

Minnesota's Children's Mental Health System

This document was prepared by the Mental Health Legislative Network. It is designed to provide a basic overview of Minnesota's children's mental health care system, outline how programs and services are funded and demonstrate the positive outcomes of community mental health services. Many of the positive changes are due to the reforms enacted under the 2007 Mental Health Initiative.

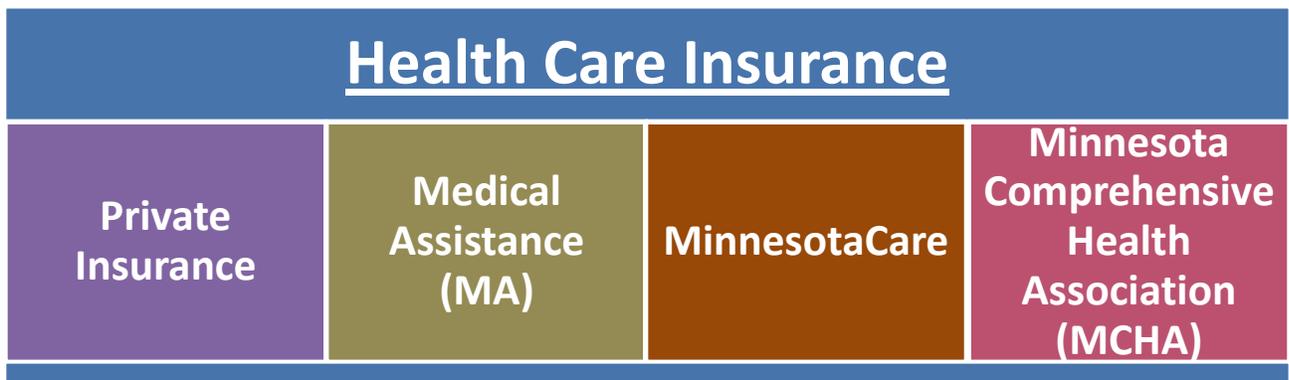
What are Severe Emotional Disturbances (SED)?

For the purposes of determining eligibility for case management and community support services, a child with a severe emotional disturbance (mental illness) must meet at least one of the following criteria:

- Hospitalized within the past three years or at risk of being admitted to residential treatment;
- Currently receiving inpatient or residential treatment for an emotional disturbance;
- A mental health professional determines the child:
 - Suffers from psychosis or clinical depression;
 - Is at risk of harming themselves or others because of an emotional disturbance;
 - Symptoms resulting from abuse or trauma;
- Significantly impaired functioning at home, in school or in the community as a result of an emotional disturbance; or
- A mental health professional determines that the disorder could last at least one year.

There is also a tool called the CASII that helps mental health providers and professionals determine what level of care a child needs.

How are Mental Health Services for Children Funded?



As the chart above shows, children with severe emotional disturbances, who have insurance, receive health care coverage through one of four entities:

- **Private Insurance:** Provided through an employer or an individual/family plan. Most private plans do not cover the model mental health benefit set. Self-insured employers do not have to offer plans that include mental health benefits. Mental health parity does not apply to many small employers or individual/family plans.
- **Medical Assistance:** Minnesota's Medicaid program. Families on MFIP (welfare) and certain children with disabilities are eligible. Covers the full model mental health benefit set.
- **MinnesotaCare:** Health care coverage for children who cannot access affordable or adequate health insurance. Covers the full model mental health benefit set.
- **MCHA:** Minnesota's high risk pool for children with pre-existing conditions who have been denied coverage in the private market. This program has very high deductibles and does not include the full model mental health benefit set.

