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

1998 REPORT TO THE GOVERNOR

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Introduction

Minn. Stat. 245.697, Subdivision 3 states, "The State Advisory Council on Mental Health shall report from time to time on its activities to the Governor, and the commissioners of health, economic security and human services. It shall file a formal report with the Governor not later than October 15 of each even-numbered year so that the information contained in the report, including recommendations, can be included in the Governor's budget message to the Legislature."

In the Council's reports of 1992, 1994 and 1996 our focus was on the type of system change that would achieve the goal of eliminating cost-shifting and other systemic barriers to the stated missions in the Minnesota Adult and Children's Comprehensive Mental Health Acts.

> ADULTS (1987):
> 245.461 Subd. 2. Mission statement. The commissioner (DHS) shall create and ensure a unified, accountable, comprehensive adult mental health service system that: recognizes the right of adults with mental illness to control their own lives as fully as possible (and)...promotes the independence and safety of adults with mental illness...
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> CHILDREN (1989):
> 245.487 Subd. 3. Mission of the children's mental health system. The commissioner (DHS) shall create and ensure a unified, accountable, comprehensive children's mental health service system...that...identifies children who are eligible for mental health services...makes preventive services available to all children...includes early screening and prompt intervention to identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs....provides mental health services to children and their families in the context in which the children live and go to school...(and) includes the child and the child's family in planning the children's program of mental health services...

This year we continue that focus. What follows is a report on activities the State Advisory Council on Mental Health ("Council") and Subcommittee on Children's Mental Health ("Subcommittee") have been involved in as we strive to bring the above mission statements closer to reality in Minnesota. Unnecessary barriers still exist that thwart the systems change envisioned by the law. On the other hand, significant achievements and system changes have taken place. We will report on those areas from the perspective of the role of the Council and Subcommittee.

This report does not attempt to provide a comprehensive overview of Minnesota's mental health system. Such a context is provided in the Department of Human Services' *Application, Community Mental Health Services Block Grant, 1999-2001, pp. 30-56.*[1] What follows are a series of briefings on issues that the State Advisory Council and Children's Subcommittee have placed as their priorities.

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[1] For copies, call 651-296-2729.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Children's Mental Health

- Funding the minimum essential services required by the Comprehensive Children's Mental Health Act would require an additional appropriation of $16.6 million per year.

- In addition to the $16.6 million needed for services mandated in the Comprehensive Mental Health Act for Children, the Subcommittee on Children's Mental Health recommends $3 million for early identification and prevention for children at risk of behavioral disorder. The Subcommittee and Council are encouraging the departments of Human Services; Children, Families and Learning; Corrections; and Housing and Finance in a cooperative effort in an early identification and prevention initiative.

- The costs of not investing in the mental health of children and their families far outweighs the funding called for -- it is clear that Minnesota must find the resources to address the emotional problems of troubled youth; failure to do so will result in continued increases in net costs to society, as the Subcommittee on Children's Mental Health has predicted since 1988.

Adult Mental Health Initiatives

- The Council supports the work and direction of the Adult Mental Health Initiatives.

- The Initiatives do not entirely correct a funding structure in legislation that still provides some disincentives to an efficient, consumer-centered, community and recovery based system.

- Redefinition of the safety net may also address inequities in the funding structure -- the Council plans to continue to monitor proposed changes.

Managed Care

- Prepaid Medical Assistance Plan contracts and Service Delivery Standards for Demonstration Projects for Persons with Disabilities contracts, combined with the monitoring systems being operationalized by the Department of Human Services should:

    1. assure that the health plans are meeting their contractual obligations;
    2. assure that quality mental health services are being delivered;
    3. assure that mental health received an appropriate share of the capitated rate; and
    4. assure that after accepting capitation payments, managed care contractors do not shift costs to other governmental entities or government funded health plans/programs.

- Minnesota needs to maintain parity for mental health services by monitoring administration of plans to ensure that laws are not violated and advocate on a federal level for parity in plans governed by federal law.

- Managed care within the Department of Corrections must also assure that appropriate, medically

necessary mental health services are delivered.

- Court ordered services covered by a health care plan or health insurance carrier should be deemed medically necessary and paid for by the health care plan or health insurance carrier.

- Legislative and other activities of the State Advisory Council on Mental Health shall be directed toward strengthening the cultural competence, sensitivity and diversity of the service delivery.

Employment

- Incorporate the employment vision into state law.

- Expand the existing and successful Coordinated Employability grant program statewide.

- Insure that the services are carefully designed to produce these outcomes:

  1. integrated community employment for people with mental illness;
  2. increased job retention and career advancement for working consumers;
  3. improved functioning and reduced symptomatology for consumers;
  4. expanded employment options, so that consumers can participate in the productive activities of their choice;
  5. improved satisfaction for individual consumers and employers;
  6. consumer involvement in all aspects of the planning development, oversight, and delivery of services; and
  7. close collaboration among state and local agencies.

- Continue to foster a spirit of interdepartmental cooperation.

Housing

Because the shortage of affordable housing prevents many persons with mental illness from living stably in the community, the State Advisory Council supports the following recommendations:

- Increased funding for existing state programs that provide direct housing assistance - including flexible funds available through adult mental health initiatives and the crisis housing assistance fund and the Bridges Program.

- Increased funding for existing state efforts to preserve the supply of federally assisted housing as well as expansion of the overall supply of affordable housing administered by the Minnesota Housing Finance Agency.

- That the Council and the Department of Human Services explore how to best organize and finance permanent supportive housing arrangements, then develop the policies to do so.

Children's Mental Health Funding, Out of Home Placements Concern Council and Subcommittee

Funding the Comprehensive Mental Health Act for Children has been the primary policy recommendation of the Subcommittee on Children's Mental Health since its inception in 1988. The *1994 State Advisory Council on Mental Health Report to the Governor and Legislature* stated that " the first priority of the Children's Subcommittee remains full implementation of the Comprehensive Children's Mental Health Act. The costs of not investing in these services for children and their families far outweigh the funding called for."

