2013 County Long-Term Services and Supports

Gaps Analysis Survey

Children's Mental Health Services

Full Report

Minnesota Department of Human Services

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Contents

Introduction

Every two years, the Minnesota Department of Human Services (DHS) gathers local information about the current capacity and gaps in services and housing needs to support older persons in Minnesota. This survey is the Status of Long Term Services and Supports (LTSS). Since 2001, all counties in Minnesota have been requested to respond to a survey of local capacity to meet long-term care needs of current residents, including any significant "gaps" in services or supports. This information is submitted to DHS through a County Gaps Analysis Survey.

In 2012, the legislature expanded the required biennial LTSS Report beyond older adults to include services for people with disabilities and/or mental illness of all ages.

A bulletin was issued in March 2013 requesting counties to complete the Gaps Analysis Survey. This survey added children and adults with mental illness and persons with disabilities to the analysis of long-term care needs of older Minnesota residents.

This report provides a statewide summary of the 2013 Gaps Analysis for children's mental health services. These results will provide an overview of statewide trends in needs, capacity and development. Individual county profiles are also available at the Gaps Analysis results website, found at the following link: www.dhs.state.mn.us/GapsAnalysis/cmh.

Background

In 1989 The Comprehensive Children's Mental Health Act[1] was passed to provide guidance in developing a state-supervised, county administered children's mental health system. Services range from education, prevention, emergency, outpatient, residential treatment, and inpatient psychiatric services. Many of the services in the Act are also included in the Medicaid State Plan and covered under the Medical Assistance and MinnesotaCare programs.

As the children's mental health system of care continues to evolve, evidence-based practices have been promoted and trained on a statewide basis. Most recently, new research on the lifelong physical and mental damage caused by traumatic events experienced as a child or teen has led to statewide clinical training on trauma-informed care.

Results

The results presented in this document are based on county self-reports of capacity, or availability of a service, in their service areas. Counties were asked to report on their

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[1] Minnesota Statutes 245.487-245.4888

capacity to meet mental health care needs of children with mental illness through several different service categories, including *Outpatient Services*, *Rehabilitative Services, Mental Health Targeted Case Management*, and *Residential Treatment Services*.

There were 78 total replies, which represent 84 of Minnesota's 87 counties (eight of which are part of multi-county agencies[2]). For the purposes of calculating our percentages, each multi-county agency is counted as one response. Within this report, the term *county* will refer to both individual counties and multi-county agencies.

Unless otherwise noted, any percentages provided in parentheses throughout this report indicate the percentage of counties that reported the finding under discussion.

Capacity of Children's Mental Health Services

Counties were asked to report on the capacity (availability) of 56 mental health services in their jurisdiction. For all services in which the county reported a gap, respondents were asked a follow-up question to identify possible barriers and limitations to access. Counties also reported on local capacity to provide culturally competent services, along with their county's priorities for service development.

Current Service Capacity

Within the categories of services, counties were asked to determine if the service currently is not available, available but limited, meets demand or exceeds demand.

Service Capacity Meeting or Exceeding Demand

As shown in Figure 1 below, the top services reported as meeting or exceeding demand include: *outpatient individual psychotherapy* (68%) *diagnostic assessment* (66%); *rehabilitative individual psychotherapy* (65%), *early childhood (pre-school) mental health services* (62%), and *referral to a mental health professional (from primary care physicians)* (60%).

Stronger service capacity exists within outpatient services which are typically delivered by a mental health professional (MHP). Additionally, some of the rehabilitative services such as *individual skills training* and *family psychotherapy* are less accessible—available in half or fewer of Minnesota counties.

