than an enlightened and compassionate mental health system attending to the needs of our young, we have a dangerous and coercive system that stands impassive, not only in the face of repeated failures, but, unbelievably, of child deaths due to treatment.

The last thing our nation needs, the last thing our children should be exposed to, is more risk, yet psychiatrists, their associations and affiliated "patient" advocacy groups today lobby for even earlier identification of children with "mental disorders" and for their treatment with newer "medications."

It is the duty and right of parents to protect their children from further harm. It is the duty of the government to support them in this.



"No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

Article 5, United Nations
Declaration of Human Rights

Workable Treatments Psychiatrists Don't Promote

There are far too many workable alternatives to psychiatric drugging to list them all here. Psychiatry on the other hand, would prefer to say there are none and fight to keep it that way.

Studies show the frequency with which physical illnesses are misdiagnosed as "mental illness"—in one study, 83% of people referred by clinics and social workers for psychiatric treatment had undiagnosed physical illnesses; 42% of those diagnosed with "psychoses" were later found to be suffering from a medical illness; 48% of those diagnosed by psychiatrists for mental treatment had an undiagnosed physical condition.

Dr. Mary Ann Block, author of *No More ADHD*, does allergy testing and develops dietary solutions to "behavioral" problems. She cites a *Journal of Pediatrics* (1995) study showing that sucrose may cause a 10-times increase in adrenaline in children resulting in "difficulty concentrating, irritability, and anxiety."

Professor Stephen J. Schoenthaler, Ph.D., a California State University criminologist, conducted a study at 12 juvenile correctional institutions and 803 public schools, in which the researchers increased fruits and vegetables and whole grains and decreased fats and sugars in children's diets. The juvenile institutions exhibited 47% less "antisocial behavior" in 8,076 confined juvenile delinquents. In the schools, the academic performance of 1.1

million children rose 16% and learning disabilities fell 40%.

Prescribing psychotropic drugs for a disease that doesn't exist, psychiatrist Dr. Sydney Walker noted, is a tragedy because "masking children's symptoms merely allows their underlying disorders to continue and, in many cases, to become worse."

What Parents Can Do

Log onto CCHR's website, <http://www.fightforkids.com> for more information.

Educate themselves. Ensure that they are getting all—not carefully selected—information in order to make an informed choice about their child's educational and medical needs.

Get a thorough medical examination for a child from a non-psychiatric physician. A child could have allergies, lead toxicity, eyesight or hearing problems, be simply in need of tutoring, or something even more basic than that—phonics. The list of possible causes is very long and well documented.

Speak out—be your child's voice. Start or join a parents' group that can speak out about the wrongful labeling and drugging of our children and provide support for each other.

If a child has been targeted or abused in the mental health system, report this to CCHR by calling 1-800-869-2247, or fill out the abuse case form on <http://www.fightforkids.com>



RECOMMENDATIONS

"Clearly, this business of treating minds—particularly this big business of treating young minds—has not policed itself, and has no incentive to put a stop to the kinds of fraudulent and unethical practices that are going on."

U.S. Representative Patricia Schroeder, Chair, House
Select Committee on Children, Youth and Families, 1992

CCHR recommends that legal safeguards be enacted nationally for parents which:

1. Makes it illegal for parents or guardians to be coerced into placing their child on psychotropic drugs as a requisite for his or her remaining in school;
2. Protects parents or guardians against their child being removed from their custody if they refuse to administer a psychotropic drug to their child;
3. Provides parents the right to "informed consent" in relation to solutions to resolve behavior, attention, and learning difficulties which includes all information about alternatives to behavioral programs and psychotropic drugs, including tutoring, vision testing, phonics, nutritional guidance, medical examinations, allergy testing, standard disciplinary procedures, and other remedies known to be effective and harmless;
4. Ensures the "informed consent" procedure includes informing parents that there is diverse medical opinion about the scientific validity of ADHD and other "learning disorders";
5. Ensures that health insurance coverage for mental health services are not made mandatory so that parents are not forced to place their child in such services;
6. Makes the use of restraint procedures on adolescents and children under the age of 16 illegal;

7. Imposes criminal penalties against anyone in the mental health system that violates such laws and protections.

What is CCHR?

The Citizens Commission on Human Rights (CCHR) was co-founded in 1969 by the Church of Scientology and Professor Emeritus of Psychiatry, Thomas Szasz, to investigate and expose psychiatric violations of human rights, and to clean up the field of mental healing.

