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

2002 Report *to the* Governor and Legislature

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This report is dedicated to the memory of Pat Bugenstein and Lisa Lopez, mental health advocates and members of the State Advisory Council who passed away in July 2002

Table Of Contents

Introduction 1

Executive Summary 2

Children's Subcommittee Legislative Work Group Report 6

Children's Subcommittee Juvenile Justice Work Group Report 8

Children's Subcommittee Outreach to Diverse Communities Work Group Report 12

Children's Subcommittee Mental Health and Schools Work Group Report 14

State Advisory Council Adult Early Intervention and Prevention Committee Report 16

State Advisory Council Access Committee Report 20

Conclusion 23

Introduction

The State Advisory Council on Mental Health was established in 1989 by Minnesota Statutes 245.697. It is also required under federal law. The Council is required to report biannually to the Governor and Legislature (Minnesota Statutes 245.697 Subd. 3).

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

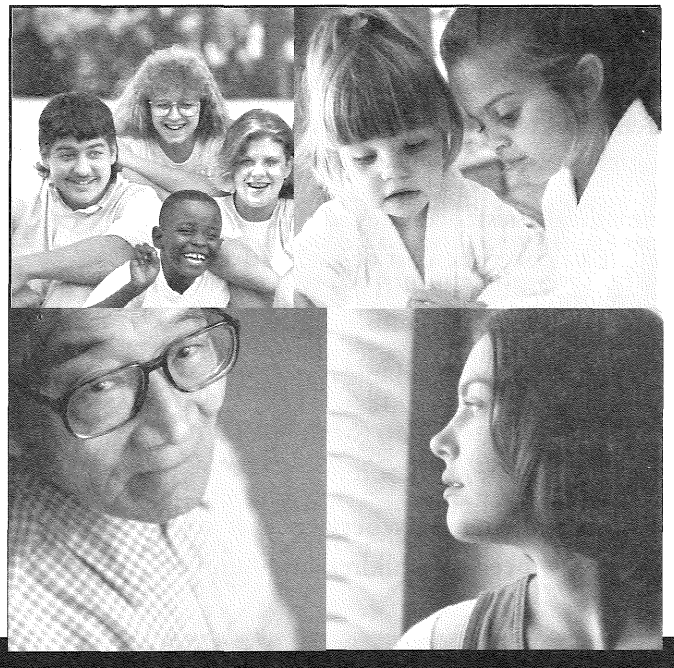
Minnesota law requires the Council to have a separate Subcommittee on Children's Mental Health, which is mandated to make recommendations to the Council on children's mental health issues. The Subcommittee is also composed of approximately 30 members, including parents of children with emotional disturbances, former consumers of children's mental health services, providers of children's mental health services, state and county elected officials and representatives of various state departments.

Over the past two years the State Advisory Council and Children's Subcommittee formed committees to address priority issues identified by the Council and Subcommittee. The issues emerged from public hearings held by the Council and Subcommittee throughout Minnesota in 1999. The Council's 2000 Report to the Governor and Legislature detailed the findings of those public hearings.[1]

The committees formed to address those issues were:

Legislative Work Group, Subcommittee on Children's Mental Health
Juvenile Justice Work Group, Subcommittee on Children's Mental Health
Mental Health and Schools Work Group, Subcommittee on Children's Mental Health
Outreach to Diverse Communities Work Group, Subcommittee on Children's Mental Health
Adult Mental Health Prevention and Early Intervention Committee, State Advisory Council on Mental Health
Access Committee, State Advisory Council on Mental Health

The recommendations in this report are a compilation of the recommendations of the above committees. In addition, the Children's Subcommittee and State Advisory Council have joint standing committees on local advisory councils and the federal block grant, which provides approximately $6 million in funding per year.



[1] For copies of the State Advisory Council on Mental Health 2000 Report to the Governor and Legislature, contact Bruce Weinstock (see conclusion, page 23), or go to http://www.dhs.state.mn.us/Contcare/PDF/mhreport.pdf.

Executive Summary

Background

Over the past two years much of the work of the State Advisory Council and Children's Subcommittee has taken place in specific committees. The committees were formed primarily based upon input received in public hearings the Council and Subcommittee held throughout the state in 1999. The issues that emerged from those hearings guided the Council and Subcommittee in developing their committee structure. **The State Advisory Council on Mental Health has formally approved each committee's recommendations.**

This Executive Summary provides the reader with the recommendations of each committee. Further detail and strategies for implementation can be found within the body of the full report.

Recommendations of the Children's Subcommittee

The Children's Subcommittee chose to have four committees to address issues of priority. The State Advisory Council on Mental Health has approved the recommendations. The committees and their recommendations are:

1. Legislative issues (for more detail, see page 6):

- Fund mandated services in the 1989 Children's Mental Health Act.
- Support and resource the Department of Human Services to assure compliance and consistency of children's mental health services across all counties.
- Increase medical assistance rates so that they are adequate to cover the cost of care and new service development.
- The state agencies that have a regulatory role with health plans and health plan representatives should together initiate a plan for the purpose of providing an adequate work force.
- Develop crisis and emergency services that are responsive to the needs of children and families, including a statewide crisis line and training for first responders and/or establishing mental health crisis teams.
- Tailor respite care services to meet the needs of children and families, flexible to use resources identified by parents.
- Fund early intervention and prevention, using best practice research.

2. Mental Health and the Juvenile Justice System (for more detail, see page 8):

- Improve access to mental health services, which includes pre screening, psychiatric services and programs in both metro and rural areas.
- Determine the prevalence rates of youth diagnosed as Severely Emotionally Disturbed (SED), and being supervised by juvenile probation in the State of Minnesota.
- Maximize the eligibility and capitalize on funding strategies that allow for a seamless delivery of mental health services for youth in the juvenile justice system.
- Develop a statewide plan to address racial disparities of youth in the juvenile justice system with mental or dual diagnosed needs.
- Identify and implement effective strategies that have allowed for collaboration and integration of services for youth with mental health needs across systems especially between social services and correction agencies.

3. Outreach to Diverse Communities (for more detail, see page 12):

- Create a multi-modal model of mental health treatment for children from diverse cultures that:
  - Provides services that are culturally appropriate and culturally competent;
  - Provides effective services in their homes, schools, and communities without disruptive removals from these settings;
  - Keeps children/youth connected to family and peers while in treatment;
  - Provides services that are family focused and health centered;
  - Provides concurrent chemical health treatment if necessary; and
  - Provides services that will enable the child to feel safe in his/her home, school or community; help the child to avoid encounters with law enforcement, and should encourage the child to complete his/her education.
- Provide for more culturally appropriate and culturally competent mental health professionals
  - Begin an organized process of training providers who work with clients from different races/cultures on how to provide culturally appropriate mental health services to children.
  - Establish incentive programs for mental health providers of diverse cultural groups to:
- Accept alternative mental health resources within diverse communities
- Build culturally competent mental health infrastructure
  - Fund culturally appropriate training and mentoring to professionals from diverse communities
  - Establish culturally appropriate training programs for mental health agencies and mental health program developers.
- Remove the negative stigma about mental illnesses.