At that time, the cost of full implementation was estimated at $16,086,054 per year. The Children's Subcommittee called upon the Governor and Legislature to appropriate these funds by fiscal year 1997. We stated that in the absence of this funding, we could expect that:

- a significant number of those needing public mental health services will not receive them;
- inadequately served children with severe emotional disturbance will be left to seek services from systems such as education and corrections where the service system is not adequately trained nor resources to provide effective services;
- without early identification and intervention of community-based services, the burden of dealing with children with emotional disturbances will be increased upon families, schools, and law enforcement;

In our 1996 Report to the Governor and Legislature, the State Advisory Council on Mental Health and Subcommittee on Children's Mental Health reiterated the recommendation that "an additional $17.8 million is needed to fund the services mandated in the Comprehensive Mental Health Act for Children. Given the likely impact on future expenses for health, juvenile justice, education and welfare, we recommend appropriation of this additional amount."

Council and Subcommittee Initiate Funding Legislation, Achieve Gains

Until the 1997-98 session of the Legislature, the State Advisory Council and Subcommittee on Children's Mental Health had relied upon the Commissioner of the DHS to act on these recommendations by including this request in the department's budget. In 1997, when the Governor's budget did not meet the goal set by the Subcommittee on Children's Mental Health, members of the State Advisory Council obtained bipartisan legislative support for specific legislation to do so.

Legislation was passed with $600,000 awarded for the first year, and $800,000 for the second year and every year thereafter. Although this amount was far short of the target, it was viewed as a significant achievement given the Legislature's general unwillingness to add spending bills that had not been proposed by the Governor. During the 1997 session, the Council and Subcommittee learned a great deal about the state's budget and legislative processes.

Accordingly, in 1998 the State Advisory Council and Subcommittee on Children's Mental Health backed legislation which requested $2 million in funding for children's mental health services. This request faced the same large obstacles as the previous year's proposal, but again achieved significant results when $300,000 was added to the funding base.

Use of New Funds

The Subcommittee on Children's Mental Health asked for and received a key role in development of processes

for distributing the additional funds appropriated in 1997 and 1998. The guiding principle envisioned by the Subcommittee on Children's Mental Health was that these funds should be targeted toward a specific set of children with serious emotional disturbances and their families to give these families the complete array of services that they would have if the Children's Mental Health Act were fully implemented. In this way, it would be possible to demonstrate on a limited scale the outcomes that would be attained if the Act were fully funded.

The grants that resulted from the efforts of the State Advisory Council and Children's Subcommittee were labeled "Service Capacity Grants". Thirteen proposals which covered a total of 25 counties were approved. In feedback from the original round of proposals, it was noted that the needs of urban areas were much different than rural areas. As a result, the $300,000 added in 1998 was targeted specifically to rural needs.

Progress of the projects (and other children's mental health services) will be tracked using a functional assessment system (CAFAS) and consumer satisfaction surveys. While it too soon to report results, it is likely that indications regarding outcomes will be available before the 1999 Legislature acts on children's mental health legislation.

Current Recommendations:

In August 1998 the Council and Subcommittee requested of the Commissioner of the Department of Human Services that the department's next proposed budget to the Governor include funding of the minimum essential statutorily mandated services as required by the Comprehensive Children's Mental Health Act. The amount needed to accomplish this goal is calculated to be $16.6 million.[2]

Early Identification and Prevention

In addition to the $16.6 million needed for services mandated in the Comprehensive Mental Health Act for Children, the Subcommittee on Children's Mental Health recommends $3 million for early identification and prevention for children at risk of behavioral disorder. The Subcommittee and Council are encouraging the departments of Human Services; Children, Families and Learning; Corrections; and Housing and Finance in a cooperative effort in an early identification and prevention initiative.

In support of this venture, a resolution was passed in October 1998 recommending the development of funding mechanisms for prevention demonstration programs in collaboration with schools and local community agencies and that in contracting for services with health plans or for county based financing of health services a detailed and specific plan to identify children at risk for emotional and behavioral disorders be implemented.[3]

Out of Home Placement Costs Escalate

Failure to provide adequate children's mental health services is a national problem that has been growing over the past decade despite efforts to increase the capacity of the system. While many factors contribute to the

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[2] See computation in *1996 Report to the Governor and Legislature* which computed to $17.8 million, which is then subtracted by appropriations subsequent to that report discussed above and adjusted for inflation.

[3] Subcommittee on Children's Mental Health minutes October 1, 1998, State Advisory Council on Mental health minutes, October 2, 1998.

sharp rise in out of home placement costs, failure to provide minimum essential mental health services for children is a major factor. For example, a large share of out of home placement costs are attributable to juvenile offenders, a significant percentage of whom meet the criteria for serious emotional disturbance (SED). Many of their offenses are the direct result of untreated disorders. This problem was brought into focus in 1997, when the impact of rising out of home placement costs in Hennepin County contributed to a proposed reduction in county funds for children's mental health services.

The Subcommittee on Children's Mental Health saw the proposed reduction in Hennepin County's children's mental health funding as an issue of statewide significance. It was contrasted with a rural county which saw its costs for out of home placements *reduced* over ten years by investing in early intervention. The payoff was not achieved for several years; it is a "hard sell" to get support for investment on the front end (early intervention) when the back end (out of home placement) is skyrocketing. The state must take responsibility for helping with this problem. Upon the urging of advocates, including the Subcommittee, Hennepin County reinstated most of the proposed reductions.

Department of Corrections

In September 1998, the Subcommittee on Children's Mental Health heard a report from staff of the Department of Corrections on the state of knowledge about out of home placements. In describing five recent studies it was noted that the available information is incomplete, inconsistent, and often contradictory. Existing studies do not concur, for example in their findings about the increase or decrease in use of out of home placements.

Despite this lack of objective data, there is significant evidence of the impact of untreated or inappropriately treated emotional disturbances on out of home placement costs. Much of the cost of out of home placements is attributable to youth in the corrections system -- the underlying relationship to emotional disturbance is clear.[4] It has been estimated that as many as 60% of youths detained in juvenile corrections facilities suffer from emotional disorders.[5] Youth detained in corrections facilities have been found to have levels of psychopathology similar to the levels of mental illness found in psychiatric hospitals.[6]

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4 Kenneth M. Rogers, M.D.; Elaine Powell, Ph.D.; Patti Camp, M.A. *The Characteristics of Repeat Offenders Referred for Mental Health Evaluation in the Juvenile Justice System* in Liberton, C., Kutash, K., & Friedman, R. M. (Eds.), The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research & Training Center for Children's Mental Health, 1997.