Additional Funding Sources

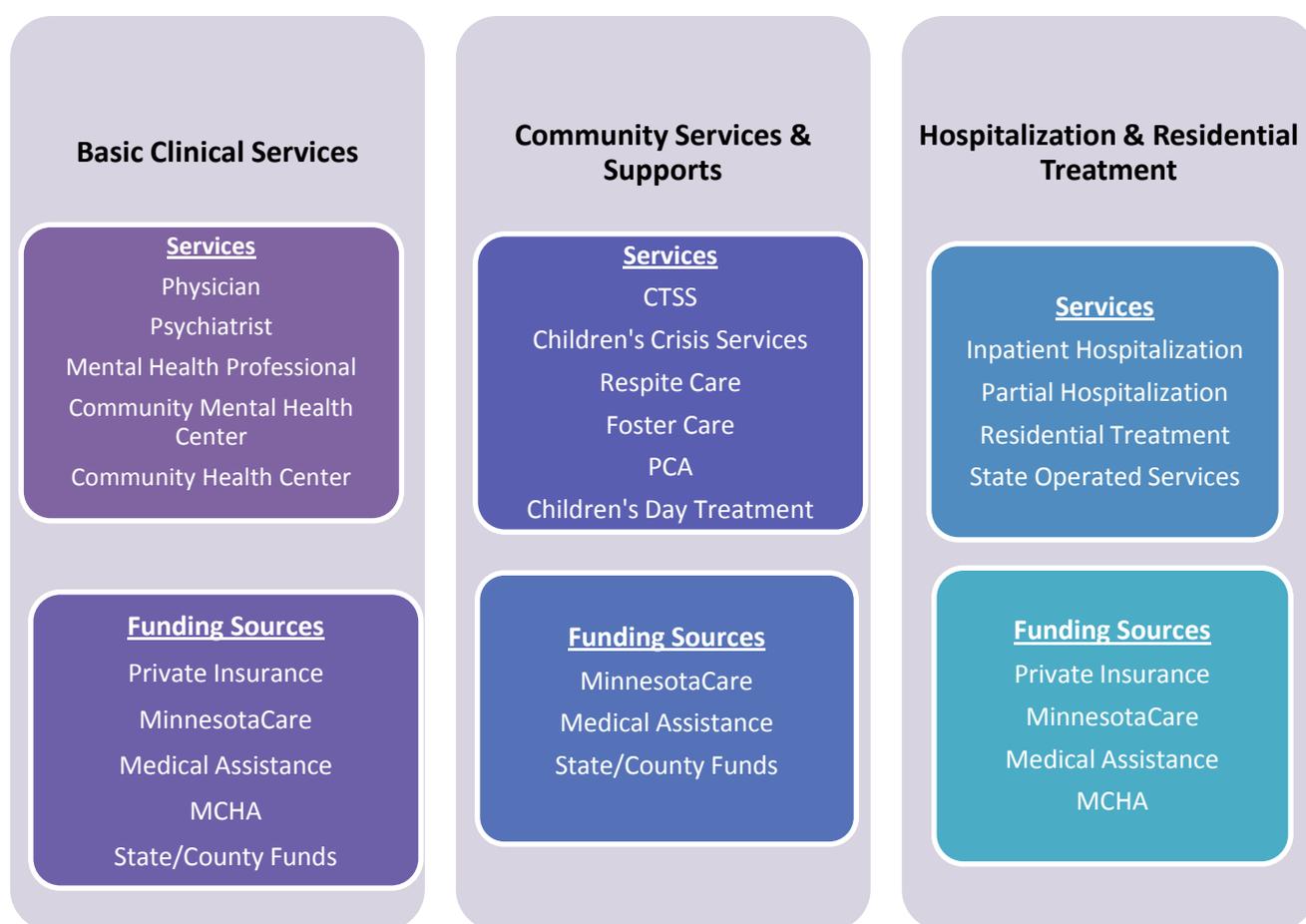
**County Children's
Mental Health Funding**

**State Children's
Mental Health
Infrastructure Grants**

**State Children's
Mental Health Block
Grants**

These funds are used to support the basic infrastructure of the community mental health system as well as to help provide treatment and services to children who are uninsured or underinsured.