4. Mental Health and Schools (for more detail, see page 14):

- Integrate and coordinate a comprehensive spectrum of mental health and other necessary services within systems serving children
- Increase training for personnel who work with our youth so that they:
  - Have a basic understanding of mental health issues;
  - Are aware of children's diagnoses in order to help children achieve more success in school;
  - Participate in cross-system training efforts, learn about service delivery systems and receive ongoing skill development and support;
  - Include parents and family members as an integral part of this training effort.
- Implement evidence-based practices
- Reduce financial barriers

Recommendations Of The State Advisory Council

The State Advisory Council chose to have two committees to address its priority issues for the past two years. Those two committees and their recommendations are:

1. Adult Mental Health Early Intervention and Prevention Committee (for more detail, see page 16):

The State Advisory Council has placed a high priority on prevention/early intervention activities. The Prevention/Early Intervention Committee addressed this issue with recommendations in primary health care, public and private workplaces, college campuses, suicide prevention research, and in health screens for young adults covered by Medical Assistance and Minnesota Care.

Primary Care Health Care

- Expand the mental health curriculum of state medical school, primary care residency programs, Physician Assistant and Nurse Practitioner training programs.

- Provide training by primary care physicians who specialize in treating mental health disorders and psychiatrists to primary care physicians.
- Encourage courses in psychiatric treatment that reflect the presentation of mental illness in a primary care setting as part of continuing medical education to primary care physicians, physicians assistants and nurse practitioners.
- Expand the curriculum mental health conferences sponsored by the Department of Human Services and the Department of Health to focus on mental health issues in primary care health care, and offer continuing medical education credit at these conferences.
- Improve reimbursement to cover the time necessary to provide comprehensive diagnostic and treatment services provided by primary care physicians, nurse practitioners and physician assistants.
- Pay for mental health screening.
- Pay for psychiatric consultation (in person, over the phone, or via telecommunication) to primary care physicians

Early Intervention/Prevention In the Workplace

The Public Sector Workplace

- Establish a mental health prevention and early intervention program for all state employees to be allocated from their existing budgets.
- Provide new funding to counties for mental health prevention/early intervention activities for county employees in human services, community health, corrections and law enforcement departments. Expand these activities to other state and county departments if funds are available.

The Private Sector Workplace

- The Governor should encourage the Minnesota Chamber of Commerce Association, the Minnesota Business Association Partnership, the Minnesota Employers Association and Minnesota health plans to initiate and maintain mental health early intervention/prevention activities in the private workplace.

Suicide Prevention

College Campuses

- Fund $200,000 to the Minnesota Department of Health to implement a pilot suicide prevention program on University of Minnesota campuses over the next two years. Expand these activities to other public college campuses in Minnesota if funding is available.

Suicide Prevention Research

- Fund $100,000 to the Department of Health to evaluate suicide deaths of Minnesota residents in 2001 and 2002 who had been enrolled in health care insurance programs. The study will follow procedures outlined in the Minnesota Data Practices Act and other data privacy statutes.

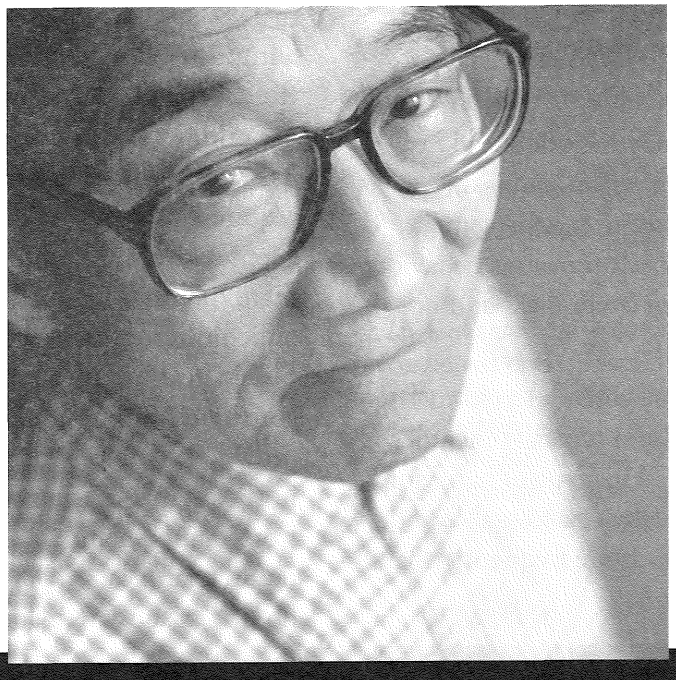
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Mental Health Screening for Adults

- Revise data gathering methods to clarify whether:
  - Complete EPSDT screening was accomplished;
  - Mental health disorders were identified;
  - A referral for mental health evaluation was made (either self-referred to the treating physician or referred to a mental health professional);
  - No referral was made because the individual was already receiving mental health treatment; and
  - Following a referral, the individual received a mental health diagnostic evaluation.
- Increase outreach to counties, physicians, etc. to increase the number of completed EPSDT screens in eligible adults.
- Use a valid, reliable, sensitive and specific mental health screening tool such as the eight minute PRIME MD tool that identifies most of the major mental health disorders in adults and can be easily administered by paraprofessionals.

- Separate the mental health screen from the rest of the EPSDT screen, providing separate payment to cover the expense of administration.

2. Access Committee (for more detail, see page 20):

- Increase Medical Assistance (MA) rates to more closely match the true cost of care.
- Support the federal 2001 Medicare Mental Health Modernization Act.
- Assure parity and equity of payments to mental health providers compared to other specialty areas, by supporting initiatives that:
  - Achieve mental health parity and equity of payments
  - Eliminate cross-system, cross-sector (public-private) cost-shifting
  - Reduce administrative burden and complexity
  - Work with the federal government to eliminate the Institutes for Mental Diseases (IMD) exclusion
- Increase the supply of mental health professionals by:
  - Defining "mental health professional" for the purpose of providing adult rehabilitative mental health services to include master's level degreed counselors who:
    - ✓ Are employed by a certified provider entity;
    - ✓ Meet the definition of mental health professional in the Comprehensive Mental Health Act, and;
    - ✓ Hold current and valid certification by a nationally recognized entity in psychosocial rehabilitation or rehabilitative counselling, such as Certified Rehabilitation Counselor (CRC) or Certified Psychosocial Rehabilitation Practitioner (CPRP).
  - Supporting initiatives to increase the supply of psychiatrists, psychologists, psychiatric nurses and psychiatric social workers.
- Other areas of concern to the Access Committee are articulated on page 22.