Today, it has more than 130 chapters in 31 countries. Its board of advisors, called Commissioners, includes doctors, lawyers, educators, artists, businessmen, and civil and human rights representatives.

CCHR has inspired and orchestrated many hundreds of reforms by testifying before legislative hearings and conducting public hearings into psychiatric abuse, as well as by working with media, law enforcement and public officials the world over.

For Further Information:

Citizens Commission on
Human Rights International

6616 Sunset Blvd.
Los Angeles, CA 90028

(323) 467-4242 or (800) 869-2247

<http://www.cchr.org>
and

<http://www.fightforkids.com>

THE BOTTOM LINE IS THAT RATHER THAN AN
ENLIGHTENED AND COMPASSIONATE MENTAL
HEALTH SYSTEM ATTENDING TO THE NEEDS OF
OUR YOUNG, WE HAVE A DANGEROUS AND
COERCIVE SYSTEM THAT STANDS IMPASSIVE,
NOT ONLY IN THE FACE OF REPEATED
FAILURES, BUT, UNBELIEVABLY, OF CHILD
DEATHS DUE TO TREATMENT.

Jan Eastgate

International President
Citizens Commission on Human Rights

Outside View: Are your children crazy?

By JANE ORIENT, M.D., Outside View Commentator

TUCSON, Dec. 15 (UPI) -- Congress and President Bush apparently think that a lot of children have a "mental health" problem. Or that enough of them do to justify taking millions of dollars from taxpayers to fund a universal "mental health screening" for children, and eventually for everyone.

Personally, I think -- from the perspective of a person who never had any -- that almost all children act crazy. Those who don't are, by definition, abnormal, because they don't act like the others.

The main problem with about half of them is that they are boys. Such children are obviously made of snips and snails and puppy dog tails. On the farm there is a solution for that: a procedure for turning boy lambs into non-ram lambs. After a quick little operation, they act like peaceful little lambs instead of aggressive, disruptive rams.

We don't do surgery like that on little boys, of course, but we do have our methods: such as behavioral therapy and chemicals.

There are those who argue with some passion that society has to do something. Bad, disruptive, antisocial or depressed little kids make lots of trouble for parents and schoolteachers. Worse, they can grow up into dysfunctional, unhappy or troublemaking adults. That snotty little boy might become a dissenting, nonconformist or even a rebellious man, who could throw a monkey wrench into our smoothly functioning society. We have to catch them early -- for their own good.

Teams of experts are awaiting the infusion of cash. They'll be ensconced in your child's school before you even know it. A bonus is that your little darlings will probably give them quite a bit of information about you also, and then you too can receive therapy you didn't know you needed.

Do you sometimes raise your voice? Ever spank them? Hug them inappropriately? Have politically incorrect attitudes? Use forbidden words? Own a gun? Smoke cigarettes, especially indoors? Read extremist literature? Refuse to recycle? Prepare for a knock on the door.

There are many tools at the disposal of the mental health squad. Counseling sessions. Drugs (Ritalin, antidepressants, tranquilizers, maybe some new ones that need to be tested on some experimental subjects of your child's age). Group therapy. Removing the child from the home. (This may be a "last resort," but often the mere threat can accomplish wonders.)

If an interview with a child raises concerns, the next step might be a home visit. This could discover poor parenting skills, inadequate housekeeping, harmful literature, or a baby who is crying or has a bruise (signs of abuse?).

It is true that some interventions have potential side effects, say drug dependence or suicide, but to assure the health of the population some shared sacrifice and risk is needed. We will have excellent means of tracking outcomes to improve future therapies. The mental health workers' impressions will all be recorded in the school records. An added benefit could accrue

to would-be employers or college recruiters.

Some cautions are in order. Democrats might think that potential future Republicans are crazy. Republicans might think the opposite. Should an extremist Christian be one of the screeners, he might think that nonbelievers are possessed by the devil. And an extremist secular humanist (if such exist) might think that an overly religious child is at risk for mental illness if not already impaired.

In fact, parents ought to be asking some very serious questions before the government experts interview the first child:

What are the credentials of the screeners? Most importantly, how many children have they raised to adulthood, and with what outcome?

What are the criteria for possible abnormality? What is the scientific validation? How often do different observers agree? Have any long-term studies shown a solid correlation with adult performance in life? Do today's oddball children fail, or might they turn into our greatest achievers?

Will you be allowed to get a second opinion? Can you see the record and enter corrections if indicated? Will the record at any point be destroyed, or will the stigma of a diagnosis such as "personality disorder" follow the child throughout life?

