STATE ADVISORY COUNCIL ON MENTAL HEALTH
and Subcommittee on Children's Mental Health

2004 Report *to the* Governor and Legislature

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Letter from the Chair

The Subcommittee on Children's Mental Health and the State Advisory Council applaud the administration's support of and interest in addressing the mental health needs of Minnesotans. During these times of fiscal constraint, it is imperative that mental health services are delivered effectively, efficiently and with active collaboration among respective state agencies.

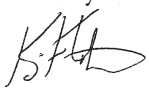
The President's New Freedom Commission on Mental Health report, Achieving the Promise: Transforming Mental Health Care in America (July 2003) highlights the difficulties in the mental health system from a national perspective. Minnesota is not unique in its struggles to provide "the right care at the right time in the right place." Persons with mental illnesses, their families, loved ones and their communities continue to face many challenges in accessing appropriate services. Subcommittee and Council members are personally and professionally acquainted with the grief and loss that results from the lack of viable resources. We continue to hear that people have trouble finding affordable housing; career development and employment support services; culturally and age appropriate services; mental health professionals and access to medications. At worst, this lack of appropriate services may result in death by suicide or in loved ones entering the corrections system.

The Minnesota Mental Health Action Group (MMHAG), hosted by Department of Human Services Commissioner Kevin Goodno and Gary Cunningham of the Citizens League, with support from Michael Scandrett and staff at Halleland Health Consulting, is an example of an inclusive effort to address the problems in Minnesota's mental health system(s)—public and private. Hundreds of people have been involved in this work, through various action teams and work groups. MMHAG plans to develop legislative proposals for the 2005 session; other changes will be made by agreements among the parties involved.

The Medicare Prescription Benefit (Part D) is due for implementation January 2006. This law poses a significant threat to the health and welfare of Minnesotans with disabilities, particularly those who are low income and who rely on medications to maintain their ability to function in work, school, and life. The law specifically prohibits states from augmenting the Medicare prescription benefit with Medical Assistance (MA) funds in any way (only states' general funds may be used). In addition, stringent "clawback" provisions and additional administrative responsibilities may result in net increased costs to states. The Subcommittee and Council urge Governor Pawlenty and the Minnesota legislature to advocate for technical amendments to this new law so that persons of all ages who have mental illnesses will not be adversely affected.

We also ask the Governor to convene the Children's Cabinet to coordinate the development and delivery of mental health services for children on the state and local levels so that children's mental health services are available to all Minnesota children in a cost-effective manner. (Minn. Stat. § 245.4873, Subd.1&2).

Respectfully submitted,



Kris Flaten, Chair

Introduction

The Minnesota State Advisory Council on Mental Health was established in 1987 by Minnesota Statute 245.697. Federal Law PL 106-321 (2000) requires that the mental health council provide input to the state's application and implementation report for continued federal block grant funds. This is submitted to the Center for Mental Health Services (CMHS), located within the Substance Abuse and Mental Health Services Administration (SAMHSA). The Council is required to report biannually to the Governor and Legislature (Minnesota Statute 245.697 Subd. 3). The Subcommittee on Children's Mental Health was established in 1989 under Minnesota Statute 245.697 Subd. 2a.

The State Advisory Council on Mental Health is composed of 30 members appointed by the governor, representing a broad range of constituencies and stakeholders from across the state. The Council includes consumers of mental health services, family members of consumers of mental health services, providers of health and mental health services, state legislators, county commissioners, representatives from state departments, and advocacy organizations.

The Subcommittee on Children's Mental Health is mandated to make recommendations to the Council on children's mental health issues. The Subcommittee is composed of 30 members, appointed by the chair of the council and includes parents of children with emotional disturbances, a former consumer of children's mental health services, providers of children's mental health services, state and county elected officials, representatives of various state departments and advocacy organizations.

The Children's Subcommittee and State Advisory Council have a joint standing committee on the federal block grant process and coordinate their work in many ways.