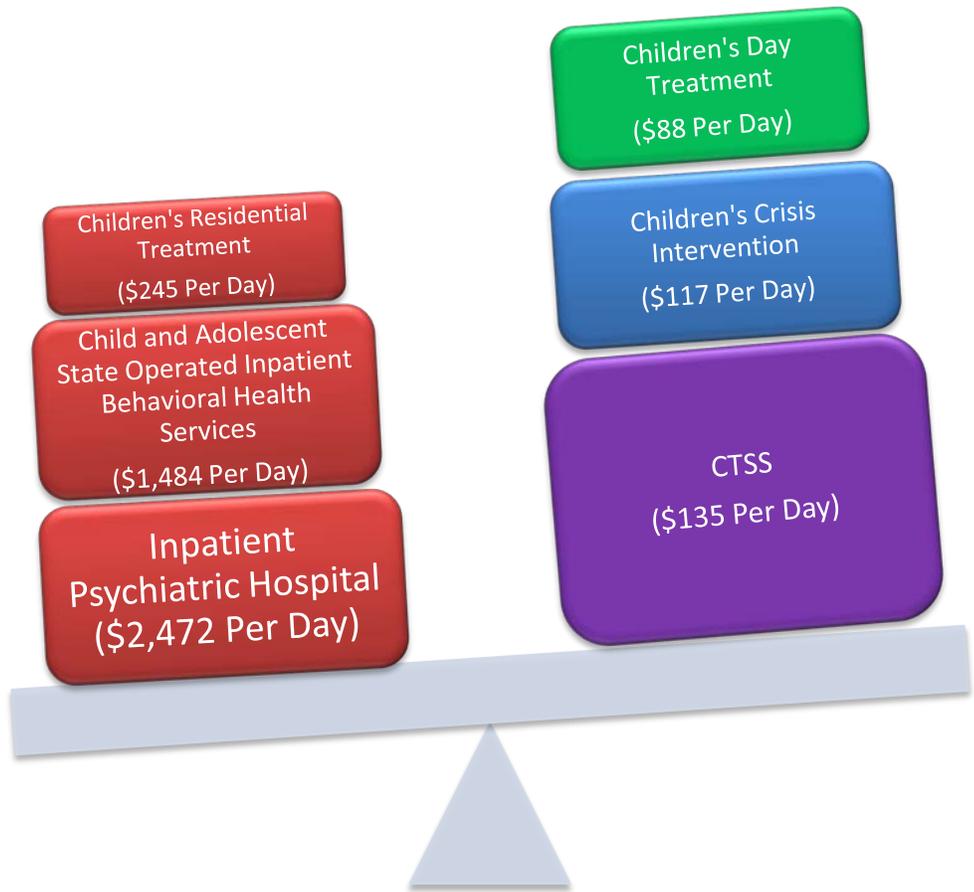
How Are Mental Health Treatments and Services for Children Delivered?



The chart above provides a basic overview of the different types of children's mental health services and how they are funded. CTSS services are a combination of different services included psychotherapy and skills training, delivered either in a day treatment setting or in-home. Mental health professionals include psychologists, specially trained nurses, clinical social workers, marriage and family therapists and licensed professional clinical counselors. Often basic clinical services and community services and supports are combined and coordinated to prevent more costly hospitalization.

How Much Money Could Community Mental Health Services Save?

Cost Comparison Between Community Children's Mental Health Services & Hospitalization

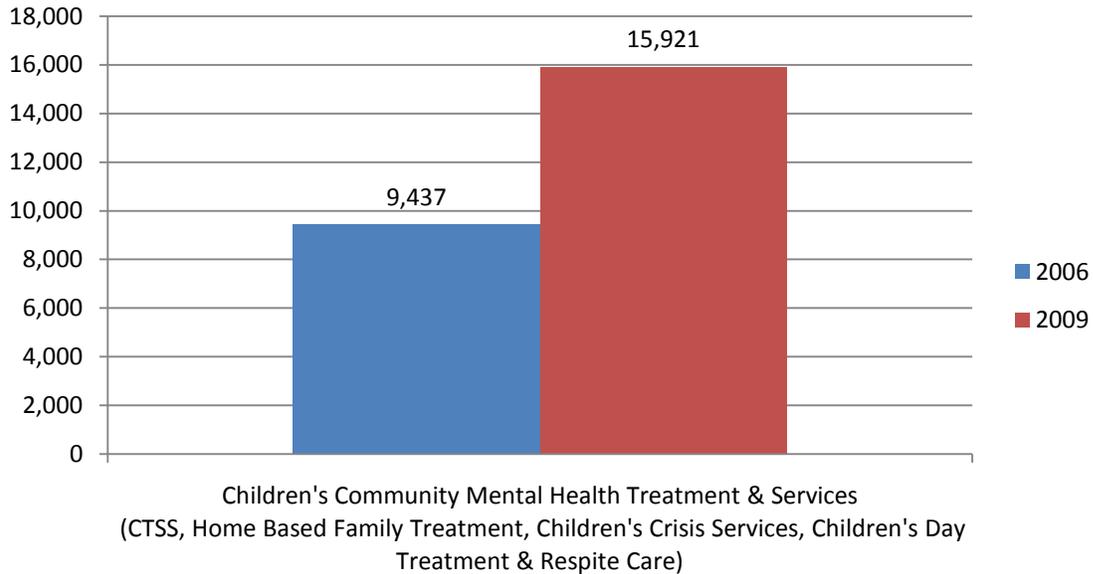


The chart above shows the immense cost savings that can result from investing in community mental health treatments and services.

