



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

# 2006 Report *to the* Governor and Legislature

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## 2006 Report to the Governor and Legislature

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### *Letter from the Chair and Vice Chair*

The Minnesota State Council on Mental Health and the Subcommittee on Children's Mental Health are pleased to present our *2006 Report to the Governor and Legislature*. The last two years have witnessed exciting new developments regarding mental health services for the State of Minnesota.

The commitment to the transformation of the mental health system was demonstrated by the Governor's Mental Health Initiative of 2006, the work of the Minnesota Mental Health Action Group, and the role the Department of Human Services in supporting those activities. The Council and Subcommittee also thank the Governor for establishing a safety net for individuals transitioning to Medicare Part D.

The Council and Subcommittee appreciate the support and active working relationship we have had with the Department of Human Services, Commissioner and Assistant Commissioner of Chemical and Mental Health Services. These relationships have resulted in many positive changes during the last two years. We commend DHS for its efforts in supporting evidence-based practices for adults and children, especially the "Hawaii Model," a state-of-the art system that matches symptoms, characteristics, demographics and other factors to specific research-based treatment strategies for children with mental health issues.

The Commissioner and Assistant Commissioner additionally supported the transition of State Operated Services' Regional Treatment Centers to 16-bed Community Behavioral Health Hospitals and the continued movement to community-based services.


This report highlights legislative initiatives and further suggestions that the Council and Subcommittee believe are important for continued improvement in the availability and quality of mental health services. The Council and Subcommittee believe that any new initiative, legislation, or programming should address several fundamental concerns, including stigma, diversity, and equal benefit sets.

The 2003 report of The President's New Freedom Commission on Mental Health states that "***Stigma leads others to avoid living, socializing, working with, renting to or employing people with mental disorders – especially severe disorders such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care.***" The Council supports initiatives aimed at effecting change and educating the public to help eliminate the misperceptions and biases that keep people with mental illnesses from living, working, and participating in the community. Such efforts must also address the needs of the fast growing diverse populations in Minnesota. The Council and Subcommittee recommend taking action to improve mental health awareness, cultural sensitivity, and competency among diverse communities in Minnesota.

Minnesota health care programs serve 500,000 people, yet these programs vary in benefit sets. The Council and Subcommittee recommend equalizing the mental health benefit sets of all publicly funded health care programs in Minnesota. We also recommend restoring Minnesota Care to its 2003 funding level.

The Council and Subcommittee are committed to working with the Minnesota Mental Health Action Group (MMHAG), the Governor, Legislature, Department of Human Services, other state departments, and local systems of care to continue to transform and improve Minnesota's mental health system.

Sincerely,



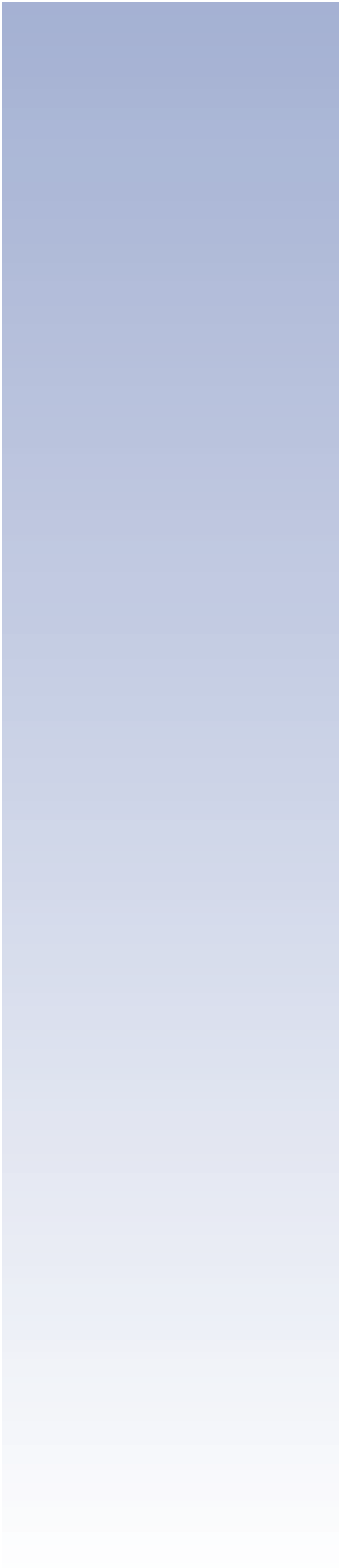
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Theresa Carufel  
Chair