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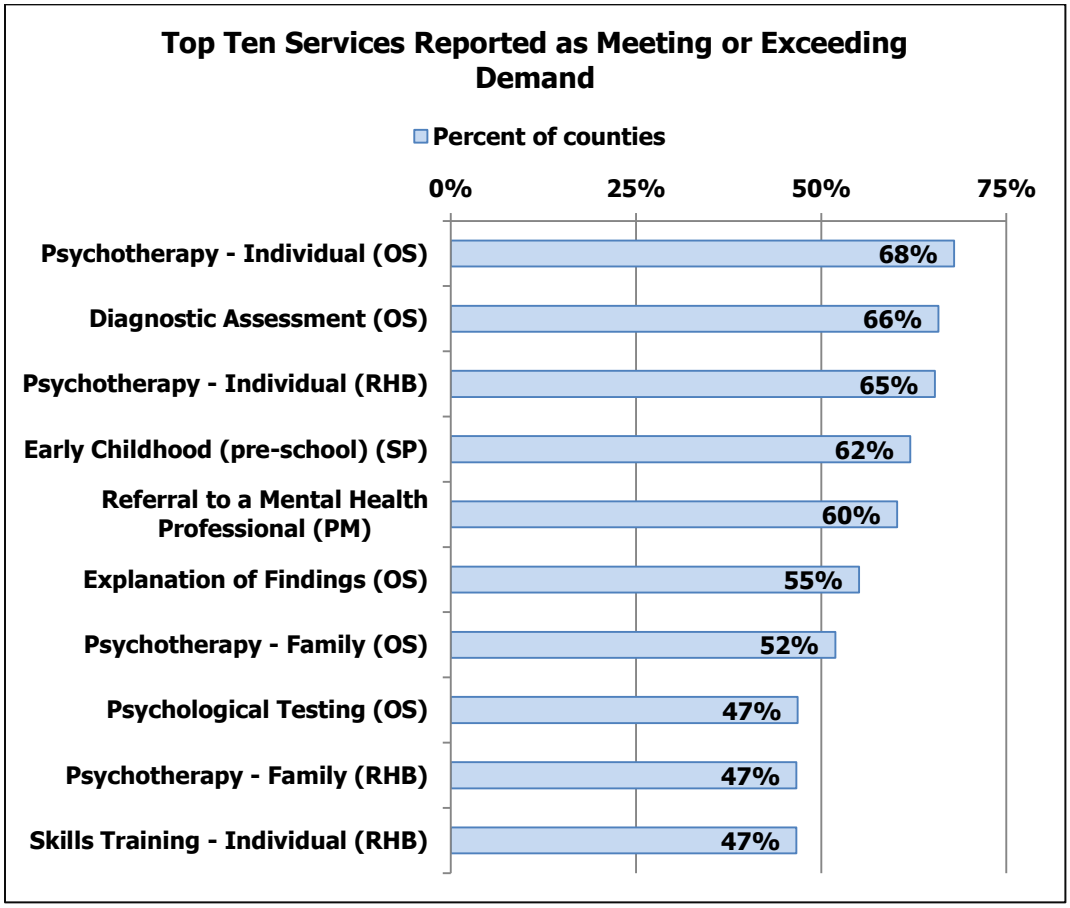
[2] The following counties submitted a single survey because they operate as multi-county human service agencies: Human Services of Faribault and Martin counties; and Southwest Health and Human Services (Lincoln, Lyon, Murray, Pipestone, Redwood and Rock counties)

Service Capacity - Exceeding Demand

Very few counties reported any mental health services exceed demand. *Individual psychotherapy* and *children's mobile crisis response* were tied at 3% with *referral to a mental health professional*, *psychological testing*, *neuropsychology* and *early childhood (preschool)* each reported by 1% of the counties. Significantly, the majority of counties report gaps in the availability of *mobile crisis response*.

Figure 1: Capacity: Top Services that Meet or Exceed Demand



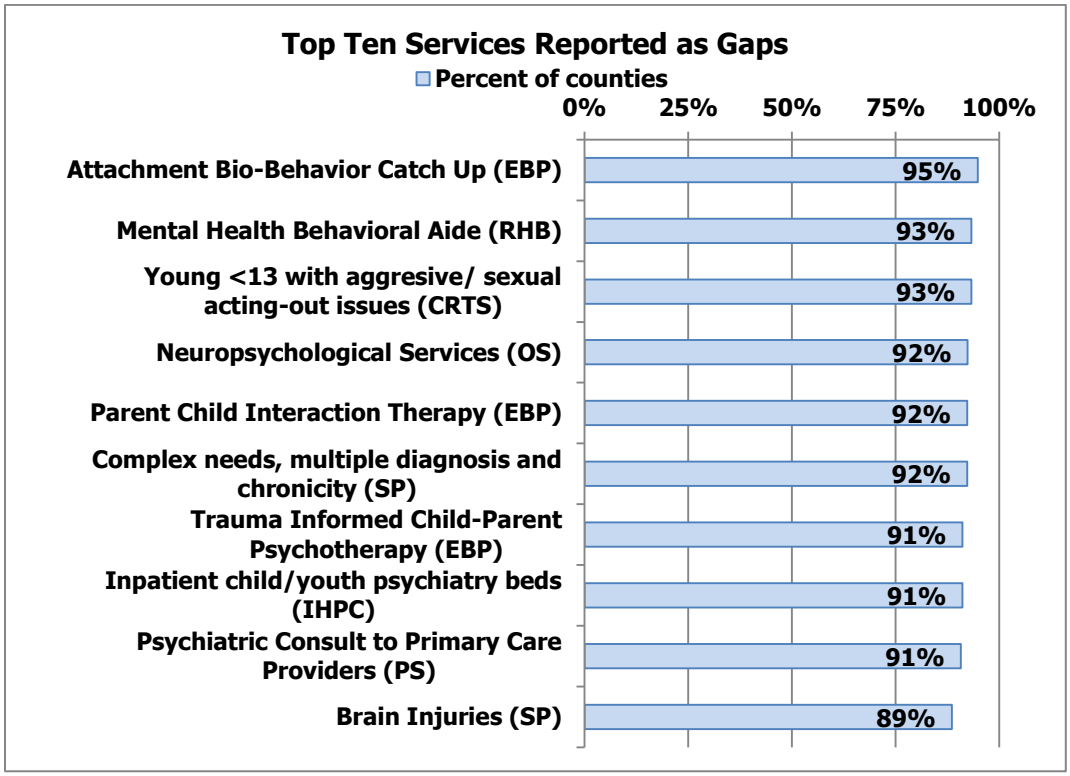
Service Category Key:

- OS: Outpatient Services
- PM: Psychotropic Medications
- RHB: Rehabilitative Services
- CRTS: Children's Residential Treatment Services
- EBP: Evidence Based Practices
- SS: Support Services
- SP: Special Populations
- IHPC: Inpatient Hospitalization Psychiatric Care
- PS: Physician Services

Most Common Service Gaps

Figure 2 below summarizes the top 10 (out of 56) services where counties reported insufficient capacity. These rankings were calculated by combining the number of counties who reported a service was *unavailable* with those that reported the service as *available but limited*. Three of the top ten include evidence-based practices (EBP) while many of the other services are more specialized in nature. Figure 3 shows the top ten services that were reported as *not available* by counties. Table 1 in Appendix A provides a complete summary of county reports of capacity for each service. Appendix B of this report includes a summary of the barriers reported by counties to developing these ten services.