5 Cocozza, J. *Responding to the Mental Health Needs of Youth in the Juvenile Justice System.* Seattle, Washington: National Coalition for the Mentally Ill in the Juvenile Justice System. Cocozza, 1991

6 Davis, D., Bean, G., Schumacher, M. A., & Stringer, T. (1991). *Prevalence of Emotional Disorders in A Juvenile Institutional Population. American Journal of Forensic Psychology, 9(1);* Pumariega, A. (in press), *Characteristics of Referred Versus Nonreferred Youth in a Corrections Facility.* Proceedings of the Ninth Annual Florida Mental Health Conference. Tampa, FL: Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida.

A large national study[7] of children with serious emotional disturbance and the services they receive showed that over the four years of the study approximately two thirds (66.5%) had a least one contact with police because of their behavior, about half (49.3%) appeared in court as a consequence, and over one third (34.4%) were adjudicated delinquent or convicted of a crime. These children (28% of the total in the survey) averaged two episodes of incarceration with an average duration of 320 days. If these statistics were applied to Minnesota's population, the correctional costs associated with children with serious emotional disturbance would exceed $34 million per year[8].

It is clear that Minnesota must find the resources to address the emotional problems of troubled youth; failure to do so will result in continued increases in net costs to society, as the Subcommittee on Children's Mental Health has predicted since 1988.

Summary of Recommendations

- Funding the minimum essential services required by the Comprehensive Children's Mental Health Act would require an appropriation of $16.6 million per year.

- In addition to the $16.6 million needed for services mandated in the Comprehensive Mental Health Act for Children, the Subcommittee on Children's Mental Health recommends $3 million for early identification and prevention for children at risk of behavioral disorder. The Subcommittee and Council are encouraging the departments of Human Services; Children, Families and Learning; Corrections; and Housing and Finance in a cooperative effort in an early identification and prevention initiative.

- The costs of not investing in the mental health of children and their families far outweighs the funding called for -- it is clear that Minnesota must find the resources to address the emotional problems of troubled youth; failure to do so will result in continued increases in net costs to society, as the Subcommittee on Children's Mental Health has predicted since 1988.

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7 Greenbaum, Paul E.; Dedrick, Robert F.; et al, *National Adolescent and Child Treatment Study (NACTS): Outcomes for children with serious emotional and behavioral disturbance*, Vol. 4, Journal of Emotional & Behavioral Disorders, 07-01-1996, pp 130.

8 In 1996, Minnesota provided services to 6,111 children with serious emotional disturbance (MN Department of Human Services, Enterprise Information System). If over a four year period, 28%, or 1,711 individuals each had two episodes of incarceration with an average duration of 320 days at an average of $126 per day (the rate charged within Minnesota's state operated juvenile corrections system) the amount per year would be 1,711 x 2 x 320 x $126 / 4 = $34, 495,373.

Adult [mental health] Initiatives - a step toward system change

> Minnesota has steadily moved people with disabilities – including people with mental illness – out of institutional settings and into communities. There is an expectation that most people with disabilities will live as independently as possible and become part of their community. They will have control; over their lives and not have "systems" making decisions about their care. This overall focus on people, not programs, is especially important for people with mental illness. The Adult Mental Health Initiatives focus on providing services in the community rather than in more restrictive settings.[9]

Currently all 87 counties, comprising 15 projects, have Adult Mental Health Initiative projects. Service redesign varies from project to project. All projects include:

- expanded crisis services
- housing and housing supports
- flexible funds

An important component of the Initiatives is the redeployment of staff from regional treatment centers (RTCs) to provide services in the community. While the planning and initial implementation of the Initiatives has taken place, the average daily population at regional treatment centers has been declining. It is unclear whether this is a direct correlation, as data collection from the Initiatives is still in its preliminary stages.

Preliminary findings

A July 31, 1998 summary of findings of a quality of life survey of consumers served by the Initiatives shows that consumers in the Initiatives find that most of their "needs are being met" well or fairly well, with the exception of work or education/job training opportunities. Almost half the consumers responding were unsatisfied in these areas. Specifically, 23% of consumers in Initiatives for six months reported that finding, achieving, or maintaining work were not being met at all and 31% reported attending, paying for, or locating education or job training opportunities were not being met at all. Particularly significant in rural areas, 30% reported availability and convenient transportation needs were not being met at all.

Reporting on positive outcomes after six months, consumers said:

- 47% said they were better able to control their life due to the services received
- 47% said they were better able to deal with crises due to the services received
- 50% felt services were available at times that were good for them
- 55 % felt they deal more effectively with daily problems due to the services received
- 51% felt they were better able to identify when they are starting to have problems and need treatment due to the services received[10]

These figures may not seem large, but reflect only six months of Initiatives implementation. The State Advisory Council has had a representative participate in Initiative site visits. According to that representative:

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9 *Adult Mental Health Initiatives: Focusing on the Community*, Minnesota Department of Human Services news release, May 1998.

10 Adult MH Initiative Feedback, Department of Human Services, August 11, 1998

> Some of the issues we hoped to explore were the impact of the project on RTC utilization, success of integration with existing community services, use of carry-over funds and plans for the next phase of each project.
>
> Of particular interest...was the consumer input into the planning and policy-making of the Initiatives and the impact of consumers of services provided. There is an obvious unevenness throughout the state in numbers of consumers serving on steering committees, and there is clearly a need to provide consumers with more training on how to serve effectively on a policy-making committee or board. Problems include high turnover of consumer/volunteers and available transportation to get participants to meetings. There is also an unevenness of communication and interaction with LACs (local advisory councils).
>
> Regarding services, some consumers...were learning valuable skills working toward independence and were served by caring, hard-working providers, but (some) also were experiencing isolation and loneliness. However, consumers also expressed a great appreciation for the freedom and independence they have living at home with the support of their case management team.[11]

RTC Staff Utilization

The most controversial aspect of the Adult Initiatives, if not the most important, was the utilization of RTC staff in the community. The initial legislative proposal called for transfer of some of the RTC appropriation as well as the staff, but what was finally passed allowed movement of staff without movement of appropriations. This has not developed into the obstacle some thought it would be. Systems have been flexible enough to allow staff movement in a meaningful way. The greatest obstacle - pay inequity and other staffing dynamics - have not necessarily been felt by the consumer. Nonetheless, the Council remains concerns about possible ramifications that could be caused by the inequities of pay to individuals providing similar services.

Cost Shifting and Funding Barriers

Despite these positive achievements the current Adult Initiatives do not fully address a recommendation we made in our *1994 Report to the Governor.* Moving of RTC staff does not completely correct a narrow categorical funding structure that compromises overall financial accountability, creates gaps in services and encourages cost shifting between the public and private sector and within the public sector.