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Wendy Rea  
Vice Chair



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### Introduction

The Minnesota State Advisory Council on Mental Health (Council) is comprised of 30 members mandated by state and federal law. Members of the Council are appointed by the Governor, and include present or former consumers of mental health services, family members, providers, state and county elected officials, advocates, state department representatives, social service directors and others. The state law also mandates the Council to have a Subcommittee on Children's Mental Health (Subcommittee), which includes parents of children with emotional disturbances, providers, advocates, state department representatives, state and county elected officials, county social service directors and others. Minnesota Statute 245.697 Subd. 3. requires the Council to file a formal report with the governor and legislature each even-numbered year.



*Governor Tim Pawlenty announces introduction of the Mental Health Initiative of 2006 at a press conference at the State Capitol on February 24, 2006.*

*Governor Tim Pawlenty introduced the Mental Health Initiative of 2006 at a press conference at the State Capitol on February 24, 2006, saying "Our current mental health care system needs improvement and this initiative will deliver significant advancements in access, quality and accountability. Nearly all of us know someone touched by the challenges of mental illness. Fortunately, the negative stigma surrounding mental illness is breaking down as people recognize it as a health care issue that can be successfully treated. Untreated mental illness creates significant and unnecessary human and economic costs, and tackling this challenge is a key part of health care reform."*

# Proposed and Enacted Legislation 2004-2006

## Enacted Council Recommendations

The Council and Subcommittee are pleased that the following recommendations from the Council's *2004 Report to the Governor and Legislature* have been enacted:

- Expansion of Medical Assistance (MA) coverage to include psychiatric consultation to primary care practitioners for adults and children (*Laws of Minnesota 2005, First Special Session, chapter 4, article 2, section 10, 15, and 17.*)
- Expansion of MA coverage to allow mental health services via two-way interactive video if medically appropriate, for adults and children. This will be of particular benefit to rural communities and others who have difficulty accessing face-to-face services (*Laws of Minnesota 2005, First Special Session, chapter 4, article 2, section 8, 15, and 17.*)

## Additional Legislative Action

The Council and Subcommittee are also pleased that the Governor and Legislature passed several other important pieces of legislation in 2005 and 2006.

- Medicaid coverage for Assertive Community Treatment Services for 16-17 year olds (*Laws of Minnesota 2005, First Special Session, chapter 4 article 2, section 7*), as well as coverage for treatment foster care for children (*Laws of Minnesota 2005, First Special Session, chapter 4, article 2, section 12*).
- Reduced parental fees under the MA TEFRA waiver (*Laws of Minnesota 2005, First Special Session, Chapter 4, Article 3, Section 5*).
- A requirement for educators to receive continuing education on mental health for re-licensure (*MN Statute Section 122A.09, Subp. 4(n); Rule 8710.7200, Subp. 2*).
- Removal of the \$500 cap on dental care from MA, GAMC and MinnesotaCare effective January 1, 2006 (*Laws of Minnesota 2005, First Special Session, Chapter 4, Article 8, Section 32 [MA], Section 5 [GAMC]*).
- \$17.5 million for permanent supportive housing for people experiencing long-term homelessness, nearly half of whom experience mental illnesses (*Laws of Mn 2006, Chapter 258, Section 22*) and \$12 million in bonding for permanent supportive housing in 2005 (*Laws of Mn 2005, Chapter 20, Section 24*).
- Managed care options for people with disabilities who choose to enroll in Medicare Special Needs Plans to provide more flexibility to meet their need (*Laws of Mn 2006, Chapter 282, Article 20, Sections 29-30*).