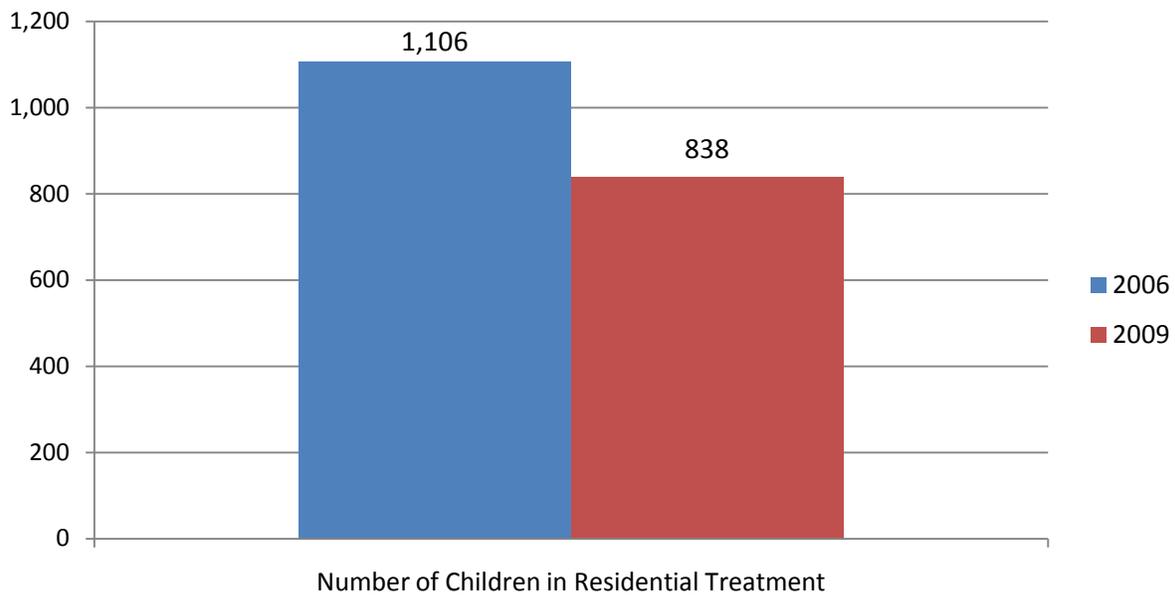
What Are The Positive Outcomes of Community Mental Health Services for Children?

All data from FY 2009 unless otherwise noted.

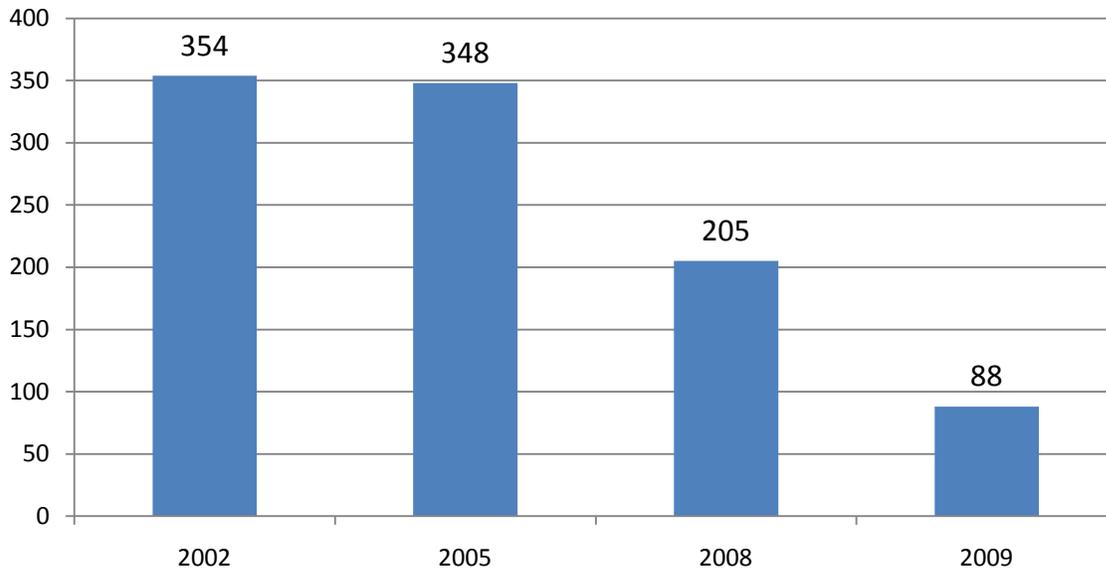
Number of Children Using Community Mental Health Services