Executive Summary

The State Advisory Council and Children's Subcommittee developed priorities for this report through a process that included all members as of June 2004:

1. Early intervention and prevention Services
2. Disparities in mental health services
3. Disparities resulting from recent changes to Minnesota laws
4. Outreach to diverse communities
5. Mental health and the schools
6. Coordination between public and private mental health systems
7. Restructuring of State Operated Services

These issues address many of the items listed in the six goals of the President's New Freedom Commission Report, *Achieving the Promise: Transforming Mental Health Care in America* (July 2003)[1]. Those six goals include:

1. Americans understand that mental health is essential to overall health
2. Mental health care is consumer and family driven
3. Disparities in mental health services are eliminated
4. Early mental health screening, assessment, and referral to services are common practice
5. Excellent mental health care is delivered and research is accelerated
6. Technology is used to access mental health care and information

In addition to these issues, the Council and Subcommittee continue to be concerned about the importance of overcoming stigma, persons entering the corrections and juvenile justice systems due to inability to access appropriate mental health services, employment for persons with mental illnesses, services to seniors, homelessness, and the lack of affordable housing.

[1] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Goal #1: Americans understand that mental health is essential to overall health

The National Strategy for Suicide Prevention published in 2001[2], preceded by *The Surgeon General's Call to Action to Prevent Suicide* in 1999[3], relies on the public health approach to intervene and prevent deaths by suicide. Minnesota followed a parallel process in developing the state suicide prevention plan and has been a leader in implementing suicide prevention projects through 11 grants managed by the Minnesota Department of Health. The Office of the Ombudsman for Mental Health and Mental Retardation recently developed a fact sheet for hospitals and treatment programs to use in educating patients and their families about risk factors for suicide and protective measures that individuals and their families can take to lessen the likelihood of death by suicide.

Mental health concerns have hit the media through several recent incidents that involved law enforcement officers. The Council has supported initiatives to increase the training of law enforcement personnel so that they can respond effectively to persons experiencing mental health crises.

Goal #2: Mental health care is consumer and family driven, and

Goal #3: Disparities in mental health services are eliminated

Parity

In order to achieve the goal of eliminating disparities in mental health services, there must be parity between the physical and mental health systems. Medical evidence of biochemical changes in brain structure and function continues to build, yet the health care system treats mental illnesses differently and separately from other medical illnesses, often requiring additional and burdensome documentation from the provider and consumer in order to access necessary services. The term "behavioral services" continues in use — even though most persons with mental illnesses don't have any higher incidence of behavioral problems than persons with other long-term health conditions. The lack of parity: philosophically, medically, and in financing, strikes increasing numbers of

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[2] *National Strategy for suicide prevention: Goals and objectives for action.* Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service. 2001.

[3] U.S. Public Health Service, *The Surgeon General's Call to Action to Prevent Suicide*, Washington, D.C. 1999.

people as unfair and wrong. Specifically, the Council supports:

- Technical amendment or repeal of the Medicare prescription drug benefit as applied to persons who are low income and/or dually eligible for Medicare and MA (Medical Assistance).
- Efforts to make Medicare coverage equitable by requiring the same level of co-payments for all medical appointments (currently a 20 percent co-pay except for mental health services that require a 50 percent co-pay)
- Federal legislation that requires all health coverage to include mental health services on par with other illnesses.
- Expansion of the Family and Medical Leave Act to cover all working parents.[4]

Disparities resulting from recent Minnesota legislation

The Council and Subcommittee recognize that the state of Minnesota is in a difficult financial situation. However, it does seem that persons of low income and/or who have mental illnesses/emotional disturbances have been disproportionately adversely affected by state budget cuts in the areas of health care and social services. For example, with infants who may be at risk primarily of emotional disturbance, "there is a pressing need to strike a better balance between options that support parents to care for their infants at home and those that provide affordable, quality child care that enables them to work or go to school."[5] Legislative changes to Minnesota's MFIP program make it very difficult for low-income parents to address the needs of their children who may have significant