The Council and Subcommittee acknowledge the following legislation that was enacted:

- Increase of the county share for a person's care at a Regional Treatment Center (RTC) from 10% to 20% (*Minnesota Session Laws 2003, 1st Special Session - Chapter 14, Article 3*).

### The 2006 Mental Health Initiative

The intent of the Minnesota Mental Health Action Group (MMHAG), co-chaired by the commissioner of the Department of Human Services (DHS), is to transform the mental health system to one that is consumer and family driven/centered to the benefit of all Minnesotans. The Steering Committee represents key stakeholders, including the State Advisory Council, from both public and private sectors. Their recommendations resulted in a county maintenance of effort provision (*Laws of Mn 2006 Chapter 264, Section 15*) and \$10 million in new money to:

- **Address workforce shortages.** \$7.5 million to increase rates by 23.7%, primarily for psychiatrists and other critical mental health professionals to create economic incentives to support their recruitment and retention. This will also generate an additional federal match of \$5.9 million (*Laws of Mn 2006, Chapter 282, Article 16, Section 10*).
- **Develop statewide mental health crisis intervention and stabilization infrastructure as a first-line safety net for children and adults.** \$2 million of the \$13 million requested, for two years (75% for adults, 25% for children), which will be used for people without health care coverage (*Laws of Mn 2006, Chapter 282, Article 22, Section 2*).
- **Monitor and track availability of mental health services.** \$336,000 for FY 2007-2008 for a statewide, web-based system to monitor and track the availability of mental health services (*Laws of Mn 2006, Chapter 282, Article 22, Section 2*).
- **Create a system for measuring mental health service outcomes.** \$436,000 for fiscal year 2007-2008 for a statewide outcomes evaluation system for mental health services to monitor treatment outcomes and improve care (*Laws of Mn 2006, Chapter 282, Article 22, Section 2*).

In addition, the Council and Subcommittee supported the following proposals of the 2006 Mental Health Initiative that were not enacted.

We recommend these items be addressed in 2007:

- Creation of an integrated payment and service model to improve the coordination between mental health care, physical health care, and social services.
- Provision of the same mental health benefit set through all publicly funded health care programs in Minnesota.

- Funding for a children’s school-based mental health services infrastructure.
- Additional funding for crisis services to:
  - Support clients in their home communities.
  - Reduce the unnecessary use of emergency room resources for mental health crises.
  - Reduce the demand for psychiatric hospital resources.
- Funding to expand evidence-based practices.
- Increase capacity to address the mental health care needs of subspecialty populations and provide culturally specific treatments.



*Consumers, family members, parents, and other advocates rally at the Capitol for the Mental Health “Day on the Hill” on March 28, 2006.*

## Council and Subcommittee Initiatives

### Psychiatry and Other Medical Professions

The State Advisory Council and Children's Subcommittee have been focusing much of their work in the past two years on the interface between psychiatry and other medical professions. The Council and Subcommittee recommend:

- That all Minnesota physicians complete six hours of continuing education on mental health topics per three-year reporting period as a requirement of licensure.
- The Council developed a standardized letter for psychiatrists to communicate to primary care providers (with the consumer's consent) the diagnoses and prescribed medications, to prompt the primary care providers to vigilantly screen individuals with mental illnesses for other medical conditions.

### Suicide Prevention

Suicide continues to be a public health problem in Minnesota, resulting in 446 deaths in 2000 and 529 in 2004.<sup>1</sup> The Council and Subcommittee strongly recommend:

- Restoration of \$1 million in funding for the state's suicide prevention plan, which was cut in 2003 and 2005.