Number of Children in Residential Treatment

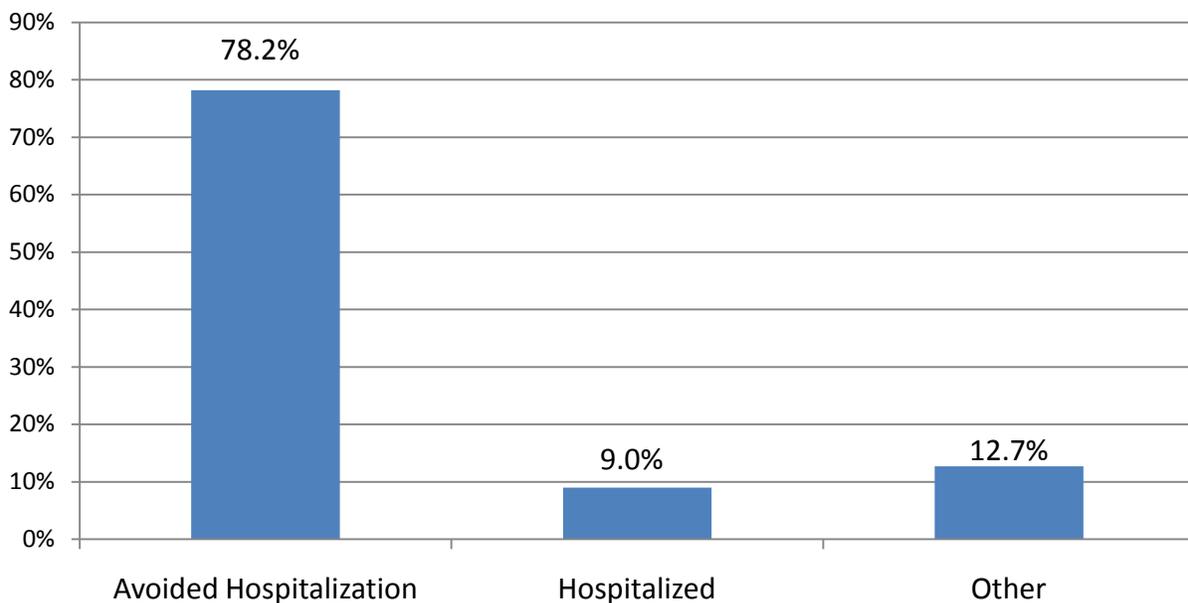


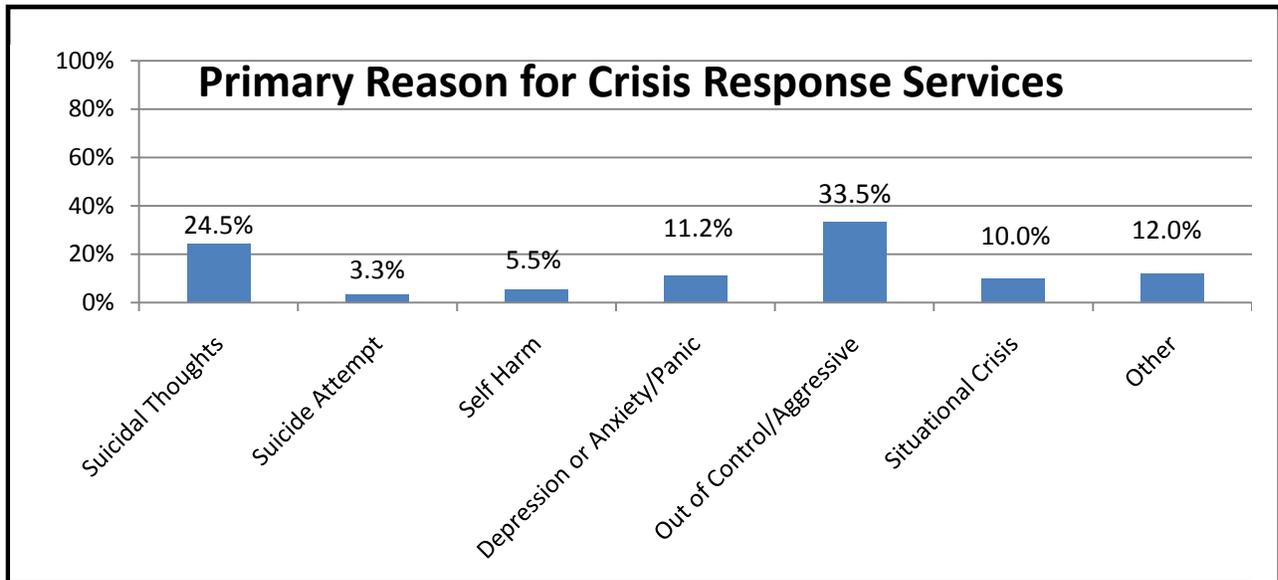
Number of Children in State Operated Regional Treatment Centers