1. Report of Children's Subcommittee Legislative Work Group

The Subcommittee for Children's Mental Health is charged with assessing and advocating for the needs of all Minnesota children who have mental health disorders. This is done as part of and in cooperation with the State Advisory Council. In the context of these responsibilities, the Legislative Work Group proposed the following be included in this report. It is expected that this document will also be a springboard for developing positions on significant legislative issues and in developing education materials to be shared with other children's mental health advocates, parents and local advisory councils.

Overview

A recent *Public Policy Brief* by the **Children, Youth and Family Consortium, University of Minnesota**, states "In any given year, approximately 1 in 10 young people suffer from mental disorders, yet fewer than 20% of those affected get the care that they need. Children of color are less likely to receive the services they need." This widely reported and supported statistic put forth in the report of the Surgeon General on children's mental health clearly defines the scope of the problem. The Brief goes on to note that nationally, the rate of suicide among adolescents has nearly tripled since 1960, making it one of the three leading causes of death for adolescents.

The Brief also states that "mental health problems are usually identifiable by watching a child's or adolescent's behavior and can be thought of in two broad categories:

- *Internalizing behaviors* may include social isolation, excessive self-criticism, sadness, withdrawal, perfectionism, over-achievement, eating disorders or other self-injurious behaviors. These behaviors are often overlooked and not recognized as problematic.
- *Externalizing behaviors* are often referred to as 'acting out' behaviors and typically include more aggressive actions. This type of behavior is more noticeable and socially unacceptable and, therefore, is responded to more frequently than the internalizing behaviors.

The Consortium succinctly defines the consequences of not providing mental health services to children. "When children or youth have mental health problems, they're not able to stay on course with their development...Lower educational attain-ment, poverty, anti-social behavior, depression and other mental health problems are just some of the difficulties typically experienced by these children and youth."

Vision

The *Public Policy Brief* takes the next step by defining roles and recommendations. For the purposes of this report, the focus is on the policymakers' role, which is defined in the Brief as "vital in assuring that mental health services are accessible statewide, are culturally responsive, adequately funded and of high quality. A continuum of services is needed, including prevention and early intervention services, community-based care, a range of treatment options, and intensive services for those most in need." The Brief further recommends emphasis on maximizing protective factors and minimizing risk factors, as supported by research from the Search and Konopka Institutes, to improve outcomes for Minnesota children.

The State of Mental Health Services for Children in Minnesota

Issue: The basis for the existing system is the Children's Mental Health Act, which was passed in 1989 and describes our state-supervised, county administered public mental health system. Although the act mandates counties provide coordinated, community-based mental health services, the state has never provided the full funding that would be required to do so. (From: Meeting Every Child's Mental Health Needs: A Public Priority). The State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health sponsored public hearings throughout the state in 1999. Parents, consumers, professionals and concerned citizens provided testimony on what is and is not working in the mental health system. A re-occurring theme from family members and professionals was the report that local programs and services for children do not exist or are inadequate, falling short of the

services defined in the act. Inpatient hospital beds and residential treatment placements are decreasing while community-based services are not available to meet needs. Although the act requires counties to provide services, each county is given some discretion in determining priorities and allocating resources, resulting in variation in available services and programs from county to county across the state. In order to ensure the Children's Mental Health Act is implemented effectively, the recommendations are:

Recommendations:

1) Fund mandated services in the 1989 Children's Mental Health Act.
2) Support and resource the Department of Human Services to assure compliance and consistency of children's mental health services across all counties.

Issue: In addition to inadequate services is also a shortage of mental health professionals across the state. One reason for this is that reimbursement rates do not cover the cost of care, providing a disincentive to providers to expand services or to even enter the field of mental health services.

Recommendations:

3) Medical assistance rates should be adequate to cover the cost of care and new service development.
4) The state agencies that have a regulatory role with health plans and health plan representatives should come together to initiate a plan for the purpose of providing an adequate work force. The plan should include strategies to:
   - grow, recruit and retain mental health professionals with expertise in children's mental health services;
   - connect mental health professionals and primary care;
   - train other professionals who provide children's mental health care; and
   - encourage informal and family supports for children.

Issue: As a result of the state hearings, the Subcommittee has prioritized three areas of need. They include crisis and emergency services, respite care and early intervention and prevention.

- Crisis and emergency services are inadequate, and responders are not trained in how to best deal with a child with mental health issues.
- Appropriate respite services are limited in availability, and funding does not allow enough flexibility to use current resources parents may have identified.
- The Citizen's League report stresses the cost to our state for failing to prevent or intervene early in a child's mental health problem; citing higher K-12 education costs, dramatically lower graduation rates, use of expensive "deep-end" mental health services, increased health care costs, increased number of children in the juvenile justice system and other out-of-home placements, and suicide. The report states, "Clearly, strong evidence exists to support early investments in a child's mental health. It not only saves money, but also reduces the human pain and suffering experienced by Minnesota's children and families. It is the smart thing to do – and the right thing to do."

Recommendations:

5) Crisis and emergency services should be developed that are responsive to the needs of children and families, including a statewide crisis line and training for first responders and/or establishing mental health crisis teams.
6) Respite care services should be tailored to meet the need of children and families and be flexible to use resources identified by parents.
7) Early intervention and prevention need to be funded, using best practice research.

Since 1999 several groups and task forces, including policy makers at the state and local level, parents, professionals and citizens at large have offered their input into improving the mental health system for children and families in Minnesota. The issues and recommendations noted above reflect some of their work and identification of priority issues. These recommendations also align with those developed by the 2002 Children's Mental Health Task Force.

2. Report of the Children's Subcommittee Juvenile Justice Work Group

Purpose:

In April 2001, the Subcommittee on Children's Mental Health requested that the Juvenile Justice Work Group develop recommendations for system change for youth in the juvenile justice system with mental health issues.

Background:

Over the last several years, a wide variety of organizations have studied and provided recommendations for youth with mental health needs and in the juvenile justice system in Minnesota. Summaries of the reports are listed below. The common recommendations included better assessments/screening, a creation of a seamless integrated continuum of services including aftercare, parent youth engagement, training and better communication and data sharing across systems.

Toward Better Mental Health In Minnesota: Barriers to Access Work Group Final Report, January 2002

1. Require mental health related career and continuing education for all health and human services professionals, i.e., primary care physicians, educators, law enforcement, clergy, etc.
2. A more integrated approach to mental health in the justice system through full partnership with one umbrella philosophy and a clear process for planning and delivery of services.
3. Mental health re-entry or transition services that have greater coordination with county case managers and probation officers.
4. Development of 24-hour crisis teams.

Toward Better Mental Health in Minnesota: Prevention, Education and Public Awareness Work Group Final Report, January 2002

1. Ensure that youth in the juvenile justice system have access to mental health screenings.
2. Training for juvenile justice providers on signs and symptoms of juvenile mental health problems.
3. Co-locate mental health services with other key systems, e.g., juvenile justice.