Figure 2: Top Ten Services Reported as Gaps



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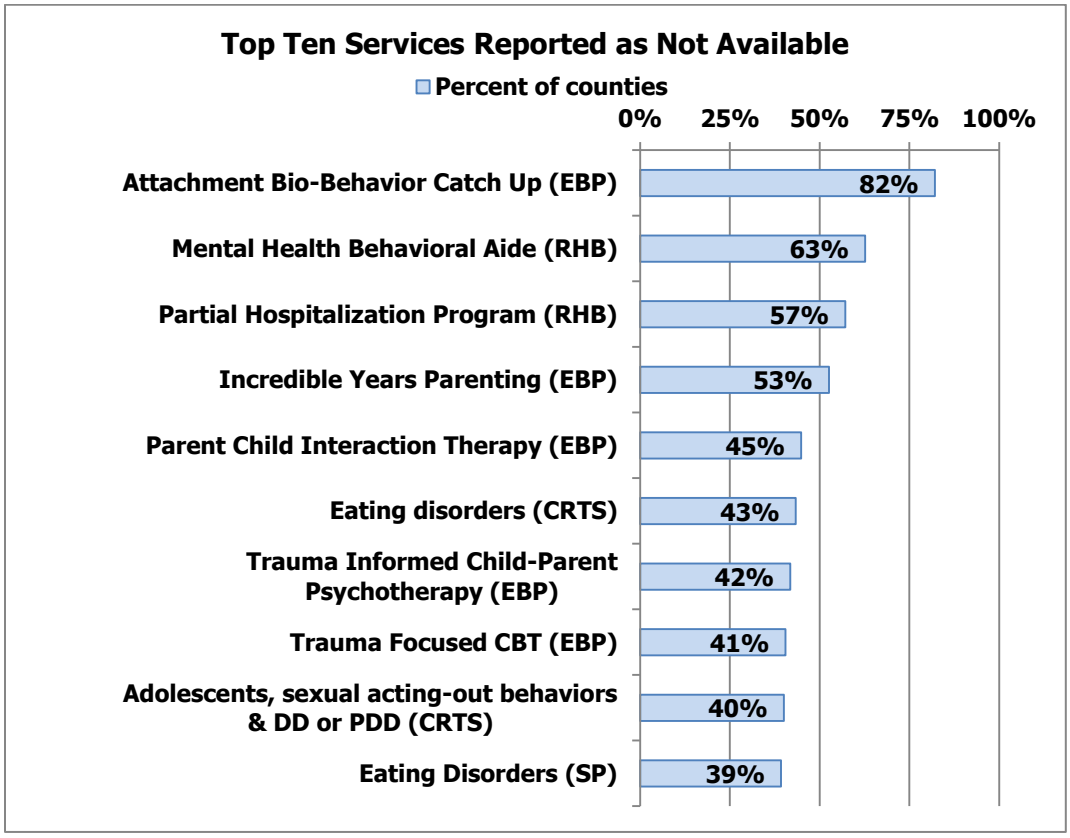
Top Ten Services Reported as Not Available

Figure 3 below summarizes the top 10 (out of 56) services where counties reported services are unavailable. Four services include the following EBP: Attachment Bio-Behavior Catch Up (82%), Incredible Years Parenting (53%), Parent Child Interaction Therapy (45%), and Trauma Informed Child-Parent Psychotherapy (42%). The rehabilitative therapies of Mental Health Behavioral Aide (63%) and Partial Hospitalization Program (57%) rank second and third respectively, as services that are not available to children within their communities. Eating Disorder treatment in both community (39%) and residential (43%) treatment are reported as unavailable. Residential treatment services for adolescents with sexual acting-out behaviors & developmental disabilities (DD) or pervasive development disorder (PDD) were reported as unavailable by 40% of the counties. Significant gaps for these specialized populations require additional analysis to evaluate resources and next steps.

Figure 3: Top Ten Services reported as Not Available



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Outpatient Services

Only 8% of the counties reported *neuropsychological services* meet or exceed demand. Additionally psychotherapy (*group psychotherapy* and *multi-family group*) services meet the demands in approximately 24% of the counties.

Mental Health Targeted Case Management (MH-TCM)

Currently counties utilize various methods to measure the effectiveness of Children's Mental Health Targeted Case Management services. Standardized measurement tools include Child and Adolescent Service Intensity Instrument (CASII), Strengths and Difficulties Questionnaire (SDQ), Social Services Information System (SSIS) as well as case notes, Child and Adolescent Functional Assessment Scale (CAFAS) and Children and Family Services Review (CFSR). Additionally, progress on the goals and treatment objectives are measured. Collaboration occurs among agencies working with the child regarding progress or lack of thereof and the need to incorporate new referrals for the child. Functional assessments are examined for possible improvements, and staff meets on a regular basis to discuss. Feedback is received from professionals and service recipients both verbally and by client satisfaction surveys, assist to gauge service effectiveness.