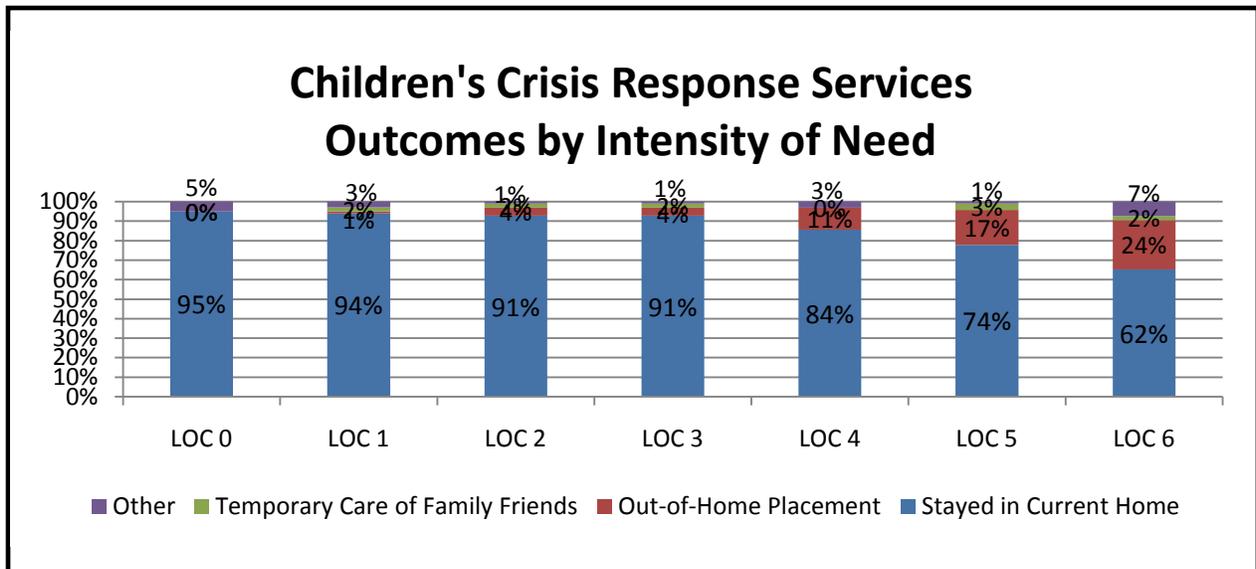
The three charts above show the use of children's community mental health treatments and services has increased over time while the number of children in more costly residential treatment and state operated regional treatment centers has declined.