What we proposed in 1994 was:

> Amend Minnesota Statutes 246.54 to increase the share of RTC costs paid by counties up to 50% (phased in 10% per year). This measure would stop short of integrating all funds, but would reduce the artificial financial incentives for counties to utilize this costly service. State funding corresponding to the percentage share of RTC costs increased would need to be provided to assist counties with this increased liability.[12]

While not conceding the point, perhaps the above recommendation may be an idea that is not achievable in

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11 "A few words from the State Advisory Council on Mental Health", Sarah Jones, Vice Chair, *Take the Initiative!*, Department of Human Services, Vol. 1, No. 2, p. 11, June 1998.

12 *1994 Report to the Governor,* State Advisory Council on Mental Health, p. 13.

light of political realities. Viewed from that perspective, the Adult Mental Health Initiatives have been a commendable effort toward the kind of system change that produces a meaningful impact in the way services are received by consumers.

"The Safety Net" - The future role of state operated services?

Discussions between the Department of Human Services and stakeholders, including the Council, are also related to the recommendation in our 1994 Report. These discussions revolve around taking a new look at the definition of the "Safety Net" - the services for which the State Operated Services assumes responsibility as the provider of last resort.

The model under exploration in these planning discussions is that some services traditionally viewed as "safety net" services may instead become part of an "enterprise system". In the "enterprise" system, revenue to pay for the services comes from purchasers of those service (such as HMOs and counties) rather than from state appropriations. The significance of this is that the appropriation base currently directed to those services could be redirected to service gaps in the mental health system or to the buyers of services (e.g., counties) to choose among more service options. The Council will continue to participate in these "safety net" discussions with anticipation that this may become another opportunity to come closer to our recommendations of 1994. We are watchful that the definition of the "safety net" will not lead to a displacement of community providers.

Summary of Recommendations

- The Council supports the work and direction of the Adult Mental Health Initiatives.
- The Initiatives do not entirely correct a funding structure in legislation that still provides some disincentives to a consumer-centered, community and recovery based system.
- Redefinition of the safety net may also address inequities in the funding structure -- the Council plans to continue to monitor proposed changes.

Managed Care & Parity: Working to ensure consumer protections

While much of the public is debating over managed health care, the conversion of Minnesota's publicly funded health programs to managed care in Minnesota has almost been completely instituted. Most adults with serious mental illness and children with serious emotional disturbance, however, are excluded from managed care. Combining the social services and medical services in one seamless system is a major challenge for the future. Minnesota has developed a demonstration project program to address the issue of combining social services and medical services. Currently, there are two *Demonstration Projects for People with Disabilities* engaged in their development. These demonstration projects are for all individuals with disabilities who receive publicly funded health services.

Prepaid Medical Assistance Plans (PMAP)

State Advisory Council and Children's Subcommittee representatives have been working to assure access and quality in Minnesota's public managed care programs.

In April 1998, the Council expressed concern regarding the mental health component of the PMAP contract.[13] Council members believed that "the PMAP contract combined with the monitoring systems being operationalized by the Department of Human Services are inadequate to:

1. assure that the health plans are meeting their contractual obligations;
2. assure that quality mental health services are being delivered;
3. assure that mental health received an appropriate share of the capitated rate; and
4. assure that after accepting capitation payments, costs are not being shifted to other governmental entities or government funded health plans/programs."

The Council requested contractual requirements and monitoring systems that identify and prevent cost-shifting, and assure that mental health dollars are not being shifted to other populations, as well as a plan to increase consumer and family participation in health plan decision-making.[14]

Current data collection and monitoring systems are inadequate to accomplish 1-4 above. Though the department has devoted increased resources to bring encounter data on line, it is questionable whether such data will be sufficient to accomplish the four above stated goals. If not, legislation or other options may be necessary. The Department has proposed some changes which may or may not address the Council's concerns. The PMAP stakeholders group is monitoring the situation.

Demonstration Projects for Persons with Disabilities (DPPD)

Similar concerns have been raised by Council and Subcommittee representatives to the Demonstration Project

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13 PMAP is an option available to counties to provide medical assistance services to residents eligible for medical assistance other than by disability. Counties can or by contract with a health plan receive a prepaid capitated rate for the services required by contract.

14 Letter from the State Advisory Council to DHS Assistant Commissioners Mary Kennedy and Elaine Timmer, April 1, 1998.

for Persons with Disabilities[15] stakeholders committee.

On January 10, 1997, the State Advisory Council adopted the following resolution:

The State Advisory Council on Mental Health strongly supports the proposed legislation for the Demonstration Project for Persons with Disabilities, as expressed in the version of December 31, 1996.

The Council particularly endorses:

1. The proposal that Medical Assistance covered services provided under involuntary commitment be deemed medically necessary, and thus the financial responsibility of the managed care organization;
2. The concept of external advocacy as expressed in the proposed legislation; and
3. The definition of eligible individuals included in the proposal.

The Council believes that:

1. Since external advocacy is integral to the design of this project such advocacy must be adequately funded;
2. There needs to be further clarification of the relationship between service coordination as defined in the proposed legislation and county case management; and
3. There needs to be further clarification as to how existing therapeutic relationships will be maintained by the managed care organization during the phase-in period.

On April 4, 1997, the Council passed the following resolution addressing the content of the benefit set under the projects:

The State Advisory Council on Mental Health endorses the legislation which enables managed care pilot projects for people with disabilities, with emphasis on the need to establish a capitation rate which is adequate to fund the array of services required by adults with serious and persistent mental illness and, where applicable, children with severe emotional disturbances.

On June 8, 1998, the department released draft Service Delivery Standards which would be used for counties in the project. Before the standards were released, the stakeholders committee was afforded opportunity for input, and the Council provided formal written comments on the draft.

Parity: Benefits far outweigh costs

While failure to treat mental illnesses has been shown to lead to greater costs, the desire to "cost cut" in this crucial area persists. Therefore, states have been passing parity laws which ostensibly require equal coverage for mental and physical health. In total, 19 states have enacted laws that prohibit health insurance discrimination against people with mental illness: Arizona, Arkansas, Colorado, Connecticut, Delaware, Georgia, Indiana, Maine, Maryland, Minnesota, Missouri, New Hampshire, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, and Vermont. Bills are currently pending in New York, Massachusetts and Puerto Rico.[16] Parity was enacted in Minnesota in 1995.