[4] It is well documented that use of infant care is substantially lower in countries that have generous parental leave policies (Kamerman and Kahn, 1995). The Family and Medical Leave Act requires employers with 50 or more workers to offer a job-protected family or medical leave of up to 12 weeks to qualifying employees (those who have worked at least 1,250 hours in the previous year) who need to be absent from work for reasons that meet the terms of the law, including the need to care for a newborn or a newly adopted or new foster child. Expansion of the law will enable parents to better care for newborn children and children with emotional disturbances. *From Neurons to Neighborhoods, The Science of Early Childhood Development, Committee on Integrating the Science of Early Childhood Development.* Jack P. Shonkoff and Deborah A. Phillips, Editors. Board on Children, Youth, and Families, National Research Council and Institute of Medicine, NATIONAL ACADEMY PRESS, Washington , D.C., p.297.

[5] *Ibid* p. 392

health conditions or risks, including emotional disturbances. Changes to Minnesota's eligibility criteria and health care programs are expected to result in 37,000 people losing health coverage.

The following recommendations are related to recent changes in Minnesota laws:

- Amend the MA co-payment requirements so that persons shall continue to receive prescriptions and services, even if they cannot afford the co-pays.[6]
- Exempt those persons who are living in residential facilities (often receiving a maximum of $94 for personal needs) and those who are spending more than 50 percent of their income for housing from the MA co-payment requirements.
- Limit the co-payment to the amount charged for a generic prescription for those prescriptions where a generic is not available.
- Restore spenddown provisions to income eligibility determinations for General Assistance Medical Care (GAMC) (removed by 2003 legislation).
- Restore MinnesotaCare GAMC to previous income eligibility and benefit levels.

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[6] Effective 10/1/03, the following co-pays were applied to Medical Assistance (MA) and General Assistance Medical Care (GAMC):

$3 per non-preventive office visit
$6 for non-emergency visits to a hospital emergency room
$3 per brand name prescription
$1 per generic drug prescription
Additional co-pays apply to GAMC

Almost all persons receiving Medical Assistance are living below 75 percent of poverty, on less than $562/month. They do not have the resources to make these kinds of co-payments.

Co-pays do ***not*** apply to children under 21 or to individuals in hospitals or nursing homes

Co-pays do ***not*** apply to services provided by community mental health centers and, regardless of provider: home-based services, case management, clozaril monitoring, lab tests, psychotherapy, psychiatrist services, day treatment, partial hospitalization, adult rehabilitative MH services (ARMHS) and health and behavior assessment and intervention.

Co-payments are not required for anti-psychotic medications such as Haldol, Serentil, Thorazine, Clozaril, Geodon, Risperdal, and Zyprexa. Co-payments will be required for all other drugs, including drugs used to treat bipolar disorder and depression, such as Depakote, Eskalith, Lithobid, Luvox, Paxil, Prozac, and Zoloft.

Co-pays for prescription drugs are limited to $20 per month per person

For individuals who are dual eligible for both MA and Medicare, co-pays will not apply to Medicare covered services

Minnesota Family Investment Program (MFIP) recommendations:

- Restore the full MFIP grant for households with family members who have disabilities and receive SSI.[7]
- Reinstate 12-month work participation exemption for MFIP parents.[8]

Childcare Assistance Recommendation:

- Restore eligibility and funding for childcare assistance to at least pre-2003 levels.

Rural mental health issues

Rural Minnesota experiences unique issues in accessing certain types of mental health services. Rural demographics are changing, with an increase in the percentages of seniors and of immigrant and refugee populations. Transportation is a major issue for many rural Minnesotans, particularly those who do not drive or who have to travel long distances for services, especially in crisis situations.

In Minnesota, there are only 10 psychiatrists per 100,000 population versus 16 psychiatrists per 100,000 nationwide. In rural areas, the ratio falls to 7.3 psychiatrists per 100,000 population. Statistics reveal that 83 percent of psychiatrists in Minnesota practice primarily in urban areas (seven-county metro, Olmsted, Stearns and St. Louis counties).

Studies show that rural patients prefer to discuss mental health issues with their primary care physician than to consult a specialist. Primary physicians may lack adequate training in mental health diagnosis and treatment.