Counties were also asked to identify changes needed to the current mental health case management reimbursement system. Those responses varied from confusion about the question to noting huge disparities between county rates, citing higher rates for larger counties with larger administrative overhead, not tied to the individual child/youth's needs. Insufficient rates were reported for Medical Assistant (MA) eligible youth, (Counties receive only the Federal portion of the reimbursement) with no reimbursement for non-MA eligible (previously some State grant funding existed for this population).

Many respondents suggested rate standardization across the state, based on client contact in either 15 minute or one hour increments. (Now, counties are paid a monthly contact rate for each child served during the month. Currently Social Service Time Study (SSTS) is used to determine rates. Some counties note that some random moments used to establish rates include hours outside the agency's normal work day (causing lower rates).

Counties also advocate that additional activities should become reimbursable, such as plan development, face-to-face visits, collateral contacts, phone contacts, travel, clinical supervision, and Skype contacts.

Additional comments were directed at inconsistencies across the managed care organizations (MCO) and the fee-for-service (FFS) program, citing different billing

procedures, rates, prior authorizations, and documentation. MCOs have different interpretations and expectations. One county noted case management works well since they contract with all the MCO that serve their county residents. If consumers move between MCO, and FFS, they still receive the same level of service.

Another suggestion was to keep rates the same for transitional youth ages 18-22 years who are still receiving children's mental health targeted case management (MH-TCM). Interestingly, recent legislation[3] was passed allowing the higher children's rate for these transitional age youth. One county requested a webinar to identify ways to maximize TCM (funding).

On the average, mental health targeted case managers reported having one monthly face-to-face contact with some counties having additional team meetings to discuss open cases. For this standard one contact-per-month, counties are paid from $338 to $2,529 per month (adult TCM has different rates established).

Psychotropic Medications

Counties were asked who prescribes psychotropic medications in their area. Interestingly, psychiatrists (51%), Medical Doctors (17%), Advanced Practice Nurse (10%) and other (19%) were checked (see Figure 4). The descriptions written as to why the respondents checked the "other" category indicates that a variety of all of the above prescribe psychotropic medications in their areas.

Figure 4. Who is prescribing Psychotropic Medications?

Entity prescribing psychotropic medications	Percent of counties
Advanced Practice Nurse	10%
Medical Doctor (MD).	17%
Physician's Assistant (PA)	1%
Psychiatrist	51%
Other, please describe	19%
Not applicable	1%

The Minnesota Collaborative Psychiatric Consultation Service, which began in August of 2012, provides psychiatric consultation to pediatricians and other providers who prescribe psychotropic medications for children. The service is provided through a contract with the Mayo Clinic and subcontracts with Sanford, Essentia, Prairie Care and

[3] Minnesota Laws 2013 Chapter 108 Article 4, Section 7

Allina Health Systems. The service operates a call center Monday through Friday from 7 a.m. to 7 p.m.

The service is designed to improve quality of care, by encouraging the use of evidence-based treatments in addition to or in place of medication where appropriate; making more efficient use of both primary care and specialty mental health service; and by improving collaboration between primary care and behavioral health services.

Rehabilitative Services (RHB)

Children's Therapeutic Services and Supports (CTSS) providers: 95% of counties reported the presence of Children's Therapeutic Services and Supports certified providers in their county.

CTSS Service Availability: Two optional CTSS services were listed as service gaps by county respondents. They report that *Mental Health Behavioral Aide (MHBA)* services (63%) and *day treatment* (28%) is not available for the child/youth in need. (See also Appendix B). Counties' survey responses indicate that many are out of compliance with statute, since the Children's Mental Health Act requires counties to ensure that day treatment is available or other alternative services exist through the county's family community support services.

Group psychotherapy (78%) and *group skills* (80%) reported as *unavailable* or *available with limitations* in supermajorities of the counties. Survey responses, thus, indicate that CTSS certified providers also may be out of compliance since law and certification require them to ensure that all core CTSS services are available for the child who needs them. (Core services are: psychotherapy, skills training, and crisis assistance).

Partial Hospitalization Program (PHP) availability

Only 12% of the counties report adequate supply of *partial hospitalization programs (PHP)* to meet current demand while 57% of the counties report that no PHP services exist in their area.

Residential Treatment Services

The survey asked whether or not children's residential treatment services are available in their area. Only 39% answered in the affirmative.

Treatment Facility Specialty Beds/Services Availability

The counties were asked about specialty residential treatment bed availability to meet unique mental health needs for children within their services area. Specific residential treatment services were not available for following children/youth: *eating disorders* (43%), *treatment of sexual acting-out behaviors for adolescents with developmental disabilities or pervasive developmental disorder* (40%), *adolescents with sexual acting out* (20%), *aggressive behaviors* (17%) and *services for young children (less than 13 years of age) with aggressive and/or sexual acting-out issues* (17%).

Barriers for Treatment Specialty Beds and Services

Some counties reported that they do not face any barriers in this area while the majority of respondents report unique challenges especially in rural areas in having adequate access to residential treatment beds. While some programs have closed due to low patient numbers and reimbursement issues, others have lengthy waiting lists. In rural locations often times the residential program holder is located up to 200-plus miles away from the families and/or may have a 30-60 day waiting list for admission. Some counties also note that they do not have large enough populations to warrant development of specialty beds or that low or fluctuating census affects the ability of the residential program holder to provide these services locally.