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15 The project administered by DHS, currently covers a limited number of counties where medical assistance services for all persons with disabilities would be delivered by or through a health care organization under a captitated rate for a defined benefit package. Services are scheduled to begin April 1999.

16 NAMI URGES NEW YORK SENATE TO PASS PARITY BILL BEFORE LEGISLATURE ADJOURNS ON THURSDAY, NAMI E-News, June 16, 1998.

Initial opposition to parity claimed that dropping the traditional co-pays or benefit limits for mental health would lead to exorbitant costs. Proponents of parity countered that removal of limits to mental health care would lead to broader health care savings and that limits were arbitrary and discriminatory.

A national study by the National Advisory Mental Health Council concludes that parity does not have an adverse economic effect. In systems already using managed care, implementing parity raised total health care costs by *less than one percent* over one year. Introducing managed parity in systems not using managed care led to a 30 to 50 percent *reduction* in total mental health costs over one year.[17]

Minnesota also has not seen a significant increase in premiums since parity went into effect. In the year after the parity law went into effect, a major Minnesota health plan said the parity law would increase premiums only 26 cents per member per month, and the Minnesota Department of Employees Relations put the cost of the mandate at only a 1 percent to 2 percent increase in premiums for state employees.[18]

Parity on the Federal Level

State laws mandating full parity *will not affect* employer sponsored plans protected under the 1974 Employee Retirement Income Security Act (ERISA). In Minnesota such plans account for 29% of Minnesota's insured population.[19] While a federal mental health parity law was passed in 1996, due to political compromises that law only addressed lifetime and yearly dollar limits to mental health treatment without addressing arbitrary increases in copayments and deductibles that would be covered by Minnesota's state law. Advocates are pressing to expand the federal law, but opposition is strong. "We still have a very big, serious problem," said Senator Pete Domenici, a sponsor of the federal legislation with Minnesota Senator Paul Wellstone. "The [current law] may be the only thing we'll have for awhile."[20]

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17 Some other findings of the report:
- Parity under managed care does not ensure access, which is highly variable across different managed behavioral health plans both before and after parity is introduced. Quality varies widely across managed behavioral health plans;
- In some cases in which managed care has led to limited access to mental health services, decreased productivity, increased absenteeism, and greater use of medical services have been observed;
- There is "some evidence" that managed care is compatible with access and quality, but further research is needed;
- In Medicaid-funded child mental health services, introducing managed care cuts and costs and also shifts treatment from inpatient to outpatient settings.

Parity in Financing Mental Health Services: Managed Care Effects on Cost, Access, and Quality; An Interim Report to Congress by the National Advisory Mental Health Council, Harold E. Varmus, M.D., National Institutes of Health, May 1998, p. 5. The report is available on the Internet at <www.nimh.nih.gov/research/prtyrpt/index.html>.

18 *Mental Health Parity: What Can It Accomplish in a Market Dominated by Managed Care?*, Alan L. Offen, Millbank Memorial Fund, p. 18.

19 Health Economics Program, Issue Brief 98-05, *Distribution of Insurance Coverage in Minnesota*, Minnesota Department of Health, health Policy & Systems Compliance Division, April 1998.

20 *Congressmen Stumped on How To Advance Full Parity; States Continue Efforts*, Mental Health News Alert, July 20, 1998, p. 6.

Some question whether the fight for parity in the context of managed care is a misplaced effort. "Many officials of managed behavioral health care companies and [others] say that benefit design is now far less important than it used to be because of the controls in use by managed care. Many limits spelled out in benefit plans -- on the number of covered days in hospital or the number of covered outpatient visits, for example -- have become anachronisms, it is maintained; what counts is what medication or number of visits or days in hospital the managed behavioral health care company allows as medically appropriate and necessary..."

With a legal definition of medical necessity[21] that further protects against discrimination against mental illness, combined with "full parity", Minnesota has a strong legal foundation available to the consumer. Such protections which, if vigilantly defended, could provide the tools needed to assure that services are delivered when needed by individuals covered by state regulated health plans.

Department of Corrections Contracts with Managed Care Organization

Concerns about managed care have become a reality in Minnesota's corrections system. Mental health services for the large number of inmates needing them in the Department of Corrections have been contracted on a capitated basis to the organization, Corrections Medical Services (CMS). An initial issue raised by the State Advisory Council concerns the accessible psychiatric medications under the drug formulary used by CMS. At time of publication, negotiations were incomplete on this very important matter, but initial drafts of the formulary relied on older, less efficient medications, despite the availability of newer medication which have been proven to be more effective with the lack of adverse side effects. The Council requests the Department ensure that the newer medications be included in the formulary. Other issues with the Department are being monitored by an advisory committee which includes Council representation.

Managed Care's Benefits are Mixed for Children

In June 1998, the national Health Care Reform Tracking Project released its *1997 Impact Analysis*,[22] which explores the impact of state managed care activities on children and adolescents with emotional and substance abuse disorders and their families. In almost all of the states analyzed managed care is improving initial access to behavioral health services by increasing the availability of services, setting standards that reduce waiting lists, increasing penetration rates and expanding provider networks, However, access to extended care has been made more difficult for children with serious disorders and their families and early intervention is not improving. Screening procedures typically do not include adequate mental health or substance abuse components, primary care practitioners are not trained in these areas, and the Early and Periodic Screening, Diagnosis and Treatment program, while incorporated into most managed care reforms, remains poorly implemented in behavioral health.

> Most often, those with knowledge about children's behavioral health issues (families, children's systems representatives, providers and child advocates) were not involved in the initial design of managed care reforms. Some states required family involvement at the service planning level, but only

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21 Minnesota Statutes 62Q.53.

22 The analysis was based on telephone interviews followed by site visits in 10 states (Arizona, Connecticut, Delaware, Iowa, Massachusetts, North Carolina, Oregon, Rhode Island, Utah and Washington) that were far enough in their reforms so that effects could be discerned. Interviews were conducted with multiple key stakeholders in each state, including officials from child mental health, Medicaid, juvenile justice, child welfare and education, families, providers, managed care organizations, and advocates.