Department of Corrections/Department of Human Services Mental Health Symposium, January 2002

1. Need better collaboration/team/cooperation.
2. Need to provide a continuum-transitional care.
3. Provision of resources to offenders.
4. Wraparound and multi-systemic approach.
5. Assessment of mental illness and criminal issues.

Supreme Court Juvenile Justice Services Task Force, Final Report, February 15, 2001

1. Statewide adoption of service outcome goals for juvenile justice services.
2. Comprehensive continuum of services available within each community.
3. A model approach for assessment.
4. Service coordination/collaboration among child serving agencies.
5. Engage parent/family involvement.

2000 Minnesota Juvenile Justice Advisory Committee Report, January 2001

1. Support the development of universal assessment tools that are race and gender neutral, that assess

alcohol, drug, mental health, educational needs, Fetal Alcohol Syndrome/Fetal Alcohol Effect (FAS/FAE).

Citizen's League Meeting Every Child's Mental Health Needs: A Public Priority, January 2001

1. Stronger state leadership role to ensure children's mental health needs are being met and systems are working together.
2. All children should be screened (for mental health) at numerous points in their development.

Focus Groups

On June 6th, 2002, the Juvenile Justice Work Group facilitated a discussion on youth in the juvenile justice system with mental health needs. Multiple counties were invited and both rural and metro population counties were represented. The questions posed to the group included:

1) What are the strengths in providing mental health services to juveniles offenders in your county?
2) What are the gaps and needs in services for juvenile offenders with mental health needs in your county?
3) What standards for mental health case management services would you like to see in place as to the corrections system?

Strengths:

- Many counties administer the Youth Level of Service Case Management Inventory (YLSI) and Massachusetts Youth Screening Instrument (MAYSI) Assessments tool for risk of delinquency and mental and chemical health needs.
- Wraparound services for integration of services between systems.
- Contracted psychiatric consultation services.
- 30-day In-house evaluation at detention centers.
- Abundance of resources and partners in the community in the metro area. Less in the rural, which appear to develop programs based upon grants.
- Functional Family Therapy and Aggression Replacement Therapy.
- Contracting with human services agencies to provide mental health services.
- Mental health case managers.
- Contracted forensic psychologist.

Barriers:

- Lack of access to psychiatric care - three-month wait for services and a lack of hospital beds for youth in crisis.
- Lack of cooperation and coordination from outside providers and also between social services.
- Difficulty with some of the managed care plans for approval of services that have proven via research to work best with high-risk clients. Inability to order chemical dependency treatment other than Blue Cross. This leaves a gap in co-disorder youth.
- Assessments do not always translate into specific treatment options.
- Too many different collaboratives operating within counties which makes it difficult at times to coordinate services and navigate the mental health system.
- Difficult to access community-based mental health services in rural counties especially for sex offenders.
- Cultural competency issues.
- Outcome-based programming.
- Lack of mental health training for Probation Officers.
- A lack of mentoring available in the community.

One could also contend that too much has been done to "admire the problem" without action being taken. Based on the above reports and focus group findings, the work group has the following recommendations for action:

Recommendations:

1(a). Improve access to mental health services, which includes pre screening, psychiatric services and programs in both metro and rural areas.

Proposed Strategies:

- Propose legislative language that a percentage of Local Collaborative Time Study funding be carved out for early identification and screening of youth in the juvenile justice system.
- Develop standardized screening tools for chemical and mental health issues.
- Develop and fund training of professional staff for the screening and assessment of youth with mental health needs and how to incorporate mental health services into case plan development.
- Modify reimbursement rates for Medical Assistance and Prepaid Medical Assistance Program (PMAP) plans by increased rates for children's mental health program services.
- Develop outcomes for reporting on the success of correctional youth in mental health programs. Based upon outcomes, promote programs that have demonstrated positive change and shift away from others identified as having no impact.
- Propose legislation in 2003 requiring a study with recommendations to address the lack of adolescent hospital beds and psychiatrists.
- Utilize State Children's Health Insurance Program (SCHIP) for mental health screening of youth in the juvenile justice system.

1(b). Determine the prevalence rates of youth diagnosed as Severely Emotionally Disturbed (SED) and being supervised by juvenile probation in the State of Minnesota.

Proposed Strategies:

- Propose legislation for a study on youth in the juvenile justice system for prevalence of mental health issues and the types of services currently or previously provided to address their needs.
- Ensure that the statewide Court Services Tracking System (CSTS) tracks the mental health diagnosis of juveniles on probation. Require correctional facilities to report yearly on the prevalence rates for youth admitted into their facility with a mental health diagnosis and meet the criteria of severely emotionally disturbed.
- Track the number of youth in correctional systems that have a mental and/or chemical health disorder and the services provided.

2. Maximize eligibility and capitalize on funding strategies that allow for a seamless delivery of mental health services for youth in the juvenile justice system.

Proposed Strategies:

- Recommend Medical Assistance restrictions for youth in locked correctional programs be removed and develop strategies to address access to funding on a federal level.
- Propose legislation for managed care companies to honor court ordered chemical dependency programming based upon evaluations.
- Utilize Temporary Assistance to Needy Families (TANF) dollars for transitional services.
- Require managed care companies to pay for wraparound facilitation services similar to other states and pay for services that have been researched and identified as best practices. This includes multi-systemic services, functional family therapy, solution-focused therapy, and mentoring programs.

3. Develop a statewide plan to address racial disparities of youth in the juvenile justice system with mental health or dual diagnosed needs.

Proposed Strategies:

- Develop a statewide forum to discuss and make recommendations as to best strategies in addressing the over representation issue for state and county systems.
- Require managed care companies to offer culturally specific mental and chemical health services.

- Require Prepaid Medical Assistance Programs (PMAP) to evaluate and market culturally specific programs based upon the unique characteristics of the clients, which they will be serving.
- Develop a plan and implementation that is initiated by juvenile courts, to address the over representation of children of color in the juvenile justice system. The planning team should include corrections, social services, education, police, judges, county attorney offices, and parents.

4. Identify and implement effective strategies that have allowed for collaboration and integration of services for youth with mental health needs across systems especially between social services and correction agencies.

Proposed Strategies:

- Require that counties/state agencies have a designated managed care representative on advisory boards, and an identified PMAP plans representative be directed to participate via county/state contracts.
- Include effective collaboration and service integration as criteria in evaluation of grant applications.
- Utilize local universities and colleges to research the effectiveness of how children's mental health and family service collaboratives deliver outcome-based services with integrated funding through the integration of service systems.
- Develop statewide standards for best practices for collaboration across agencies and incorporate them into development and review of future state grant awards.
- Ensure that wraparound services are being delivered based on the Child and Adolescent Service System Program (CASSP) model, which includes a strength based approach, informal supports, and a parent/youth driven process.