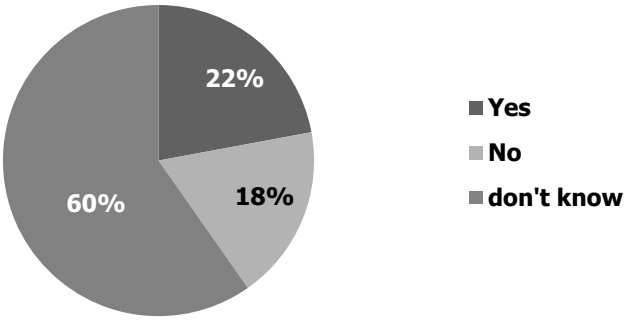
Counties point to the need to expand intensive home-based services to either divert children from out-of-home placement or support the child and family in the transition back to their home. Additional services they wish to develop include MHBA services, stabilization for children in the hospital, who are ready for discharge but awaiting a higher the next step-down in care and additional provider and parent training to meet the complex needs of these children in their communities.

Mental health parity was again mentioned since some private insurance does not cover residential treatment services.

Qualified staffing at the residential treatment facilities, as required in licensing requirements, is lacking, according to respondents. One solution mentioned to be explored is child psychiatry through tele-medicine.

Over one-fifth (22%) of counties reported that there are persons in their county who could move to the community if supports were available (see Figure 5). Three-fifths (60%) of counties indicated they did not know if they had persons who fit this description.

Figure 5. Individuals receiving residential treatment services who could move to community setting with adequate supports



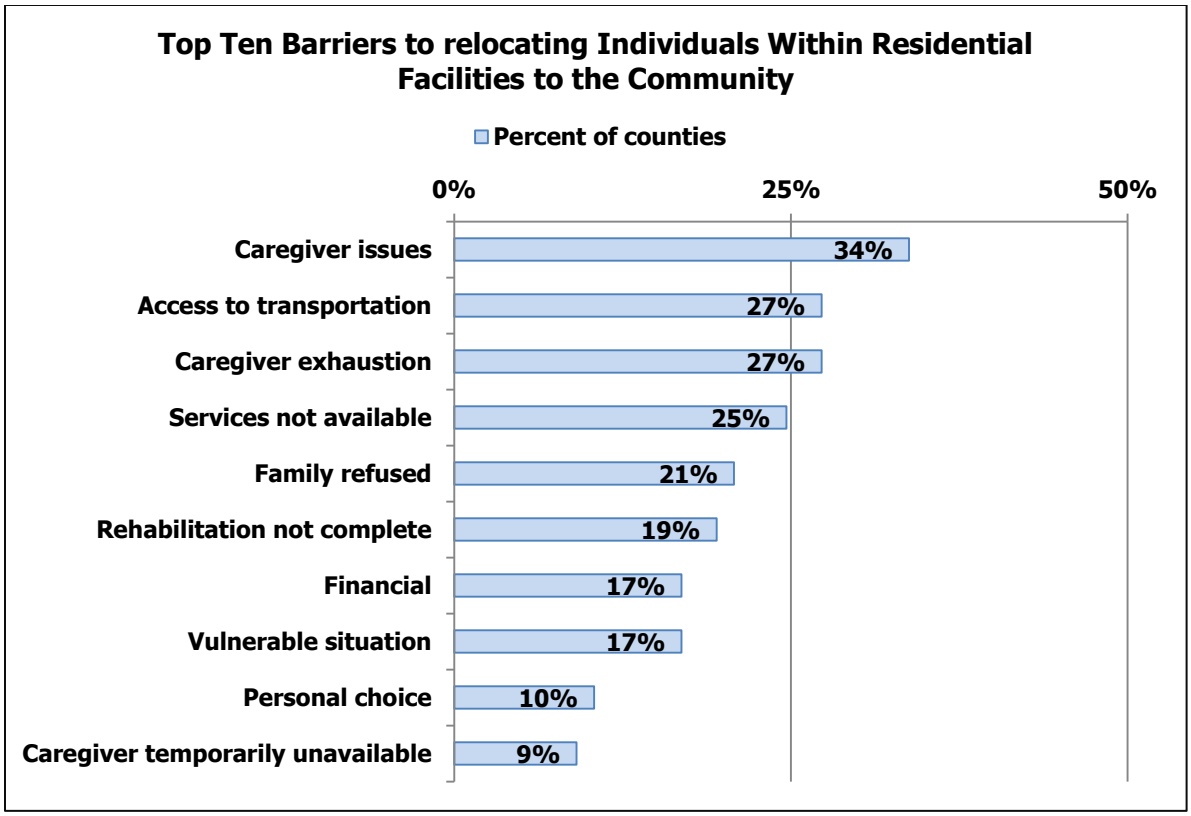
Barriers to Return to Community

Figure 6 below summarizes the percentage of counties who reported the presence of specific barriers to relocating individuals receiving mental health services from residential services into the community. *Caregiver issues* (34%), *access to transportation* (27%), *caregiver exhaustion* (27%), and *services not available* (25%).