What will happen if your child fails the screen? What sort of treatment will be given? Who will supervise it? What if you don't approve of it?

What's the very worst thing that the program will have the power to do to you or your child, say if your worst enemy was to gain control of it?

Who might profit from the program (perhaps discoverable by asking who lobbied for it)? Do drug companies expect to have a large number of new consumers of their psychoactive drugs?

What are the results of studies of long-term use of drugs like Ritalin, which has effects on the brain similar to those of cocaine? Have there even been any such studies?

Can you refuse to participate in the program? If you do refuse, what are the repercussions?

What is the evidence that the program, at best, will be anything other than a waste of millions of dollars? Miraculously, throughout human history most of those crazy children have become stable, productive adults without federally mandated psychiatric treatment. Still more amazingly, their parents have managed also.

Psychiatry in the hands of government, instead of independent physicians who are working for patients, reeks of Orwell's "1984" or the Soviet era. The very need to ask the questions should tell us the right answer for this program: It's crazy.

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(United Press International's "Outside View" commentaries are written by outside contributors who specialize in a variety of issues. The views expressed do not necessarily reflect those of United Press International. In the interests of creating an open forum, original submissions are invited.)

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Diagnoses Taken from DSM

1. Mathematics Disorder
2. Disorder of Written Expression
3. Expressive Language Disorder
4. Communication Disorder
5. Conduct Disorder
6. Disruptive Disorder
7. Separation Anxiety Disorder
8. Selective Mutism
9. Caffeine Intoxication
10. Cannabis-induced Anxiety Disorder
11. Nicotine Dependence
12. Nicotine Withdrawal
13. Other or Unknown Substance Intoxication
14. Social Phobia
15. Anxiety Disorder due to _____
16. Pain Disorders
17. Hypoactive Sexual Desire Disorder
18. Premature Ejaculation Disorder
19. Gender Identity Disorder
20. Sleepwalking Disorder
21. Insomnia due to _____
22. Narcissistic Personality Disorder
23. Medication-induced Movement Disorders
 - Neuroleptic-Induced Parkinsonism
 - Tardive Dyskinesia
 - Postural Tremor
24. Parent-Child Relational Problem
25. Partner Relational Problem
26. Sibling Relational Problem
27. Relational Problem not Otherwise Specified
28. Physical Abuse of Child (focus on victim)
29. Neglect of Child (focus on victim)
30. Noncompliance with Treatment
31. Malingering
32. Bereavement
33. Academic Problem
34. Occupational Problem
35. Identity Problem
36. Religious or Spiritual Problem
37. Phase of Life Problem

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S.F. No. 1028 - Criminal Offenders with Serious and Persistent Mental Illness Incarceration Discharge Plans

Author: Senator Linda Berglin

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 11, 2005



Section 1 expands the discharge plans for offenders with serious and persistent mental illness by requiring the Commissioner of Human Services, in collaboration with the Commissioner of Corrections, to offer to develop a discharge plan for every offender who has been incarcerated for more than three months and is being released from a county jail or a county regional jail. Further, if an offender is being released on supervised release, the commissioner may offer the offender the option to have a discharge plan developed. At least 75 days before discharge, instead of two and a half months, the offender's agent must make appointments for the offender to meet with a psychiatrist, and with other appropriate program staff.

This section also adds a subdivision that requires state correctional facilities, county jails, and county regional jails to arrange for offenders with serious and persistent mental illness to have photo identification when they are released from incarceration. The photo identification card must not disclose the offender's incarceration or criminal record, and must list an address other than the address of the correctional facility or jail.

This section is effective January 1, 2006.

Section 2 amends the county jail chapter of law, consistent with section 1, requiring the Commissioner of Human Services, in collaboration with the Commissioner of Corrections, to develop a discharge plan for community-based services for every offender with serious and persistent mental illness who is incarcerated for more than three months and is being released from county jail or regional jail.

This section is effective January 1, 2006.

Section 3 provides a blank appropriation to the Commissioner of Human Services for purposes of providing discharge plans.

JW:rd

Senators Berglin, Koering, Kubly, Solon and Dille introduced--

S.F. No. 1028: Referred to the Committee on Health and Family Security.

1 A bill for an act

2 relating to human services; providing for discharge
3 plans for offenders with serious and persistent mental
4 illness who are released from county jails or county
5 regional jails; appropriating money; amending
6 Minnesota Statutes 2004, section 244.054; proposing
7 coding for new law in Minnesota Statutes, chapter 641.