Children's Crisis Response Services Outcomes

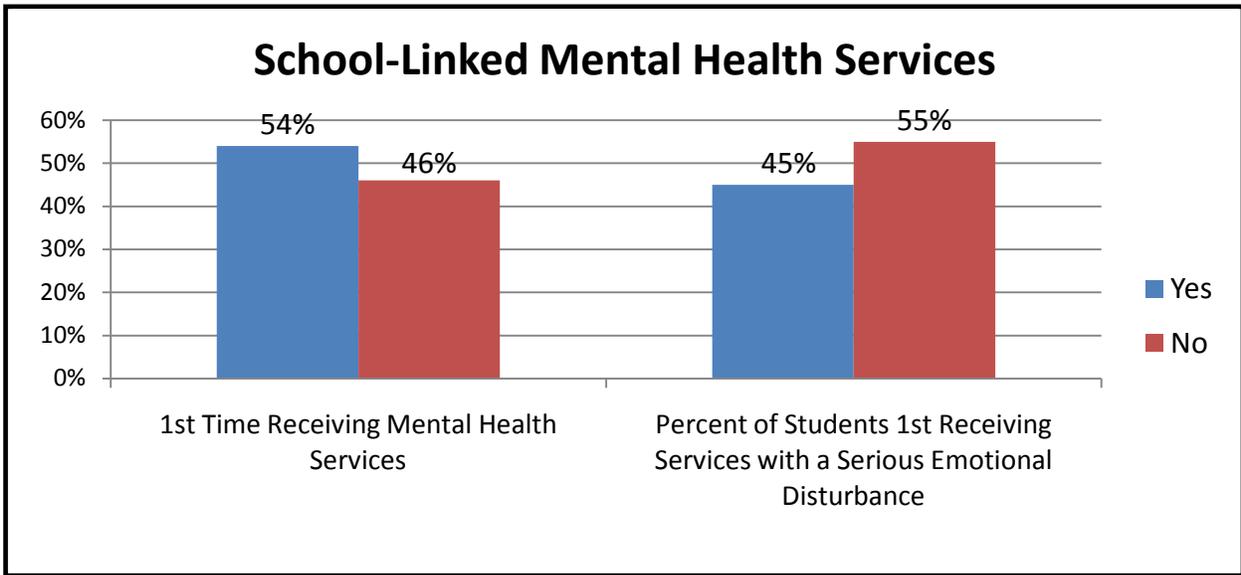




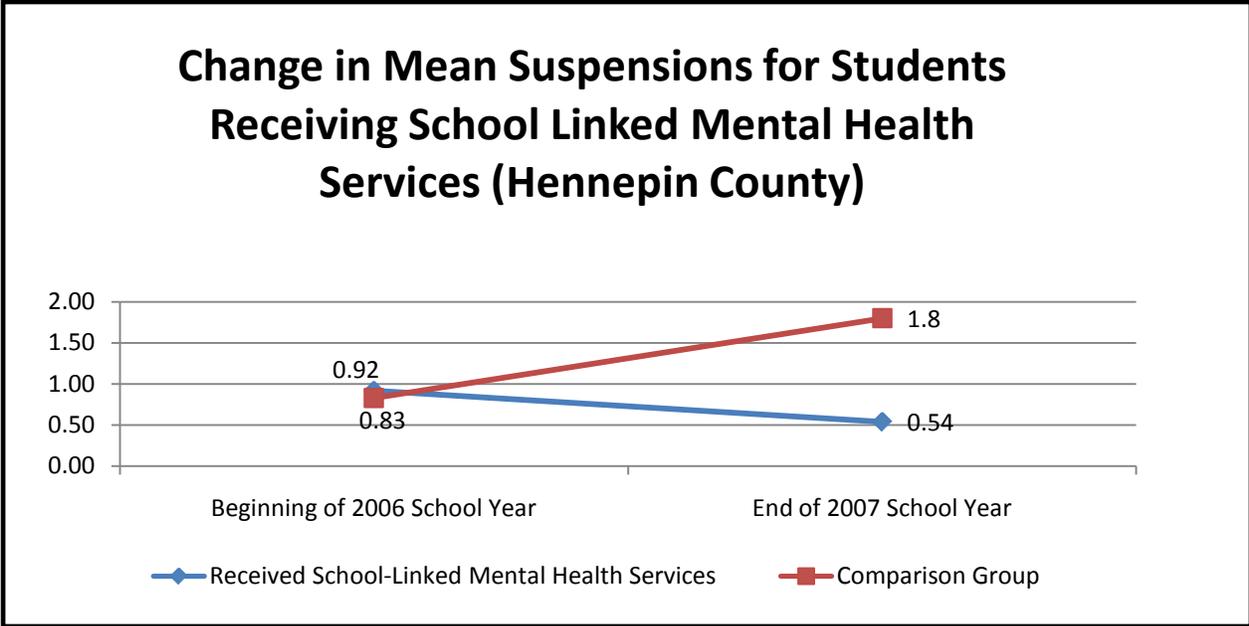
The two charts above describe the nature and outcome of children’s crisis response services funded through the state children’s mental health infrastructure grants. In over 78% of crisis response situations the child was able to remain in their home. Without these services in place, the only alternative that parents have is to take the child to the hospital or call 911. Children’s crisis services cost \$107 per day on average, a huge savings when compared to the cost of hospitalization, paramedic services or police response. These grants also include funding for follow-up and stabilization services to help avert future crises.