Barriers to return to the community weigh heavily on two general deficiencies in local children's mental health systems: first, lack of community based resources and, second, lack of supports for families struggling with the extraordinary demands of raising children with severe and complex mental illnesses.

The survey confirms that efforts to build local service-delivery infrastructure remain unfinished. Since 2007, the Children's Mental Health Division has engaged in a multi-pronged infrastructure development strategy: First, provide targeted grants to build clinical capacity for underserved population groups and uninsured individuals and create crucial services where they are lacking. Second, expand the public healthcare benefit to include necessary mental health services that are not yet covered. Third, grow the healthcare workforce with highly-qualified, culturally-competent mental health clinical professionals. Fourth, reach children in a normalized environment where access is easier and treatment is more effective.

Figure 6: Barriers to Relocating Individuals within Residential Facilities to the Community, Percent of Counties



With 25 percent of counties responding that services are not available, the survey offers clear evidence that clinical infrastructure development must remain a top-priority goal for DHS. More resources are needed to provide equal access to the full array of children's mental health services to children in every Minnesota community.

The high percentage of respondents citing caregiver exhaustion points to a well-known shortage of Respite Care, a support service that can relieve parents' exhaustion and stress. The State has funded grants to counties, since 2008, to build Respite Care capacity. Clearly the need remains unmet. DHS will need to assess the level of committed resources; whether existing resources are being used effectively; and whether a different method of resourcing Respite Care might produce wider access.

Several survey categories point to a general need for stronger support of families. The category "caregiver issues" is vague, but the high rate of counties identifying it as a barrier to bringing children home from residential facilities indicates trouble among families. Add to that barrier, the following: *caregiver exhaustion*; *family refused*, (i.e., refused to allow the child to come home); *vulnerable situation*; and *personal choice* (not to go home). The picture that emerges is that of homes and communities unable support a child, even one that has successfully completed an extended period of treatment and a picture of families unable to care for its own members.

The survey does not answer the question, "why?", but suggests a line for further state examination. Research indicates that parents of children in a foster placement

(including residential treatment, in Minnesota) often have mental illnesses of their own. When adult mental health providers fail to connect the impact of a parent's mental illness to its effects on her children, does that constitute a failure to support the child's upbringing and create a *caregiver issue*? A *vulnerable situation*? Or does the mother's own mental illness result in a refusal bring the child home? What, beyond lacking a regular time for respite, could be causing barriers internal to the child's family? Could it be the failure to recognize and address an accumulation of a parent's own adverse childhood experiences (ACE); traumatic events that have disrupted a parent's ability to form secure and trusting relationships with her children?

There is a need for more intensive home-based therapeutic services, including partial hospitalization, day treatment and for mentors, support groups, adult-child day treatment for parents that addresses the impact of the parent's mental illness on the health and development of the child. More mobile crisis response services would not only address extant emergencies, but would offer families more confidence they back-up would be available if their children came home. The lengthy waiting list for CADI waivers is noted as delaying critical supports to return the child to the home. Skilled respite service options are very limited which could ease caregiver exhaustion issues.

Evidence Based Practices (EBP)
Attachment Bio-Behavior Catch Up (82%), Incredible Years Parenting (53%), and Parent Child Interaction Therapy (PCIT) (45%) were identified as the top three EBPs that are not available in local service areas, with Trauma Informed Child-Parent Psychotherapy (42%) and Trauma Focused CBT (41%) rounding out the top five. Additionally, the validated assessment tool for young children (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised or DC: 0-3R) isn't available in 13% of the reporting counties.

DHS is supporting training in these evidence-based practices and training will continue to be offered to increase local provider's expertise. The first clinician cohort for *Attachment Bio-Behavior Catch Up* will complete their training in 2014.

Support Services
Counties were asked about the availability of support services to their communities. Approximately 25% of the counties report they can meet the demands in areas of outreach, prevention, promotion, and respite care. The remaining counties have either limited or no additional support services available for their families in need.

Special Populations
Specialized services for specific populations include co-occurring disorders reported under this category. Roughly one third of the counties reported that services are not available for children/youth with eating disorders; co-occurring mental illness and substance use disorders; brain injuries; and those who display complex needs with multiple diagnoses and chronicity, as well as specialized mental health services in juvenile justice settings.

Crisis Response

36% of the counties reported that no crisis response services are available. Interestingly, 3% felt that the crisis services exceed the demand. State grant funding continues to help build this service across the state. The 2013 Legislature appropriated an additional $750,000 per year in grants to establish four adult/child mobile crisis teams. However, DHS remains an estimated $3 million short of financing statewide children's crisis response services.

Inpatient Hospitalization Psychiatric Care

Counties were asked about the availability of inpatient child/youth psychiatry beds, psychiatrists involved in the treatment services and the presence of adequate/timely discharge planning. Approximately one third of the respondents identified inpatient psychiatry is not available in their jurisdictions. Furthermore, issues with adequate and timely discharge planning and psychiatry visits were reported.

Physician Services

Among the various physician services the counties were asked to report on, less than 20% felt that the physician services with behavioral health were meeting the demand for *assessment/interventions*, *integrated primary care with behavioral health*, and *consultations and psychiatric referrals*. As the departments of Health and Human Services move forward with healthcare or medical home models, it is hoped that these deficits will begin to lessen.