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

9 Section 1. Minnesota Statutes 2004, section 244.054, is
10 amended to read:

11 244.054 [DISCHARGE PLANS; PHOTO IDENTIFICATION; OFFENDERS
12 WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.]

13 Subdivision 1. [OFFER TO DEVELOP PLAN.] The commissioner
14 of human services, in collaboration with the commissioner of
15 corrections, shall offer to develop a discharge plan for
16 community-based services for every offender with serious and
17 persistent mental illness, as defined in section 245.462,
18 subdivision 20, paragraph (c), who (1) is being released from a
19 correctional facility, or (2) has been incarcerated for more
20 than three months and is being released from a county jail under
21 section 641.01 or a county regional jail under section 641.261.

22 If an offender is being released pursuant to section 244.05, the
23 commissioner may offer the offender may-choose the option to
24 have the discharge plan made one of the conditions of the
25 offender's supervised release and shall follow the conditions to
26 the extent that services are available and offered to the

1 offender.

2 Subd. 2. [CONTENT OF PLAN.] If an offender chooses to have
3 a discharge plan developed, the commissioner of human services
4 shall develop and implement a discharge plan, which must include
5 at least the following:

6 (1) at least 90 days before the offender is due to be
7 discharged, the commissioner of human services shall designate
8 an agent of the Department of Human Services with mental health
9 training to serve as the primary person responsible for carrying
10 out discharge planning activities;

11 (2) at least 75 days before the offender is due to be
12 discharged, the offender's designated agent shall:

13 (i) obtain informed consent and releases of information
14 from the offender that are needed for transition services;

15 (ii) contact the county human services department in the
16 community where the offender expects to reside following
17 discharge, and inform the department of the offender's impending
18 discharge and the planned date of the offender's return to the
19 community; determine whether the county or a designated
20 contracted provider will provide case management services to the
21 offender; refer the offender to the case management services
22 provider; and confirm that the case management services provider
23 will have opened the offender's case prior to the offender's
24 discharge; and

25 (iii) refer the offender to appropriate staff in the county
26 human services department in the community where the offender
27 expects to reside following discharge, for enrollment of the
28 offender, if eligible, in medical assistance or general
29 assistance medical care, using special procedures established by
30 process and Department of Human Services bulletin;

31 (3) at least ~~2-1/2-months~~ 75 days before discharge, the
32 offender's designated agent shall secure timely appointments for
33 the offender with a psychiatrist no later than 30 days following
34 discharge, and with other program staff at a community mental
35 health provider that is able to serve former offenders with
36 serious and persistent mental illness;

1 (4) at least 30 days before discharge, the offender's
2 designated agent shall convene a predischarge assessment and
3 planning meeting of key staff from the programs in which the
4 offender has participated while in the correctional facility,
5 county jail, or county regional jail, the offender, the
6 supervising agent, and the mental health case management
7 services provider assigned to the offender. At the meeting,
8 attendees shall provide background information and continuing
9 care recommendations for the offender, including information on
10 the offender's risk for relapse; current medications, including
11 dosage and frequency; therapy and behavioral goals; diagnostic
12 and assessment information, including results of a chemical
13 dependency evaluation; confirmation of appointments with a
14 psychiatrist and other program staff in the community; a relapse
15 prevention plan; continuing care needs; needs for housing,
16 employment, and finance support and assistance; and
17 recommendations for successful community integration, including
18 chemical dependency treatment or support if chemical dependency
19 is a risk factor. Immediately following this meeting, the
20 offender's designated agent shall summarize this background
21 information and continuing care recommendations in a written
22 report;

23 (5) immediately following the predischarge assessment and
24 planning meeting, the provider of mental health case management
25 services who will serve the offender following discharge shall
26 offer to make arrangements and referrals for housing, financial
27 support, benefits assistance, employment counseling, and other
28 services required in sections 245.461 to 245.486;

29 (6) at least ten days before the offender's first scheduled
30 postdischarge appointment with a mental health provider, the
31 offender's designated agent shall transfer the following records
32 to the offender's case management services provider and
33 psychiatrist: the predischarge assessment and planning report,
34 medical records, and pharmacy records. These records may be
35 transferred only if the offender provides informed consent for
36 their release;

1 (7) upon discharge, the offender's designated agent shall
2 ensure that the offender leaves the correctional facility,
3 county jail, or county regional jail with at least a ten-day
4 supply of all necessary medications; and

5 (8) upon discharge, the prescribing authority at the
6 offender's correctional facility, county jail, or county
7 regional jail shall telephone in prescriptions for all necessary
8 medications to a pharmacy in the community where the offender
9 plans to reside. The prescriptions must provide at least a
10 30-day supply of all necessary medications, and must be able to
11 be refilled once for one additional 30-day supply.