3. Report of the Children's Subcommittee Outreach to Diverse Communities Work Group

While the provision of mental health services for children and families of diverse communities in Minnesota is increasing in capacity, there is still a scarcity of mental health services available to those communities. To increase the number of mental health services available to children from diverse communities, the Outreach to Diverse Communities Work Group has researched this issue and has identified the mental health needs of the diverse communities. Listed below are the diverse communities' mental health needs and our recommendations to the State of Minnesota for changes to the mental health system.

1. Address the Mental Health Needs of Children from Diverse Communities

Children from diverse communities with mental health needs:

- Must receive services that are culturally appropriate and culturally competent
- Should be able to receive effective services in their homes, schools, and communities without disruptive removals from these settings;
- Should remain connected to family and peers while in treatment;
- Should receive services that are family focused and health centered;
- Should receive concurrent chemical health treatment if necessary; and
- Should receive services that will enable the child to feel safe in his/her home, school or community; help the child to avoid encounters with law enforcement, and should encourage the child to complete his/her education.

Recommendation:

- Create a multi-modal model of mental health treatment for children from diverse cultures to include the above recommendations. State and local governments, mental health providers, cultural representatives from diverse communities, school personnel, corrections' personnel, and chemical health professionals, psychiatrists, and physicians should develop the model.

2. Need for More Culturally Appropriate and Culturally Competent Mental Health Professionals

There are efforts underway to increase the number of mental health professionals for all treatment populations. However there remains a serious dearth of mental health professionals who are trained to understand the vast effect that culture has on the understanding and the practice of mental health with people from diverse communities. This lack of cultural sensitivity and culturally appropriate knowledge has often led to misdiagnosis and inappropriate treatments.

Recommendations:

- Begin an organized process of training providers who work with clients from different races/ cultures on how to provide culturally appropriate mental health services to children.
- Establish incentive programs for mental health providers of diverse cultural groups to:
  1. Provide cultural training to other mental health providers, to become cultural consultants to mental health providers who are not culturally trained; and
  2. To work in high need communities. Such incentive programs may include sign-on bonuses or loan repayment programs accompanied by accountability and quality assurance measures.

- Put pressure at the legislative level to make cultural training a licensure requirement in the State of Minnesota for mental health providers.

3. Accept Alternative Mental Health Resources within Diverse Communities

Families who live in diverse communities often have an individual who is skilled in the healing arts and skilled in the cultural aspects of the health practices accepted within that community. Frequently the parents of a child with mental illness will seek those mental health services from a skilled health practitioner within their own community. However, if those mental health services are not available within the community, then families must look outside of their community for their mental health services.

Recommendations:

- Require health plans and community mental health programs to provide access to services of culturally specific healers for the diverse populations they serve.
- Promote mental health models such as that of the Albuquerque Veterans Administration, which have Medicine Men and culturally specific healers on their mental health staff.
- Educate legislators and mental health agencies about the excellent mental health programs that include alternative healing methods unique to diverse cultural groups.
- Ask mental health consumers from diverse communities about their preference for the inclusion of alternative healing methods in their mental health treatment plan.

4. Need for Local Mental Health Infrastructure

There is a lack of local mental health professional resources in diverse communities. These mental health resources are needed to help people from diverse communities develop their own mental health programs, training sites, therapeutic foster homes, and day treatment programs. Without having these resources available within the community, people who live in diverse communities must look outside of their community for mental health services.

Recommendations:

- Provide funding, culturally appropriate training, and mentoring to professionals from diverse communities so they can establish the mental health services needed to serve children and their families in their own community.
- Invite mental health program directors that have developed and administered mental health programs to assist in establishing mental health programs for people of diverse cultures in Minnesota.
- Utilizing cultural experts, establish culturally appropriate training programs for mental health agencies and mental health program developers.
- Establish mental health training sites that provide culturally appropriate training at mental health agencies.

5. Remove the Negative Stigma about Mental Illnesses

There is still a great deal of misunderstanding and misinformation among members of diverse communities regarding the causes and treatment of mental illness. More information about mental health and mental illness must be directed toward diverse communities so that treatment for mental illness will be obtained; and individuals who have a mental illness will no longer feel "left out" of the community.

Recommendations:

- Begin a statewide campaign that promotes the truth about mental illness and treatments available for mental illness using providers, children and families from diverse communities.
  - Statewide campaigns must include examples of how children from diverse communities may have unique mental health needs, and how those agencies address those needs.
- Develop culturally appropriate educational programs and media kits for distribution to people from diverse communities in Minnesota.
- Advertise the availability of culturally appropriate mental health services for children from diverse communities.

4. Report of the Children's Subcommittee Mental Health and Schools Work Group

Vision:

Mental health services for young children and adolescents with mental health problems are connected to community-based mental health services and school-based programming. Children and adolescents receive the help they need in a coordinated, timely manner.

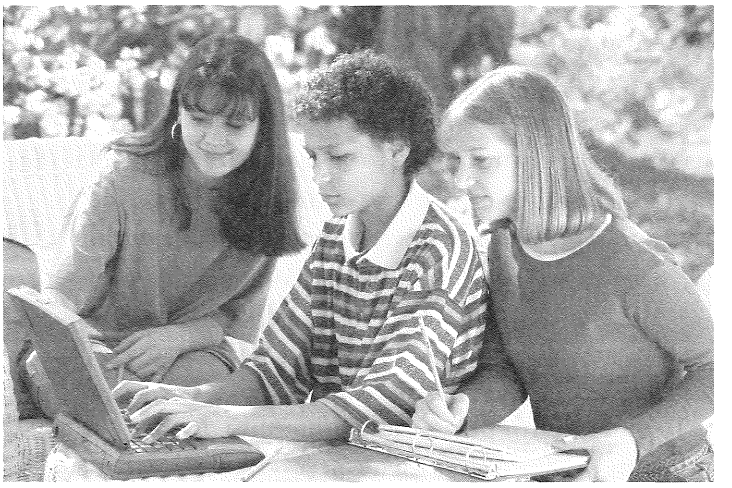
Background

Untreated mental health problems can develop into more serious emotional disturbances as children mature, which is not only challenging to families, but disproportionately consumes school resources. In the United States, one in 10 children and adolescents suffers from mental illness severe enough to cause impaired functioning at home, in school and in their communities; about five percent of all children experience an extreme functional impairment. Sadly, in any given year, less than one in five of all children who experience mental illness receive needed treatment.[2]

Mental health problems cause students to:

- fail more classes
- miss more days of school
- earn lower grades
- repeat more grade levels
- drop out at a higher rate
- have more difficulty finding and keeping a job
- be more likely to get involved in the criminal justice system.[3]

The 1997 Comprehensive Community Mental Health Services for Children and Their Families-Report to Congress states that when a comprehensive spectrum of mental health and other necessary services are organized into a coordinated network they are much better at meeting the diverse and changing needs of children, adolescents, and their families. School functioning improvements such as increased academic grades, increased school attendance, decreased law enforcement contacts and improved



living arrangements for children and families were noted when they received a comprehensive array of mental health services for at least six months.