Improve access to quality care that is culturally competent

Although there is an increase in the awareness and understanding of the unique mental health needs of communities of diverse cultures and languages on the federal, state and local levels, the implementation of recommendations at all levels of government has been slow and minimal. Consequently, culturally and linguistically diverse communities continue to be under or improperly served.

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[7] The 2003 legislature reduced the MFIP grants for households with family members with a disability who receive SSI. Grants are reduced by $125 per month for each family member on SSI. SSI, or Supplemental Security Income, is a federal program that provides assistance to adults and children with severe disabilities, including serious emotional disturbances and mental illnesses. SSI grants are approximately $500 per month and are intended to help meet the family's basic needs for shelter, clothing, or food. Reducing the incomes of these families undermines the family's ability to care for their relatives with disabilities.

[8] Current policy is a one-time 12-week exemption rather than 12-month work participation exemption.

The number of immigrants, refugees and persons from diverse cultures to the state of Minnesota continues to grow. Thus the need for cultural and linguistic competence[9] in mental health services is even more imperative. Implementation of the following recommendations will make mental health services competent and effective for all residents of the state—irrespective of their origin and ethnicity:

- Establish state standards for mastery of cultural and linguistic skills in working with persons with mental illnesses/emotional disturbances.
- Require state wide training in cultural and linguistic competence for all administrators and employees in all state departments, counties and private health plans. [10]
- Make such training a licensure requirement in the state of Minnesota for all mental health providers.
- All employees and trainees working in the human services and mental health services, should demonstrate mastery and ongoing implementation of cultural and linguistic skills in working with their clients, as evaluated by state established standards.
- Emphasize culturally and linguistically competent screening, identification and assessment tools and methods for all children and families across all "basic spheres of life" -- social, physical, intellectual, emotional (including chemical health) and spiritual [Dr. Allden,1999].[11]
- Ensure that all children and families from diverse communities have access to culturally and

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[9] *"Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. `Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. `Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities"* (Based on Cross, T., Bazron, B., Dennis, K., & Isaacs, M., (1989). *Towards A Culturally Competent System of Care Volume I*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center) See also: [8] Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda, *Federal Register: December 22, 2000 (Volume 65, Number 247) [Page 80865-80879] http://www.omhrc.gov/clas/finalcultural1a.htm#final4*

[10] *Guidelines for Culturally Competent Organizations*, January 2004, Minnesota Department of Human Services. See this document for explanation of cultural and linguistic competence, pp. i-vi.

[11] *English Language Learners (ELL) Companion to Reducing Bias in Special Education Evaluation.* Chapter 12: Mental Health Issues Affecting Immigrants and Refugees. Prepared by Community-University Health Care Center (CUHCC) University of Minnesota, March 2003, for Minnesota Department of Children, Families and Learning.

linguistically competent providers and interpreters without disruptive removal of children from their home, community and educational settings. Services should be family centered and include bilingual and bicultural providers "at no additional cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation."[12]

- Ensure that members of minority and diverse communities are provided with essential mental health education in their own language and by their cultural representatives so that they understand their mental health needs and are accepting of and able to benefit from services available to them.
- Encourage competent mental health providers to serve communities with high needs through state-sponsored special incentives (e.g. educational loan forgiveness programs).
- Promote the study and development of evidence-based practices within culturally diverse communities that respect the unique and traditional values of those communities (including culturally based methods of healing).
- Promote and improve diverse employee representation in state and county departments, proportionate to demographics of the communities they serve, and provide a list of individuals from diverse communities who can be accessed for consultation.

[12] "Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda," *Federal Register: December 22, 2000 (Volume 65, Number 247) [Page 80865-80879] http://www.omhrc.gov/clas/finalcultural1a.htm#final4*

Goal #4: Early mental health screening, assessment and referral to services are common practice

A. Kathryn Power, director of the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA), presented the vision for SAMHSA's Strategic Prevention Framework. Quoting the National Institute of Mental Health, she said, "'Prevention refers not only to interventions that occur before the initial onset of a disorder, but also to interventions that prevent co-morbidity, relapse, disability, and the consequences of severe mental illness.…'" She added, "Good prevention focuses on common risk factors that can be altered."[13]