Cultural Competence

As Minnesota's cultural demographics continue to diversify, it is important to assess the capacity of the mental health service system to serve children from diverse cultural communities. The 2013 Gaps Analysis survey asked additional questions regarding each county's assessment of their provider network's preparation for working with specific cultural communities.

As summarized in Figure 7 below, only a small percentage of counties believe that their providers are "very prepared" to deliver care that is culturally competent to *racial and ethnic minority communities* (9%), *new American, immigrant and refugee communities* (4%) and *gay, lesbian, bisexual and transgender (GLBT)* communities (21%). Most notably, 30% of counties report their provider network is "not at all prepared" to deliver care that is culturally competent to n*ew American, immigrant and refugee communities*.

Figure 7: Cultural Competence: How prepared are providers for providing services to the following communities

Community	very prepared	somewhat prepared	not at all prepared
Racial/ethnic minority communities	9%	83%	8%

Community	very prepared	somewhat prepared	not at all prepared
New American/ immigrant/ English Language Learners / refugee communities	4%	66%	30%
Gay, lesbian, bisexual, transgender, queer and/or intersex communities	21%	79%	0%
Other cultural community	9%	80%	11%

Counties were also given an opportunity to provide an explanation of the rating they gave for each demographic community.

Racial/ethnic minority communities: Although a few counties reported experiences working with many of these communities, many counties (especially in rural locations) reported that they do not have much diversity in their area and therefore have not had a reason to become prepared to work with other groups. The counties that have experience working in this area discussed their collaborations with other counties, tribes, and other referral sources to provide culturally competent care to individuals. Some counties responded that language interpreters and accepted norms are issues for working within these communities. Surprisingly several counties noted they have a lack of diversity since the county demographics are mainly Caucasian. Cultural competency training varies greatly across the state with some noting no training available and others embracing specific curriculums and outside resources.

New American/Immigrant/English Language Learners/Refugee: The counties report varying abilities to serve these populations. Access to interpreters and very limited access to bilingual therapists are major barriers. Some counties utilize the Language Line with success while others comment that much of their work is lost in translation. Several counties report lack of diversity, with preparation needed if these populations move into their areas.

Counties tended to respond differently in their description of preparedness to work with the Gay, Lesbian, Bisexual, and Transgender (GLBT) community. Many rural counties report that they have either no services available or very limited capacity.

Transportation to specific therapists is a barrier to accessing culturally appropriate services. More of the urban counties report working with diverse populations and they note that many therapists are trained to meet the needs. One county noted that this population isn't talked about a lot. Support in the schools and with therapists (training) would be helpful. Although counties tended to be aware of providers with bilingual staff or culturally specific resources, no counties reported that they were aware of culturally specific providers for their community.

Even though many counties do not have much experience with diverse communities, many reported optimism that any needed assistance and resources can be obtained when needed to meet individual needs. These results indicate that additional supports

are needed in order to help prepare the children's mental health network to provide culturally competent services.

Issues and Barriers Related to Service Capacity
Counties were asked to discuss any issues or barriers they believe are critical to overcome in their county in order to ensure that children have the necessary mental health service options within the home and community-based options.

Rehabilitative Mental Health Services, known as Children's Therapeutic Services and Supports or (CTSS)

Partial Hospitalization Programs (PHP)
Counties reported no barriers to CTSS services.

Home and Community-Based Services

Counties reported a variety of issues and barriers as critical to overcome in order to ensure that children have the necessary home and community-based mental health service services. These barriers include *workforce shortages, lack of transportation, low reimbursement rates, lack of specialized services, lack of CADI slots*, and l*ack of mental health treatment parity*.

The most common barrier noted in the children's mental health system was the *lack of child psychiatrists* and *clinical nurse specialists (CNS)* (who can evaluate and prescribe medications) and the l*ack of mental health therapists* (particularly in the rural areas). *Additionally adequately trained staff to meet the local service demands* is lacking in many areas of the state.

Secondly, counties overwhelmingly responded that *lack of transportation to service providers* is a major obstacle (especially in rural counties). Some counties report that families must drive up to three hours each way to see a provider, necessitating them to take an entire day off from work for a single appointment. It is a barrier regardless of whether a child is covered under a Managed Care Organizations (MCO) and or the fee-for-service (FFS), particularly in areas where limited options exist with no public transportation necessitating reliance on family or volunteer drivers.

Additional gaps were noted for *specialized treatment services* such as *day treatment*, *respite, crisis, and school based services* (State grant funding continues to increase the availability of co-located mental health services in schools but, not all districts have access to mental health service providers.) *Mental health behavioral aide (MHBA) services* ranked third overall in the service gaps (see Appendix B #3 for additional details). *Services for transitional youth* was also reported as a barrier; while some youth need services beyond age 18, many who have received children's mental health services do not qualify for adult services.

Counties also report that the *availability of Community Alternatives for Disabled Individuals (CADI) slots* remains limited, causing lengthy waiting lists, delaying essential services that sometimes result in higher levels of care.

Mental health parity does not exist with coverage issues under commercial plans. While it is unclear whether additional services might become available under the Essential Benefits under the Affordable Care Act (ACA), additional analysis is needed. Currently parents with commercial insurance plans may find their child/youth eligible for additional Minnesota Health Care Programs (MHCP) covered benefits through Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Counties report barriers with high TEFRA parental fees. Additionally, they report further education must occur to increase parent's knowledge about the program.