### Colleges and Universities

Symptoms of mental illness frequently first appear at college age, however many forego treatment due to inadequate health insurance coverage. Young adults between the ages of 19 and 29 are the largest and fastest growing segment of the U.S. population lacking health insurance.<sup>2</sup> Treated mental health issues lead to retention, graduation, and entrance into the workforce, frequently with access to employer sponsored insurance. The Council and Subcommittee recommend:

- That all state colleges and universities require full time students to have health insurance covering mental health services.

<sup>1</sup> Total known suicides (suicide under any mentioned cause), Minnesota Trauma Data Bank, Injury & Violence Prevention Unit, Minnesota Department of Health, 2005.

<sup>2</sup> Report of the Commonwealth Fund, May 24, 2006.

**Parent Statements**

*“My child had an early screening done. Thanks to this screening, he was able to be enrolled in the ECFE (Early Childhood Family Education) program at the age of two to get special help. It was beneficial to our family as he would not have otherwise gotten the help until kindergarten.”*

*– Julie,  
Renville County*

*“The screening test - Ages and Stages Questionnaire, Social Emotional (ASQ, SE) screening given to my child that time helped all of us in the family to know why my child is unable to play with toys or look at us in the face.”*

*– Chidi,  
Hennepin County–  
Brooklyn Park*

**Mental Health Screening Across the Lifespan**

A growing body of research has shown that early identification, assessment and intervention for mental health problems can help forestall or prevent more serious problems, such as school failure, substance abuse, involvement in the criminal justice system, or suicide. Screening is the first step in early intervention, recognizing emotional and behavioral problems and providing help at an early and effective point.

Early and periodic mental health screening leads to earlier intervention and treatment of problems, which results in reduced long-term impairment and often, recovery.

Mental health screening is a brief, culturally sensitive process designed to identify children, youth or adults who may be at risk for impaired mental health functioning. Similar to vision or hearing screenings, a mental health screen simply serves as an ‘alerting mechanism’ to efficiently and accurately identify and recommend follow-up for individuals who may be dealing with an impairment that could impact their functioning. Screening provides an opportunity for families to gain access to a wide variety of services. Individuals are NOT diagnosed based on the results of a mental health screening.

Mental health screening plays a vital role in the identification of both children and adults who have, or are at risk of developing, mental health problems. The President’s New Freedom Commission on Mental Health stated in their July 2003 report that “for consumers of all ages, early detection, assessment, and links with treatment and support will help prevent mental health problems from worsening.” To effectively reduce the incidence and negative impact of mental illness, the state must insure that everyone in Minnesota has the opportunity to access effective mental health screening, assessment and treatment options.

The Council and Subcommittee recommend:

- Routine mental health screening should begin in infancy and continue throughout the lifespan.
- Mental health screening must adhere to standards and principles as with screening for any potential health problems.<sup>3</sup>
- The social/emotional component of the early childhood developmental screening program be required to be completed using a social/emotional screening instrument approved by the commissioner of education, and consistent with the standards of the commissioners of health and human services.
- A separate mental health screening code for all Minnesota state health care programs.
- A separate mental health screening code for all private health care plans.

<sup>3</sup> *Screening and Early Detection of Mental Health Problems in Children and Adolescents*, Substance Abuse and Mental Health Services Administration, 2005.



### Culturally Diverse Communities

The Council and Subcommittee recommend that the Minnesota Departments of Health, Education and Human Services take steps to:

- Educate diverse populations about mental health issues and encourage them to access mental health support and/or services, with the intent to eliminate stigma.
- Encourage training opportunities and incentives for more individuals from diverse communities to become licensed mental health professionals.
- Require demonstration of competency in cultural issues for all state employees and professionals.
- The Council and Subcommittee continue to support the recommendations about diversity as presented in our *2004 Report to the Governor and Legislature*.<sup>4</sup>