Mental health prevention and intervention strategies need to take place everywhere people are: in schools, colleges, workplaces, faith communities, civic organizations, jails and prisons. 'Dr. Robert Haggerty, a former Institute of Medicine committee chair, believes we can decrease mental illnesses the same way we have decreased heart disease—through preventive intervention. "Mental illnesses are not preordained," he says. "Research indicates that it may be possible to prevent many mental disorders if the proper steps are taken. If we were less fatalistic about mental illness, we could avoid tremendous suffering…researchers are now looking at ways to intervene during the prodromal—or early symptom—phase of manic-depressive illness and schizophrenia. Their research suggests that it may be possible to actually prevent the onset of a psychotic episode and its traumatic, disabling effects."[14] Many persons seem to first experience mental illnesses in the 17to 25 year old range, often a time of transition, with the first move away from home, experience with full-time work, or post-secondary education. Thus it is important to develop and fund programs targeted towards prevention and early intervention strategies in high schools and on college campuses.

Promote the mental health of young children

The Subcommittee and Council endorse several of the policy recommendations from the Institute of Medicine's compendium, *Neurons to Neighborhoods: The Science of Early Childhood Development:*

1. Develop and fund all-day kindergarten programs statewide that integrate socio-emotional and pre-academic skill development. There should

[13] Kathyrn Power, Director, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Dept. of Health and Human Services, at the SAMHSA in-services training on the strategic prevention framework, Rockville, MD. July 28, 2004, p. 1.

[14] Dr. Robert Haggerty, at the SAMHSA in-services training on the strategic prevention framework, Rockville, MD. July 28, 2004., p. 4.

be major efforts to first establish these in neighborhoods with diverse populations and high percentages of recent immigrants. We particularly noted the critical role of self-regulatory capacity in early school success. "School readiness initiatives should be judged not only on the basis of their effectiveness in improving the performance of the children whom they reach, but also on the extent to which they make progress in reducing the significant disparities that are observed at school entry in the skills of young children with differing backgrounds."[15]

2. Increase the state's capacity to address the mental health needs of young children by:
   - Developing interdisciplinary training for public health, mental health, education and early childhood professionals;
   - Providing mental health screening, referral and consultation in all Head Start programs;
   - Developing therapeutic preschools, utilizing the Children's Therapeutic Services and Supports (CTSS) benefit of Minnesota Health Care Programs and parallel benefits in private insurance plans;
   - Providing reimbursement to mental health professionals for consultation to primary care providers, childcare facilities, and early childhood programs.

The rationale for these recommendations: "Substantial new investments should be made to address the nation's seriously inadequate capacity for addressing young children's mental health needs. Expanded opportunities for professional training and incentives for individuals with pertinent expertise to work in settings with young children are essential first steps toward more effective screening, early detection, treatment and ultimate prevention of serious childhood mental health problems." [16]

3. Ensure that training for childcare providers includes the development of skills to work with young children with mental health challenges, such as has been done by Minnesota Project Exceptional. This inclusion model supports continuous enrollment of children with mental health challenges in their child care settings and is

[15] *From Neurons to Neighborhoods, The Science of Early Childhood Development, Committee on Integrating the Science of Early Childhood Development.* p. 388.

[16] *Ibid,* p.388.

based on, "The major funding sources for child care and early childhood education should set aside a dedicated portion of funds to support initiatives that jointly improve the qualifications and increase the compensation and benefits routinely provided to children's non-parental caregivers. These initiatives can be built on the successful experience of the U.S. Department of Defense." [17]

4. Environmental protection, perinatal health services, and early intervention efforts should be substantially expanded to reduce documented risks that arise from harmful prenatal and early postnatal neuro-toxic exposures[18]:
   - Minnesota Department of Health (MDH) and the Department of Human Services (DHS) provide joint training to professionals in local public health, social services, education, children's mental health and health care about the known relationships between mental health diagnosis/disorders in children and environmental exposures and the ingestion (intentional and non-intentional) of alcohol, drugs and chemicals.
   - DHS and MDH develop professional collaboration between local public health, social service and children mental health agencies and organizations and promote the use of scientifically based strategies to prevent or reduce chemical and environmental exposure for pregnant women, children and their families. Public health nursing and other home visiting programs are ideal venues for this collaboration.
   - DHS and MDH jointly plan for research and data collection projects that will enhance the understanding of the relationship between mental health disorders, psychosocial predictors and chemical and environmental exposures.
   - DHS and MDH work collaboratively to disseminate public information through presently available means, including Web sites, regarding the known relationships between chemical and environmental toxins and children's mental health disorders.