Recommendations:

1. **Integrate and coordinate a comprehensive spectrum of mental health and other necessary services within systems serving children**

- Connect children's mental health services and procedures and ensure coordination of those across systems.
- Clarify the respective roles and responsibilities of the child serving systems so that a coordinated system can be achieved.
- Strengthen early detection practices in systems that serve children and mandate procedures to facilitate access to needed assessments and services for children and families in a seamless way.
- Link children's mental health services by integrating school-based and community-based services and personnel.

[2] Report of the Surgeon General's Conference on Children's Mental Health, January 2001.
[3] U.S. Department of Education, 1998

2. **Increase training for personnel who work with our youth so that they:**

- Have a basic understanding of mental health issues.
- Know how to recognize mental health concerns in children.
- Are aware of children's diagnoses and how they affect learning so that they can help children achieve more success in school.
- Participate in cross -system training efforts, learn about service delivery systems and receive ongoing skill development and support.
- Include parents and family as an integral part of the development and delivery of this training effort.

3. **Understand and implement evidence-based practices**

- Involve families as essential partners in planning and provide ongoing support for family-centered practices.
- Provide culturally appropriate mental health services.
- Increase understanding of comprehensive confidentiality laws.
- Support transitions between programs and to adult services.
- Provide prevention, early intervention and after school programs and services.
- Provide support and opportunities for meaningful parent involvement.

4. **Reduce financial barriers**

- Provide funding and leverage resources to achieve agreed upon goals.
- Fully fund mandated services.
- Blend and de-categorize funds to facilitate flexible use based on individual needs.

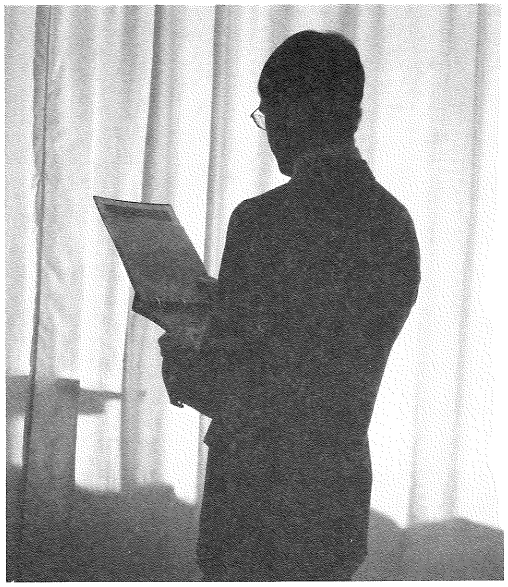
Background Information

The State Advisory Council has placed a high priority on prevention/early intervention activities. The majority of Minnesotans who suffer from mental health disorders go untreated, and those who are treated are often treated late in the course of their illness. This results in significant human suffering, and significant societal costs.

Unfortunately, minimal resources are now directed towards activities that would result in early identification and effective treatment of these disorders. The Prevention/Early Intervention Committee addressed this issue with recommendations in primary health care, public and private workplaces, college campuses, suicide prevention research, and in health screens for young adults covered by Medical Assistance and MinnesotaCare.

Primary Health Care

Primary care physicians, nurse practitioners and physician assistants provide a significant amount of mental health treatment in Minnesota. Their training in the recognition and treatment of mental health disorders is often inadequate, and there may be financial disincentives for them to provide quality mental health services. For example, research indicates that physicians frequently do not identify treatable disorders, and as many as one of every eight patients seen in primary care have an undetected psychiatric disorder.



Physician/Nursing Education

Currently, primary care physicians (i.e., Family Practice, Internal Medicine, and Pediatricians) are trained to recognize mental illness in artificial settings such as a psychiatrist's office or on an inpatient psychiatry ward. They are exposed to the most severe forms of psychiatric disorders, and are not trained to recognize the subtle presentation of conditions in a primary care setting. For example, patients may complain of fatigue or insomnia to their physician instead of articulating those symptoms as feelings of depression.

Nurse practitioners and physician assistants also tend to receive minimal training in the identification and treatment of mental health disorders in primary care settings.

The Council recommends:

- Expansion of the mental health curriculum of state medical school, primary care residency programs, Physician Assistant and Nurse Practitioner training programs.
- Encourage programs to provide training in the primary care setting. Training should be provided by primary care physicians who specialize in treating mental health disorders and by psychiatrists who are familiar with this population.
- Organizations and associations that offer continuing medical education to primary care physicians, physicians assistants and nurse practitioners must be encouraged to offer educational courses in psychiatric treatment that reflect the presentation of mental illness in a primary care setting.
- Mental health conferences sponsored by the Department of Human Services and the Department of Health must expand their curriculum to focus on mental health issues in primary health care. Continuing medical education credit must be offered at these conferences.

Reimbursement Issues:

Health plans often do not reimburse primary care professionals for the time needed to accurately diagnose and appropriately treat a patient's mental health disorder. This discourages effective early identification and treatment.

The Council recommends:

- Improved reimbursement that covers the time necessary to provide comprehensive diagnostic and treatment services provided by primary care physicians, nurse practitioners and physician assistants.
- Payment for mental health screening
- Payment for psychiatric consultation (in person, over the phone, or via telecommunication) to primary care physicians

Early Intervention/Prevention In the Workplace

The Surgeon General's Report on Mental Health noted that untreated mental health disorders have a significant financial impact, costing the U.S. economy $63 billion/year due to the loss of productivity in usual activities. Mental health early identification and intervention efforts in the workplace can significantly improve both productivity and absenteeism. A recent Rand Corporation study focusing on treatment of depression in primary care noted a five percent increase in patients who were maintaining employment in the effectively treated group. Given that worker absenteeism from serious depression costs employers $17 billion a year, Dr. Kenneth Wells, the study's lead researcher stated, "If that finding were extrapolated across all of those disabled by depression, it would move the stock market."

Most employed individuals who suffer from mental health disorders are unaware that they have a disorder, and do not seek treatment. Lack of public awareness, combined with problem of stigma, result in needless suffering and societal costs.

It is in the best interest of public and private sector employers to promote mental health early intervention and prevention activities.

The Public Sector Workplace

A number of state and county programs have promoted early identification/recognition efforts in the workplace. The State of Maine Human Resources, in coordination with private sector employers, has had a successful program of early identification of depression in the workplace. Minnesota had a successful one-year pilot project that took a public health approach to depression in state employees.

The Council recommends:

- Combined funding of $300,00 from all state departments to be allocated from their existing budgets to implement a mental health prevention and early intervention program for all state employees.