### Mental Health Needs of Juveniles in the Corrections System

Approximately 70% of boys, and 80% of girls in juvenile corrections have mental health problems.<sup>5</sup> Research shows that addressing the mental health issues of juvenile offenders can significantly reduce recidivism. Juvenile offenders who receive structured, meaningful and sensitive mental health treatment recidivate at rates 25 percent lower than those who do not receive treatment. Furthermore, treatment specifically in their home or community can reduce recidivism by up to 80 percent.<sup>6</sup> *(Continued on page 8)*

<sup>4</sup> *2004 State Advisory Council on Mental Health Report to the Governor and Legislature*, pages 7-9.

<sup>5</sup> Teplin, LA, Abram, KM, McClelland, GM, Washburn, JJ, Pikus, AK, (2005). "Detecting Mental Disorders in Juvenile Offenders Who Receive Services," *American Journal of Public Health* 95: 1773-1780.

<sup>6</sup> "Minnesota Children's Mental Health Task Force. "Blueprint for a Children's Mental Health System of Care." (Minnesota Department of Human Services, August 2002)

The Council and Subcommittee recommend:

- Developing and funding of an adequate infrastructure within the correctional system to identify and treat mental health problems of youth in the correctional system using evidence-based and promising practices.
- Increasing public awareness of the service gaps addressing mental health issues as a priority in the juvenile justice system.
- Developing a database to monitor the long term outcomes of youth in the corrections system who have a mental and/or a chemical disorder.
- Supporting the Juvenile Justice Advisory Committee's efforts to address the issue of disproportionate minority contact within the juvenile justice system.<sup>7</sup>
- Establishing a task force, including representation from the departments of corrections, human services, health and education, as well as consumers, parents, advocates and local justice systems, to develop and implement a comprehensive system to prevent youth with mental health issues from entering the juvenile justice system.

### **Mental Health and Schools**

Schools in Minnesota continue to face the challenge of educating students whose mental health concerns are interfering with their education. The recent reduction in federal funding will widen the gap between school success and under performance. Communities in Greater Minnesota that were already experiencing scarcity of services will be further jeopardized by these federal funding cuts.

The Council and Subcommittee recommend:

- Continued education of school staff on early identification and interventions
- Continued development of a collaborative interagency effort that supports all children to be successful in schools.
- Adequately staff student support teams that include licensed mental health professionals in schools to help facilitate early intervention and provide teacher training, leadership and collaborative planning with other resources, agencies, and mental health professionals.
- Partnering with families to increase family participation in schools.
- Promotion of a natural and culturally respectful response to meet a family's need for support.
- Development of youth leadership to decrease stigma and influence children's mental health policy.

<sup>7</sup> *Annual Recommendations to the Governor*. Juvenile Justices Advisory Committee, 2006.

## Conclusion

The State Advisory Council and Children's Subcommittee have appreciated the opportunities to advise the Governor and the Legislature during the past two years on issues relating to mental health.

We will continue to advocate that all persons in Minnesota have access to timely, appropriate and quality mental health services.

## Resources

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. U.S. Department of Health and Human Services Pub. No. SMA-03-3832. Rockville, MD: 2003.

<http://www.mentalhealthcommission.gov/>



*Former State Advisory Council Chair Kris Flaten addresses the audience at the Governor's February 24, 2006 Mental Health Initiative press conference.*

*“Your ongoing participation will be essential to helping legislators, other policy leaders and members of the general public understand the importance of integrating physical and mental health care, creating incentives for early identification and intervention and forestalling the significant and unnecessary human and economic costs that result from untreated illness. Moreover, we can use this opportunity to engage more people in a deeper discussion of mental health issues that may help to lift the stigma that prevents many individuals from seeking and getting the medical care they need.”*  
—Governor Tim Pawlenty, March 17, 2006 letter to Kris Flaten, Chair of the State Advisory Council on Mental Health.

<http://mentalhealth.dhs.state.mn.us>