> two states required it at the systems level advising or overseeing managed care reforms. In most states, managed care has had little impact on the availability of culturally diverse providers, a pre-existing problem in most states.[23]

This study has significance for Minnesota. Managed care promises change, but not necessarily that much needed reforms will happen. Screening, access to extended care, family involvement and culturally competent services are areas of concern in Minnesota's children's mental health system. The interrelation between mental health, social services, corrections and education currently transcends managed care. The State Advisory Council and Children's Subcommittee will continue to be involved in systems change discussions *(for more information, see page on children's mental health).*

On December 5, 1997, the State Advisory Council adopted the following resolutions for 1998. They will continue to be priorities in 1999:

> 1. The 1998 legislative priorities of the State Advisory Council on Mental Health include: 1) maintaining equal treatment and coverage for mental health services as stipulated in the Minnesota law on parity; and 2) ensuring that court ordered services covered by a health care plan or health insurance carrier will be deemed medically necessary and paid for by the health care plan or health insurance carrier.
>
> 2. Legislative and other activities of the State Advisory Council on Mental Health shall be directed toward strengthening the cultural competence, sensitivity and diversity of the service delivery.

Summary of Recommendations

- Prepaid Medical Assistance Plan contracts and Service Delivery Standards for Demonstration Projects for Persons with Disabilities contracts, combined with the monitoring systems being operationalized by the Department of Human Services should:

  1. assure that the health plans are meeting their contractual obligations;
  2. assure that quality mental health services are being delivered;
  3. assure that mental health received an appropriate share of the capitated rate; and
  4. assure that after accepting capitation payments, managed care contractors do not shift costs to other governmental entities or government funded health plans/programs.

- Minnesota needs to maintain parity for mental health services by monitoring administration of plans to ensure that laws are not violated and advocate on a federal level for parity in plans governed by federal law.

- Managed care within the Department of Corrections must also assure that appropriate mental health services are delivered.

- Court ordered services covered by a health care plan or health insurance carrier should be deemed medically necessary and paid for by the health care plan or health insurance carrier.

- Legislative and other activities of the State Advisory Council on Mental Health shall be directed toward strengthening the cultural competence, sensitivity and diversity of the service delivery.

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23 *The Bell*, Newsletter of the National Mental Health Association, August 1998, p.6.

Employment: Successful programs promote recovery

> Across the country, the term "recovery" is popping up in conferences and in mental health publications. Historically, that word rarely appeared when folks discussed serious and persistent mental illnesses....If the word recovery surfaced it generally was attached to a more medical model context such as "symptom reduction."
>
> But many in the consumer movement consider recovery in a different light. When our lives became consumed with a medical diagnosis and the stigma of mental illness permeated our universes, many of us experienced great loss: Loss of self-esteem, loss of standing in our communities, loss of a career, loss of our mate, loss of family, loss of our home, loss of hope for the future. To many of us, recovery means our success in bringing back some, or all, of what we lost...For the last five years...consumers have sent a clear message to the state mental health system that their key indicator of recovery is employment....Work builds self-esteem, provides income that promotes true consumer choice, results in community integration, socialization and more independence and gives us a reason to stay on our medications.[24]

In Minnesota, considerable progress has been made in the development of employment support services for persons with serious mental illness, but a great deal remains to be done.[25]

Interagency Cooperative Agreement

Since 1985, two state agencies, the Department of Economic Security, Rehabilitation Services Branch (DES-RSB), and the Department of Human Services, Mental Health Division (DHS-MHD), have had an Interagency Cooperative Agreement to improve the employment services for Minnesotans with serious and persistent mental illness. This collaboration has led to significant increases in the provision of publicly funded vocational rehabilitation services for people with mental illness, making Minnesota a national leader in this area.[26]

In 1992, DES-RSB and DHS-MHD - in conjunction with consumers, advocates, family members, service providers, and other stakeholders - developed a "Vision Statement on Employment Services in Minnesota for Persons with Mental Illness," the guiding principle of which is that "people with mental illness will have choice, access and a sense of productivity."[27]

Coordinated Employability Projects

Since 1992, legislative initiatives spearheaded by the League of Women Voters have established a state grant program that funds a number of highly innovative "Coordinated Employability" projects at the local level. These projects, which are administered by DES-RSB in partnership with DHS-MHD, provide both initial and

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24 "Work Paves the Way for Recovery", Larry Frickes, *The Bell, National Mental Health Association Newsletter, July 1998, p. 5.*

25 *Employment Options Initiative Concept Paper*, Revised August 4, 1998, p. 1.

26 *Employment Options Initiative Concept Paper*, Revised August 4, 1998, p. 1-2.

27 *Employment Options Initiative Concept Paper*, Revised August 4, 1998, p. 2.

extended support services to workers with serious mental illness. Thus far, the 20 projects funded by these grants have successfully provided employment services to a substantial number of individuals who would not otherwise have been served. Key components of these projects include:

- interagency collaboration among local vocational rehabilitation field offices, counties, mental health service providers, community support programs, and community rehabilitation programs;
- an emphasis on individualized, community based employment; and
- consumer involvement in the planning, development, oversight, and delivery of services.[28]

The Coordinated Employability program works. Experience to date strongly suggests that collaboration among local vocational rehabilitation offices, mental health providers, and community rehabilitation providers significantly improves the provision of employment services for people with mental illness.[29]

Unfortunately, limited funding has precluded the expansion of these innovative services statewide. Vast areas of Minnesota remain without access to specialized vocational rehabilitation services for persons with mental illness, and program capacity is limited even within the metropolitan areas.[30]

The employment of people with mental illness is important to all Minnesota citizens, for several reasons:

- It contributes to the state's overall financial health and well-being.
- It supports the worthy goals of welfare reform.
- It responds to the moral challenge and the legal requirements of the federal Americans with Disabilities Act.

And it's also a very wise investment: According to the federal Office of Management and Budget, Americans with disabilities who receive publicly funded vocational rehabilitation services repay $11 in taxes for every $1 invested in them.

Most people with mental illness want to work, but huge numbers remain unemployed.

There are at least 83,400 Minnesotans with serious and persistent mental illness, 85% of whom aren't working. This represents a missed opportunity for the state's economy and a tremendous problem for the individuals and families involved.[31]

Proposal of the Employment Initiative [32]

1. Incorporate the employment vision into state law.

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[28] *Employment Options Initiative Concept Paper*, Revised August 4, 1998, p. 2.

[29] *Employment Options Initiative Concept Paper*, Revised August 4, 1998, p. 2.

[30] *Employment Options Initiative Concept Paper*, Revised August 4, 1998, p. 2.

[31] *Employment Options Initiative Concept Paper*, Revised August 4, 1998, p. 1.

[32] *Employment Options Initiative Concept Paper*, Revised August 4, 1998. Approved by the State Advisory Council on Mental Health, September 4, 1998.