[17] *Ibid*, p. 393

[18] *Ibid*, P.393

5. Early intervention efforts should be substantially expanded to reduce documented risks that arise from seriously disrupted early relationships due to chronic mental health problems, substance abuse, and violence in families.":[19]
   - Expand integrated public health/mental health/child welfare collaborations, such as those developed by Carlton and Olmsted Counties in their Federal Block Grant pilot projects. [20]
   - Expand substance abuse treatment options for parents that allow children to receive appropriate supports and protections while remaining with their parents.
   - Create or expand programs that reduce the impact of domestic and community violence on children's mental health development. Current Minnesota examples include the Harriet Tubman/ Minneapolis Police Program, a replication of the Yale CSC Child Witnesses of Violence Program and the St. Could Women's Shelter Children's Mental Health Program.

Improve and expand school mental health programs

Some children are not successful because the systems designed to serve them have been unable to overcome systemic barriers to integration and coordination between schools and other mental health services. A coordinated statewide effort is needed to create and sustain the policies and procedures that facilitate coordination across systems and remove the following barriers:

- Fragmentation and concerns about liability for mental health services, especially as it pertains to service coordination between the educational and mental health systems;
- Insufficient funding to allow participation by mental health providers in coordinated, family-friendly approaches aimed at developing multi-service plans to address the comprehensive needs of children and families;
- Concern about the lack of culturally appropriate resources, training, and understanding of mental health issues in the schools; and
- Lack of sufficient support and training for implementation of

[19] Ibid, P.393

[20] These projects provide services and supports for parents with mental illnesses or emotional disturbances.

evidence-based practices that help facilitate students' success in the schools.

Effective models to address these concerns exist but are not available statewide. The following should be implemented in every community:

- A process for coordinating services into a single plan such as IIIP (Individualized Interagency Intervention Plan);
- Family and strengths-based planning such as wraparound services;
- Designated service coordinators, such as family/school coordinators, liaisons or case managers;
- Federal funding for grant initiatives targeted towards innovative and coordinated services for mental health services in the schools;
- Family support groups and advocacy organizations that help families and professionals access mental health services in the schools; and
- An integrated continuum of school and community-based mental health services that implement evidence-based practices.[21]

A coordinated statewide effort is needed so that children's mental health services are developed and delivered at the local level in schools and in the community. This will ensure that strength-based, family-driven services are available in the least restrictive environment to support early identification, assessment, service coordination and on-going treatment.

[21] *Report on Minnesota's Family Services and Children's Mental Health Collaboratives*, October 2003, Minnesota Department of Human Services.

The Public and Private Mental Health Systems

The public and private mental health systems are fragmented with wide variations across the state in terms of the types of services available, access to services and quality of those services. Partnerships have begun to develop between the public and private systems. One example is the East Metro Adult Crisis Stabilization Collaborative (EMAC), a collaboration of 12 organizations, including counties, hospitals, health plans, and the state. EMAC started in July 2003 and is funded through a combination of public and private funds. The goal is to provide innovative alternatives to hospitalization by expanding community resources in crisis interventions. The result has been improved access to crisis services that meet the individual's level of need and are often based in the community rather than the hospital.

The Minnesota Integrative Behavioral Healthcare Coalition is a second example of a partnership between private and public sectors. The group is composed of primary care physicians, pediatricians, psychiatrists, health plan representatives, the University of Minnesota School of Medicine, the Minnesota Department of Health and the Minnesota Department of Human Services. The goal of the group is to improve the capabilities of primary care physicians in treating persons who have a mental illness and to explore funding strategies to enhance greater collaboration and consultation between mental health and primary care providers.