The chart on the previous page shows the effectiveness of Children’s Crisis Response Services in keeping children out of the hospital, even those with the very highest needs. This chart shows the outcomes of children based on their CASII assessment of needs/risk. The LOC scores indicate a range of functional problems and the corresponding level of care needed, from LOC 0 (small impairment needing minimal services) to LOC 6 (high impairment which requires 24-hour supervised hospitalization). As the chart shows, even children with the highest CASII scores were able to avoid hospitalization in the majority of cases.

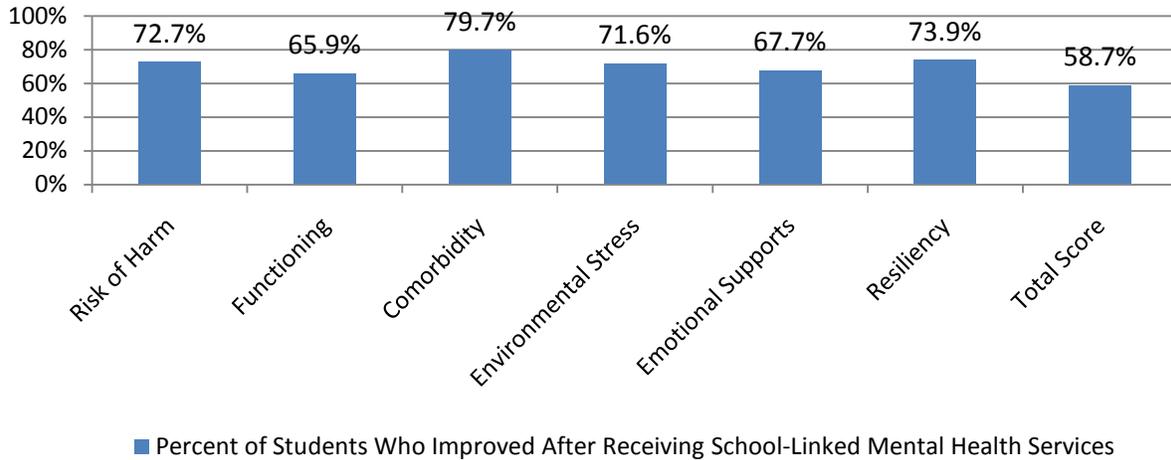


The chart above shows the effectiveness of connecting children and adolescents who have not received mental health services in the past. Of the students who were served through school-linked mental health services, 54% are getting mental health treatment for the first time. The chart also shows that of these students, 45% were identified as having a serious emotional disturbance. These programs are primarily funded through state infrastructure grants with some funding from Medical Assistance, MN Care and private insurance as well.



The chart above shows the positive impact of school-linked mental health services on student's suspension rates in Hennepin County. Students who received school-linked mental health services saw a dramatic drop in their suspension rates while students with a comparable number of suspensions who did not receive services were suspended even more than the previous year. Of the students receiving services, 50% had between 1 and 6 fewer suspensions. Data provided by Hennepin County.

Children Demonstrating Improvement Following School-Linked Mental Health Services



The chart above shows the positive outcomes in the lives of students who receive school-linked mental health services. This chart shows the outcomes of children based on their CASII assessment of needs/risk. The LOC scores indicate a range of functional problems and the corresponding level of care needed, from LOC 0 (small impairment needing minimal services) to LOC 6 (high impairment which requires 24-hour supervised hospitalization). The chart depicts the percent of students with high initial CASII scores whose scores dropped, meaning they got better after receiving school-linked mental health services. The students pictured in this chart all had initial scores of 4 or higher, which indicates the need for intensive integrated services. Of these students, 57% no longer needed as intensive services after receiving school-linked mental health care. As a result of these services, students are able to learn better and are less likely to cause disruptions in the classroom. Success in school leads to success later in life.

If you have any questions about the cost-effectiveness of community mental health treatment and services please contact Sue Abderholden (NAMI Minnesota) at 651-645-2948 ext. 105, 612-202-3595 or sabderholden@nami.org.