Both the Comprehensive Mental Health Act (M.S. 245.461-466) and the DES-RSB legislation (268A) should be amended to incorporate the 11 principles of the interdepartmental Vision Statement on Employment Services in Minnesota for persons with Mental Illness.

2. Expand the Coordinated Employability grant program statewide.

This demonstrably successful grant program should be expanded to all 87 counties, at an estimated annual cost of $18 million. The expanded funding would support locally designed vocational rehabilitation and extended employment support services for more than 6,500 Minnesota citizens with serious mental illness, enabling them to choose, get, and keep real jobs and to advance in their chosen careers. (For fiscal background data and assumptions, please see the Attachment.)

3. Insure that the services are carefully designed to produce these outcomes:

- integrated community employment for people with mental illness;
- increased job retention and career advancement for working consumers;
- improved functioning and reduced symptomatology for consumers;
- expanded employment options, so that consumers can participate in the productive activities of their choice;
- improved satisfaction for individual consumers and employers;
- consumer involvement in all aspects of the planning development, oversight, and delivery of services; and
- close collaboration among state and local agencies.

4. Continue to foster a spirit of interdepartmental cooperation.

The expanded program should continue to benefit from the expertise and cooperation of two state agencies. For strategic reasons, it probably makes the most sense for DES-RSB, through its Extended Employment program, to continue serving as the program's fiscal agent. (This is because funds expended for services during a period when a person has an active plan in the RSB vocational rehabilitation program can be counted as state match for federal funds.) However, it is our clear intention that DES-RSB will administer the funds in close collaboration with DHS-MHD, as specified in the Interagency Cooperative Agreement between the two departments and M.S. 268A.13 (Employment Support Services for Persons with Mental Illness).

Housing Needs Are a Major Concern for Persons with Mental Illness

Persons with serious and persistent mental illness encounter many difficulties in trying to obtain housing in the community. A number of factors contribute in causing these problems, and among them are the following:

Potential Loss of Federally Assisted Housing

For many years, the federal government provided a major portion of the funding needed for developing multifamily housing for low-and very low-income persons. Two major "project-based" strategies have been to subsidize building income on behalf of eligible tenants or provide construction/financing subsidies. These strategies have been used individually as well as in combination to ultimately make rents affordable. In return, building owners pledged to serve low- and very low-income households for set time periods. Properties developed in this manner now serve many seniors and persons with disabilities (including mental illness) around the state.

The limits on these time pledges began expiring earlier in this decade for a portion of the state's subsidized housing stock, and this trend will continue for approximately the next two decades. In locations with strong housing markets, owners may be capable of obtaining far higher rents than those paid by low- and very low-income households. Since there is basically no direct federal funding available to meet this need, it must come from state/local sources. The Minnesota Housing Finance Agency (MHFA) recently received state appropriations for this purpose, but additional resources will be needed in the future.

Cost of Unsubsidized Rental Housing

The gap between what low- and very low-income persons can afford to pay for housing and unsubsidized development costs is great and continues to grow. Many organizations are involved in trying to develop such affordable housing, but none typically has sufficient resources to be the sole subsidy provider. Instead, organizations must do considerable outreach and coordination to forge funding partnerships, lengthening the already complicated and expensive development process.

Pressure on Tenant-based Rental Assistance

The other basic method for helping low- and very low-income households obtain adequate rental housing is to subsidize part of the cost for securing a unit in the open market. The "tenant-based assistance" strategy has been used since the 1970s, and nearly all support has come from the federal government through what are known as the section 8 Certificate and Voucher programs. Problems currently affecting this programming include:

- Not only has federal funding not kept pace with growth in demand, but the level of funding has been frozen in the last few years. Long waiting lists have resulted in many places - for example, it's not uncommon in parts of the Twin Cities to hear of households waiting two, three or more years for their names to come up on the lists.

- Second, this approach only works if a sufficient number of private owners are willing to meet regulations and participate in the programs. The number unwilling to begin or continue participating is growing in many locations - for example, recent studies have documented a definite loss in the Twin Cities area.

- Third, this approach also only works if there's an adequate supply of units at or below the maximum rent levels permitted. The federal government has "rolled back" these limits in recent years, adding to already-existing pressures.

Bridges Program

In response to the need, some small-scale initiatives targeted to persons with mental illness have been funded with state appropriations. The Minnesota Housing Finance Agency and the Department of Human Services coordinate in administering the "Bridges program" which provides both social supports and rental help. The Department of Human Services is also operating an initiative providing county consortia with resources for reconfiguring adult mental health programming; some consortia have used a portion of these funds for providing rental assistance comparable to Bridges because the need is such a high priority in their communities.

Impact from Low Vacancy Rates

Rental market vacancy rates in many parts of the state are tremendously tight, given the great difficulty in developing new affordable housing, continual loss of a portion of the existing stock due to deterioration, redevelopment, etc. These conditions make it a "sellers' market," and landlords can pick and choose from among applicants. For example, the Twin Cities rate is around 1%, and it is not uncommon to hear of 10-15 or more households applying for the same unit.

Persons with severe mental illness may have a hard time competing under these circumstances. They can't afford paying multiple applications fees. They may not be physically or emotionally able to make repeated trips to check units or submit applications. They may have negative marks on their rental histories because of basic leasing requirements weren't met previously.

Licensed housing

The state provides Group Residential Housing (GRH) funds to support persons in licensed boarding care and board and lodging facilities; residents, however, pay almost all of their incomes (typically SSI) to supplement the GRH payment in providing their food and lodging. This leaves persons with only about $60 a month for other living expenses.

GRH doesn't pay enough at this time to make foster homes feasible for persons with mental illness. Further, the boarding care and board and lodging concepts are not considered as being truly part of the community, but rather small-scale institutions. Because of inadequate funding, they are often located in crime-ridden areas.

Crisis Housing Assistance

The goal of Crisis Housing Assistance is to retain housing for up to 90 days for a person with serious and persistent mental illness who goes into an inpatient treatment program and has no other source of funding to retain their housing. The program has grown from 153 individuals served in 1996 to 201 in 1997, with 320 projected for 1998.

The current budget base is $74,000 a year. Actual expenditures were $73,455 in CY 1996; $119,677 in CY 1997; and $94,855 in the first six months of 1998. The projection for CY 1998 is that $192,000 will be

needed. The difference between budgeted and actual expenditures has been covered by one-time savings from delayed starts in other new programs.