Restructuring of Minnesota's State Operated Services and Residential Facilities

The State Operated Services Division (SOS) of the Department of Human Services operates five regional treatment centers (state psychiatric hospitals or RTCs) providing inpatient and outpatient mental health and chemical dependency services. SOS also provides community-based services people with mental illnesses.

Funding of two inpatient units for adolescents operated by SOS was moved to an "enterprise" system in 2003. This means that SOS provides these services in the marketplace with other providers and that revenues collected from third-party payment sources fund the ability to provide service. These two units provide 63 staffed state hospital beds for adolescents who are involved with multiple service systems and for whom short-term, acute care hospitalization has not been effective.

In 2003, the Minnesota Legislature adopted a proposal to expand community-based adult mental health programs to create a broader array of services close to home for consumers and their natural supports of family

Goal #5: Excellent mental health care is delivered and research is accelerated

and friends. These services may include 16-bed units in hospitals; Intensive Residential Treatment Services (IRTS)[22] and Assertive Community Treatment (ACT)[23].

With the development of these community-based services, SOS plans to transition from the RTC campus-based system to a community-based system. The proposal retains most of the existing base appropriation and anticipates new revenues from redesigned services that are MA reimbursable. The county share for services in the RTCs or large residential facilities increased from 10 percent to 20 percent.

Rates of admission to the RTC programs have been decreasing. It is expected that the trend will continue as community-based services become more available.

The Council commends the state's decision to maintain the base of $140 million to increase the capacity to provide mental health services in the community. We recommend that any savings generated be reinvested in developing these community-based services rather than be returned to the general fund.

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[22] There will be approximately 35 IRTS facilities in Minnesota with a 90-day length of stay.

[23] Assertive community treatment (ACT) is a way of delivering comprehensive and effective services to individuals who are diagnosed with severe mental illnesses who have needs that have not been well met by traditional approaches to delivering services. Principles of Assertive Community Treatment

- Services are targeted to a specific group of individuals with severe mental illness.
- Rather than brokering services, treatment, support and rehabilitation services are provided directly by the ACT team.
- Team members share responsibility for the individuals served by the team.
- The staff to consumer ratio is small (approximately 1 to 10).
- The range of treatment and services is comprehensive and flexible.
- Interventions are carried out in the community rather than in hospital or clinic settings
- There is no arbitrary time limit on receiving services.
- Treatment, support and rehabilitation services are individualized.
- Services are available on a 24–hour basis.
- The team is assertive in engaging individuals in treatment and monitoring their response.

There currently are approximately 20 ACT teams in Minnesota.

Goal #6: Technology is used to access mental health care and information

One objective of Goal #6 of the New Freedom Commission Report is to "Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations." Telemedicine/videoconferencing/online consultation should be used when possible and appropriate to ensure that people are able to access services in a timely manner. Training programs for mental health professionals need to require rotations in rural health care settings. Loan repayment programs should be increased and recruiting strategies should be developed to increase the number of providers in rural settings. This is also consistent with an objective of Goal #5 of the New Freedom Commission Report, to "Improve and expand the workforce providing evidence-based mental health services and supports."

Conclusion

The Subcommittee and Council will continue to participate with the Minnesota Mental Health Action Group. The Subcommittee will focus its work through three work groups: Mental Health and the Schools, Early Intervention and Prevention, and Juvenile Justice and Corrections issues. The Council will focus on issues critical to youth transitioning to adulthood (17to 25 year olds) and on the coordination of care between primary care providers and psychiatry. The Subcommittee and Council will continue to address legislative issues and issues of cultural diversity.

The Subcommittee and Advisory Council are available and ready to work with the Governor, Legislature, Commissioner of Human Services and other state departments and counties as Minnesota's mental health system transitions into a consumer- and family-driven, responsive and flexible system that conforms to the goals of the New Freedom Commission so that all Minnesotans are assured access to timely and quality mental health services.

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National Association for Rural Mental Health: www.narmh.org/

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