The program is to be coordinated and implemented by State Department of Employee Relations, Employee Assistance Program, with technical support provided by the Department of Human Services. Added new funds of $125,000 will be provided for the Coordinator for two years.

- The legislature will provide new funding to counties for mental health prevention/early intervention activities for county employees in human services, community health, corrections and law enforcement departments.

The Council would support expansion of these activities to other state and county departments as well, if funds were available.

The Private Sector Workplace

The Council is very impressed by the mental health early intervention activities of Employee Assistance programs in a number of Minnesota's private sector companies.

The Council recommends:

- That the Office of the Governor encourage the Minnesota Chamber of Commerce Association, the Minnesota Business Association Partnership, the Minnesota Employers Association and Minnesota Health Plan organizations to initiate and maintain mental health early intervention/ prevention activities in the private workplace.

Suicide Prevention

College Campuses

Research [US Dept. of Education; The Big Ten Student Suicide Study; American College Health Association Study {ACHA}; National College Health Risk Survey] has shown that 1,088 suicides occur on college campuses each year. This does not include suicide deaths off campus. ACHA has shown that 9.5% of 16,000 students surveyed have seriously contemplated suicide.

Suicide prevention activities on college campuses can be successful. An example is the JED Foundation program, which is implementing a nationally recognized college campus suicide prevention program structured after The National Strategy for Suicide Prevention released by the former Surgeon General, David Satcher.

The Council recommends:

- New funding of $200,000 to the Minnesota Department of Health to implement a pilot suicide prevention program on University of Minnesota campuses over the next two years.

The Council would support expansion of these activities to other public college campuses in Minnesota if funding were available.

Suicide Prevention Research

Little is known about the antecedents to suicide deaths in Minnesota. Gathering this information is essential in designing effective suicide prevention programs. For example, one study found that 50% of individuals who had committed suicide had seen their doctor within the last 30 days, and that their depressive symptoms had often been recognized but not treated by the physician.

The Council recommends:

- Funding of $100,000 to be provided to the Department of Health to evaluate suicide deaths of Minnesota residents in 2001 and 2002 who had been enrolled in health care insurance programs. The study will follow procedures outlined in the Minnesota Data Practices Act and other data privacy statutes.

The study will determine:

- How many of these individuals had been receiving medical care;
- The type of specialists who were seen;
- If the patients had been treated with medication for medical and/or psychiatric disorder;
- The type(s) of medication used;
- Whether they had been hospitalized for psychiatric treatment;
- If they had been hospitalized, the type(s) of services that were provided, the type(s) of instructions provided upon their release and the amount of family involvement in the process.

EPSDT (Early Periodic Screening, Diagnosis and Treatment) Mental Health Screening for Adults

Background Information:

EPSDT (Early Periodic Screening, Diagnosis and Treatment), known in Minnesota as Child Teen Checkup, is a federal entitlement to all individuals aged 0-21 in Minnesota who have Medical Assistance (MA) or Minnesota Care insurance coverage.

The screening is mandated to include health and dental screening, as well as a screen for social/emotional problems and a mental health history. This is the only entitlement for adult mental health early intervention/prevention services in Minnesota.

18-21 year old adults are at significant risk of developing mental health disorders such as depression, anxiety disorders and schizophrenia. Mental health screening of this age group would result in early identification and treatment of disorders that, if left unrecognized and untreated, would eventually lead to intense suffering and significant excessive costs in mental health and health treatment, lost productivity, family disruption, etc.

Although the Minnesota Department of Human Services (DHS) does not provide data on the

number of completed screens for the 18-21 year-old eligible population, a study that the Department commissioned noted that, for the 15-21 year-old age group, only three out of 1,000 eligible individuals had complete EPSDT screening. For the entire eligible group (ages 0-21), only 2% of those screened were referred for a mental health assessment (the base rate of mental health disorders in the general population is approximately 18%, and is estimated to be 25-30% in the MA population).

DHS has developed a proposed interview aid for EPSDT screening, with one tool suggested for the 0-21 year old population. This tool has not been validated for children, adolescents or adults.

Under the present method of data gathering, there is no way to determine whether:

- Complete EPSDT screening was accomplished;
- Mental health disorders were identified;
- A referral for mental health evaluation was made; either self-referred to the treating physician or referred to a mental health professional;
- No referral was made because the individual was already receiving mental health treatment;
- Following a referral, the individual received a mental health diagnostic evaluation.

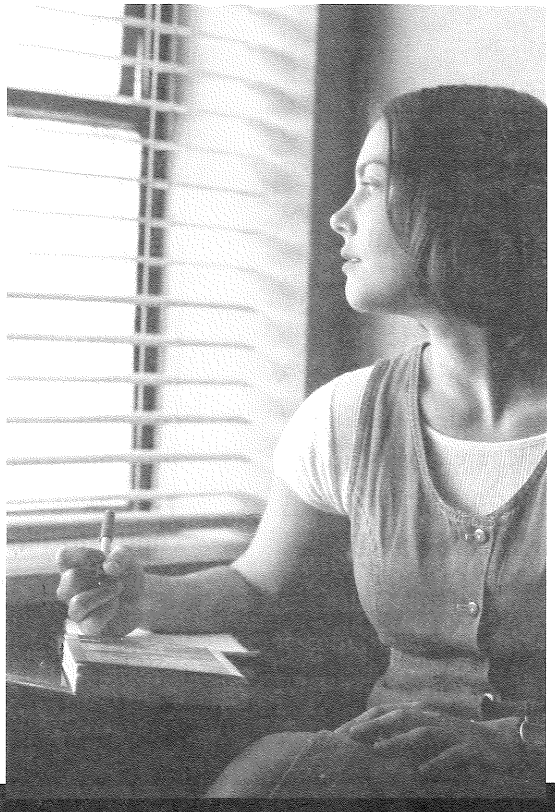
The Council recommends:

1.) Revise data gathering methods to allow identification of the issues outlined above.

2.) Increase outreach to counties, physicians, etc. to increase the number of completed EPSDT screens in eligible adults.

3.) Use a valid, reliable, sensitive and specific mental health screening tool, such as the eight minute PRIME MD tool, that identifies most of the major mental health disorders in adults and can be easily administered by paraprofessionals.

4.) Separate the mental health screen from the rest of the EPSDT screen, providing separate payment to cover the expense of administration.



The Access Committee identified and discussed the key mental health access goals as identified in the United States Surgeon General's 1999 Report. Using a series of decision-making tools, we prioritized four strategy areas. Following these prioritized areas, we have also summarized other areas of concern, which should be addressed in the near future.