The Department of Human Services contracts with the Minnesota Housing Partnership to administer the fund. Administrative costs equal about 4% of the total funds distributed.

In 1997, 66 agencies from all regions of the State were the applicant agency for the consumer. Average turnaround time from initial request to payment is less than five days.

The proposed increases will allow total funding for this program (including the current base) to increase to $200,000 for FY 2000 and $250,000 for FY 2001. There are no major administrative problems with the current program and none are expected with the expanded program. The expanded funding will provide crisis housing assistance for about 600 more people than would have been served with the current base. This should reduce lengths of hospitalization and facilitate reintegration into the community after hospitalization.

Crisis Housing Assistance Outcomes

Initial data from 1996 and 1997 indicates that, of those served:

- 92% were able to keep their housing while they were hospitalized
- 90% said they would have lost their housing without Crisis Housing Assistance
- 92% said treatment was less stressful knowing that Crisis Housing Assistance was allowing them to retain their housing.

A typical comment from a person who was served by this program: "This program has helped me immensely while in treatment. I probably would've been homeless and no where to turn to afterwards."[33]

Summary of Recommendations

Because the shortage of affordable housing prevents many persons with mental illness from living stably in the community, the State Advisory Council supports the following recommendations:

➢ Increased funding for existing state programs that provide direct housing assisance, including flexible funds available through adult mental health initatives and the crisis housing assistance fund and the Bridges Program.

➢ Increased funding for existing state efforts to preserve the supply of federally assisted housing as well as expansion of the overall supply of affordable housing administered by the Minnesota Housing Finance Agency.

➢ That the Council and the Department of Human Services explore how to best organize and finance permanent supportive housing arrangements, then develop the policies to do so.

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33 The figures and outcomes quoted regarding this program were supplied by a Department of Human Services memorandum, October 14, 1998.

APPENDIX A

MINN. STAT. 245.697 - STATE ADVISORY COUNCIL ON MENTAL HEALTH

Subdivision 1. **Creation.** A state advisory council on mental health is created. The council must have 30 members appointed by the governor in accordance with federal requirements. The council must be composed of:

(1) the assistant commissioner of mental health for the Department of Human Services;
(2) a representative of the Department of Human Services responsible for the medical assistance program;
(3) one member of each of the four core mental health professional disciplines (psychiatry, psychology, social work, nursing);
(4) one representative from each of the following advocacy groups: mental health association of Minnesota, Minnesota alliance for the mentally ill, and Minnesota mental health law project
(5) providers of mental health services;
(6) consumers of mental health services,
(7) family members of persons with mental illness,
(8) legislators;
(9) social service agency directors;
10) county commissioners; and
11) other members reflecting a broad range of community interests, as the United States Secretary of Health and Human Services may prescribe by regulation or as may be selected by the Governor.

The council shall select a chair. Terms, compensation, and removal of members and filling of vacancies are governed by section 15.059. The commissioner of human services shall provide staff support and supplies to the council.

Subd. 2. **Duties**. The state advisory council on mental health shall:

(1) advise the Governor, and heads of state departments and agencies about policy, programs, and services affecting people with mental illness;
(2) advise the commissioner of human services on all phases of the development of mental health aspects of the biennial budget;
(3) advise the Governor about the development of innovative mechanisms for providing and financing services to people with mental illness;
(4) encourage state departments and other agencies to conduct needed research in the field of mental health;
(5) review recommendations of the subcommittee on children's mental health;
(6) educate the public about mental illness and the needs and potential of people with mental illness;
(7) review and comment on all grants dealing with mental health and on the development and implementation of state and local mental health plans; and
(8) coordinate the work of local children's and adult mental health advisory councils and subcommittees.

Subd. 2a. **Subcommittee on children's mental health.** The state advisory council on mental health (the "advisory council") must have a subcommittee on children's mental health. The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health. Members of the subcommittee must include:

(1) the commissioners or designees of the commissioners of the departments of human services; health; children, families and learning; finance, and corrections;
(2) the commissioner of commerce or a designee of the commissioner who is knowledgeable about medical insurance issues;
(3) at least one representative of an advocacy group for children with emotional disturbances;

(4) providers of children's mental health services, including at least one provider of services to preadolescent children, one provider of services to adolescents, and one hospital-based provider;
(5) parents of children who have emotional disturbances;
(6) a present or former consumer of adolescent mental health services;
(7) educators currently working with emotionally disturbed children;
(8) people knowledgeable about the needs of emotionally disturbed children of minority races and cultures;
(9) people experienced in working with emotionally disturbed children who have committed status offenses
10) members of the advisory council;
11) one person from the local corrections department and one representative of the Minnesota district judges association juvenile committee;
12) county commissioners and social services agency representatives.

The chair of the advisory council shall appoint subcommittee members described in clauses (3) to (11) through the process established in section 15.0597. The chair shall appoint members to ensure a geographical balance of the subcommittee. Terms, compensation, removal and filling of vacancies are governed by subdivision 1, except that terms of subcommittee members who are also members of the advisory council are coterminous with their terms on the advisory council. The subcommittee shall meet at the call of the subcommittee chair who is elected by the subcommittee from among its members. The subcommittee expires with the expiration of the advisory council.

Subd. 3. **Reports.** The state advisory council on mental health shall report from time to time on its activities to the Governor, and the commissioners of health and human services. It shall file a formal report with the Governor not later than October 15 of each even-numbered year so that the information contained in the report, including recommendations, can be included in the Governor's budget message to the Legislature. It shall also report to the Legislature not later than November 15 of each even-numbered year.

APPENDIX B

Mission - State Advisory Council on Mental Health

To lead mental health system development and reform which assures accessible, high quality mental health services that promote recovery for all.

Vision:

A comprehensive, consumer-driven mental health system which is accessible, effective, efficient, accountable and equitable.

Values:

1) Respect
2) Cooperation
3) Justness
4) Compassion
5) Creativity
6) Dedication
7) Courage
8) Integrity

Goals:

1. **Develop mechanisms to provide timely and effective advice to the Governor, Legislature, and heads of state departments on policy, programs and services pertaining to adults with serious mental illness and children with severe emotional disturbances.**

2. **Effectively collaborate with local advisory councils to speak in a single voice about the concerns, issues, and problems affecting the mental health system.**

3. **Advocate for a full integration of funding to allow for mental health services to effectively meet the individual needs of consumers.**

4. **Advocate for fair and equitable health care for all by assuring that mental health benefits have parity with other health benefits and link health care to social services.**