12 Subd. 3. [PHOTO IDENTIFICATION.] State correctional
13 facilities, county jails, and county regional jails shall
14 arrange for offenders with serious and persistent mental illness
15 to have photo identification when they are released from
16 incarceration. Correctional facilities, county jails, and
17 county regional jails will ensure that offenders who lack photo
18 identification are issued a photo identification card before or
19 immediately upon release. The photo identification card must
20 not disclose the offender's incarceration or criminal record.
21 The photo identification card must list an address other than
22 the address of a correctional facility, county jail, or county
23 regional jail.

24 [EFFECTIVE DATE.] This section is effective January 1, 2006.

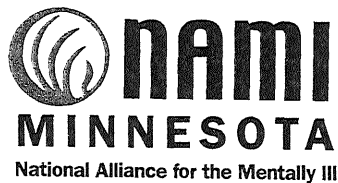
25 Sec. 2. [641.155] [DISCHARGE PLANS; OFFENDERS WITH SERIOUS
26 AND PERSISTENT MENTAL ILLNESS.]

27 Pursuant to section 244.054, the commissioner of human
28 services, in collaboration with the commissioner of corrections,
29 shall offer to develop a discharge plan for community-based
30 services for every offender with serious and persistent mental
31 illness, as defined in section 245.462, subdivision 20,
32 paragraph (c), who has been incarcerated for more than three
33 months and is being released from a county jail or a county
34 regional jail under this chapter.

35 [EFFECTIVE DATE.] This section is effective January 1, 2006.

36 Sec. 3. [APPROPRIATION.]

1 \$..... is appropriated to the commissioner of human
2 services for fiscal year 2006 for the purpose of providing
3 discharge plans under Minnesota Statutes, section 244.054, to
4 offenders with serious and persistent mental illness who are
5 released from county jails or county regional jails. This
6 appropriation is in addition to any other appropriations to
7 provide discharge plans under Minnesota Statutes, section
8 244.054.



March 17, 2005

Dear Members of the Health and Family Security Committee:

The National Alliance for the Mentally Ill of Minnesota is strongly supporting SF 1000 and SF 1028. The increasing numbers of people with mental illness that are ending up in our corrections system is of great concern to NAMI. While we will continue to work on developing community services so that people don't end up in prison or jail due to their untreated or undertreated mental illness, we are also working to make sure that when someone with mental illness leaves our jails and prisons that they have access to appropriate medication and mental health services.

The Criminal Justice Mental Health Consensus Project Report which was coordinated by the Council of State Governments, contains excellent recommendations as to what can be done all along the continuum. They specifically recommend ensuring that people with mental illness have discharge plans which include provisions for applying for health care programs so that they will have coverage when they leave the prison. While Minnesota has done this, the provisions contained in SF 1000 would streamline this process and make it more effective. Some people with mental illness end up in our prisons due to lack of treatment. Under our case management laws, the prison does not qualify as an institutional setting. SF 1000 would allow people to qualify if they meet all the provisions except for the hospitalization/residential treatment facility. This will really help people from ending up back in our criminal justice system.

The Bazelon Center for Mental Health Law issued a report in 2001 on how to help people with mental illness successfully transition from jail to the community. An important piece of a successful transition is ensuring that people with mental illness are connected to community supports and are enrolled in any health care or economic assistance programs for which they are eligible. SF 1028 requires that discharge plans be developed for people with mental illness who have been in jail more than three months. The bill also requires corrections to provide photo identification for people being discharged. If someone does not have a driver's license, a photo identification is necessary for check cashing, job applications, etc. While this bill does have a cost associated with it, NAMI believes it will be cheaper than continuing the current revolving door.

The Re-Entry Council released a report this year called "Charting the Safe and Successful Return of Prisoners to the Community." In their recommendations they underlined the importance of ensuring that people with mental illness who are eligible for public benefits receive them immediately upon their release from incarceration. They believe that it is very important for people to obtain the necessary mental health treatment and supports when they leave jail or prison.

Thank you, and again I urge your support for these two pieces of legislation.

Sincerely,

Sue Abderholden
Executive Director

Member



Community
Solutions Fund

NAMI-MN National Alliance for the Mentally Ill of Minnesota

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