1. Medical Assistance - Reimbursement of Mental Health Services

Medical Assistance (MA) does not currently pay the "true cost of care". This failure to pay the true cost of delivering services is reaching crisis proportions. Historically this shortfall was compensated for by higher rates paid by individuals with private insurance. Since the advent of managed care, this compensating balance has been eliminated. Examples of the problems this is creating are listed below:

1) Cost of living adjustments (COLA) for adult residential program grants, adult and family community support grants -Historically, many mental health services have not received COLA increases comparable to other programs funded by the state. For example, the Consumer Price Index change from 1990 to 2000 was 32.1%; however, these mental health providers received only 18% in inflationary increases during this time period, while MA funded mental health services received only 3%. Some providers experience staff layoffs, unfilled staff vacancies, reduced services, and long waiting lists - all putting clients at risk.
2) Outpatient mental health and psychiatric services - Current MA rates for outpatient psychiatric services are discounted 25% from the median charge submitted in 1989. The rate covers about 55% of the cost of producing the service today. Low rates lead to long waiting lists, poor purchasing power for consumers, high staff turnover, and overuse of other less appropriate services. Several community mental health centers and other health care providers dedicated to a public mission have closed clinics, laid off staff, or filed bankruptcy. In the 2001 legislative session, the fiscal note attached to increasing rates up to the median of 1999 charges was about $23 million for the 2002-2003 biennium, a 44% increase. $4.5 million was appropriated, an aggregate 8.8%. This problem is compounded by the common practice of programs to bill the amount they know they will get paid, rather that the cost of providing a service. This then artificially lowers reimbursements based on the median amount billed.
3) Clinic reimbursement rates - As best practices embrace outpatient community treatment, the financing system has not adjusted to offset the impact of a high volume of MA clients and uncompensated care concentrated in relatively few providers. About half of all MA funded outpatient mental health services are provided by about 35 community mental health centers (CMHCs). MA rates based on individual practice do not support the comprehensive array of services, non-billable consultation services, supervision and quality assurance, emergency/ crisis services, and added overhead on 1989 charges minus 25%.

   Historically, most mental health services were provided in hospital settings whose reimbursement rates were adjusted based on a disproportionate share and bad debt. The legislature recognized this situation by enhancing the rates for community health centers, Federally Qualified Health Centers (FQHCs), and rural health centers. However, similarly situated community mental health centers do not receive this enhanced rate, despite the fact that they are non-profit Essential Community Providers under contract with counties to meet the mandates of the Mental Health Act and accept all clients regardless of ability to pay. Several states have extended the same Medicaid reimbursement rate policies used for community health centers and/or FQHCs to CMHCs, in effect instituting

a disproportionate rate adjustment for these key provider types.

4) The Institute for Mental Disease (IMD) Exclusion bars Medicaid reimbursement for all services provided to adults ages 22-64 in an IMD, which includes psychiatric hospitals and community based residential facilities of 16 or more beds.

The Council recommends:

Formulate a letter to U.S. Congressional House and Senate committee chairs supporting legislative network efforts to address these issues. Advocate/promote MA rates that more closely match the true cost of care.

2. Medicare Reimbursement for Mental Health Services

The Council recommends:

Support the 2001 Medicare Mental Health Modernization Act and address other mental health issues pertaining to Medicare coverage. In summary, this bill:

a. Reduces the co-payment for mental health services from 50% to 20%, making it equal to all other health care services covered by Medicare;

b. Increases access to services by adding additional residential and outpatient settings to be eligible for providing Medicare services;

c. Increases access to services by adding additional licensed and trained mental health providers as eligible providers under Medicare.

3. Increase Market Value of Mental Health Professionals

Low pay and lack of training for community-based mental health staff are significant barriers to the creation of appropriate residential and treatment programs for people with serious mental illnesses. Individuals in the human services fields are seeking higher paying jobs elsewhere, and those staff who remain frequently are not trained to address the special needs of people with the most serious mental disorders.

To assure parity and equity of payments to mental health providers compared to other specialty areas, we support initiatives that:

- **Achieve mental health parity and equity of payments;**
- **Eliminate cross-system, cross-sector (public-private) cost-shifting;**
- **Reduce administrative burden and complexity;**
- **Work with the federal government to eliminate the IMD Exclusion**

4. Increase the Supply of Mental Health Professionals

Reports from primary consumers, family members and service providers indicate that there is a shortage of qualified mental health professionals in relationship to the demand for mental health services, especially for persons in the state's target population of persons with serious and persistent mental illness. Shortages of qualified mental health professionals appear to be more acute in greater Minnesota, especially the disciplines of psychiatry, social work and nurses.

Minnesota remains one of only two states in the country that does not licensure masters' degreed counselors and therefore does not allow duly trained and degreed counselors to provide services as mental health professionals. Minnesota has hundreds of qualified master level degreed counselors who in most states would be licensed mental health professionals.

The Council recommends:

For the purpose of providing Adult Rehabilitative Mental Health Services (ARMHS), the Minnesota Department of Human Services (DHS) utilize its authority to define "mental health professional" to include master's level degreed counselors who are employed by a certified provider entity; and

1. Meet the definition of mental health professional in the Comprehensive Mental Health Act, and;
2. Hold current and valid certification in by a nationally recognized entity in psychosocial rehabilitation or rehabilitative counselling, such as Certified Rehabilitation Counselor (CRC) or Certified Psychosocial Rehabilitation Practitioner (CPRP).

Support initiatives to increase the supply of psychiatrists, psychologists, psychiatric nurses and psychiatric social workers.

Other Areas Of Concern To Address Include:

- Access to a full range of housing alternatives and supports, employment services and supports, and transportation which are critical to successful community living.
- Broad based solutions to be implemented to solve the inpatient psychiatric bed shortage
- Strengthen the role of the Departments of Health and Commerce to ensure enrolees' access to full range of mental health benefits. This includes monitoring health plan contracts to assure payment equity, geographical access, and timely delivery of mental health treatment services.
- Assure that individuals voluntarily seeking treatment are not forced to accept civil commitment in order to access needed services.
- Accessing and coordinating appropriate services for persons in transition, e.g., youth to adult, adult to senior, long-term residential (state hospitals, nursing homes, halfway houses) to community based services, corrections to community based services, community based hospitals to community based care.
- Accessing and coordinating care for persons with multiple health issues in addition to their mental illness, e.g., geriatric, developmental disabilities, chemical dependency, and other long-term health concerns.
- Accessing and coordinating culturally specific and appropriate services.
- Encourage the prohibition of policies and practices by professional licensing organizations and training programs that disqualify individuals based on a history of mental illness rather than a functional assessment of their job related knowledge, skills and abilities.

Conclusion

As noted in the introduction, this report is a compilation of recommendations from six independent committees of the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health. The Council and Subcommittee also regularly deliberate and submit recommendation on other issues as they arise. For more information about the State Advisory Council or Children's Subcommittee, contact:

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This information is available in other forms to people with disabilities by contacting us at 651-582-1824 (voice), or through the Minnesota Relay Service at 711 or 1-800-627-3529 (TDD) or 1-877-627-3848 (speech-to-speech relay service).

Minnesota Department of **Human Services**

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