Highest Priority for Children's Mental Health Service Development for 2013 through 2015

Counties were asked about their highest priority for service development for the next two years. Some counties noted they will continue to offer current services, increasing preventative and early intervention services. For those counties that plan to maintain current services, they also identified plans to increase collaboration and coordination between providers and coordinate with primary care.

The majority of counties identified various priorities for the next year. The counties' primary goals center on workforce issues, noting the lack of child psychiatrists, clinical nurse specialists/advance practice nurses, and mental health professionals. Respondents did not suggest many remedies beyond expanding tele-mental health services citing scarce resources that are cost prohibitive for local agencies to access.

Secondly, integrating or developing both school-based and school-linked services was conveyed by many of the respondents. Additional state grant funding was allocated in 2013 to continue to expand these services.

The third priority is transportation to access necessary mental health services. Some counties plan to increase their use of technology, thereby increasing availability and reducing travel expenditures and time. However, transportation is a major obstacle prevailing across many regions of the state, affecting all service areas.

Next, developing crisis beds, crisis respite, crisis stabilization, and local treatment foster homes to reduce inpatient admissions was identified. This is another area that the state has directed resources to build local service capacity.

Developing and/or obtaining specialized treatment services were identified. Regional issues continue to emerge, especially in rural areas where the demand for specialized services is not sufficient to support local service capacity. Families must often travel great distances to access these types of services and supports. Many services previously identified as gaps were also mentioned in this section, such as eating disorder

treatment and autism services. Counties also plan to focus on anticipating and navigating any changes from the state, health plans and Affordable Care Act (ACA) in the areas of eligibility, programs and procedures.

Overall HCBS System Improvements

Counties were asked to rate their county's improvement across a number of factors that support local HCBS systems. Counties were given a one-to-five scale where "one" equals *no improvement* and "five" equals *significant improvement*. The average county rating for each area is summarized in Figure 8 below. Further detail on the results of this section can be found in Appendix A. On average, counties rated themselves at the mid-point or higher across all items except *there was sufficient local workforce to meet the health/LTC industry and market needs in jurisdiction*. In particular, counties rated themselves lower in the area of sufficient local workforce to meet the needs in their jurisdiction.

Figure 8: Average rating of HCBS system improvements for 2013

HCBS Improvement Measure	Average
All persons in jurisdiction (regardless of income) were able to access information in order to make informed choices about long-term care	3.3
All persons in jurisdiction (regardless of income) were able to access in-person assistance in order to make informed choices about long-term care	3.3
All persons in jurisdiction (regardless of income) were able to participate in a Long Term Care Consultation, as needed	3.3
The health and support service systems in jurisdiction were culturally competent to adequately meet the needs of families who have diverse cultural backgrounds	3.0
There were communication patterns and referral protocols between health care and long-term care providers in jurisdiction that allow for maximized care coordination	3.2
There was sufficient local workforce to meet the health/LTC industry and market needs in jurisdiction	2.8

*Level of improvement a county's HCBS system has achieved around the following statements: (1= No improvement, 2=Very little improvement, 3=Some improvement, 4=Medium amount of improvement, and 5= Significant improvement)

**A rating of No improvement might indicate that service needs are already being met

Conclusion

Results from the 2013 Gaps Analysis Survey, indicates the counties identified a variety of gaps within the mental health services field. This is especially apparent with regard to EBP and specialized treatment services. Major barriers to offer these services center on small numbers of children/youth that quite often display complex needs that are faced with limited or no local provider choices. Counties also tend to report that their provider networks are only somewhat prepared to provide culturally competent services to Minnesota's ever changing diverse communities. Some counties report plans to increase some mental health home-based treatment services, but many will be focusing on maintaining their current networks and preventing the loss of services and providers as funding streams continue to decline.

Based on the findings from the 2013 Gaps Analysis, a number of recommendations should be considered by the state, lead agencies, regional development and planning organizations and the broader mental health services network.

Increase technology and training to address gaps in service availability and workforce.

Many of the gaps reported by counties are influenced by limited workforce availability, provider expertise, and transportation issues, especially in large geographic rural areas of the state. In these areas it is challenging for local providers to achieve enough economies of scale in providing these specialty services to sustain business models. Strategies to address these barriers could include building on the existing service provider's expertise to deliver critical specialized services by offering additional regional training to extend the geographic reach of such services. Another example is to further promote the use of tele-medicine to obtain consultations thus, reducing travel time and transportations costs for the family.

Service Development and Planning

Planning for and developing mental health services should be a joint venture across many partners, including lead agencies (counties, tribes and health plans), mental health providers, school districts, local collaboratives, in conjunction with the broader community (including families and caregivers).

Differing coverage exists for commercial and public pay children/youth. As policy changes emerge with implementation of the ACA, families will rely upon both provider communities and health navigators to direct them to with coverage questions.

Lead agencies should promote and contract for services while exploring alternative and innovative models of service delivery at the local levels that focus on the following elements: supporting prevention and early intervention, initial training and ongoing support implementing EBP, and evaluating innovative ways to prevent residential and hospital placements. Rural areas are particularly impacted by service capacity issues

and face unique barriers to supporting community life. Lead agencies must guide local partners in examining these barriers and develop alternatives that make sense in their particular areas.

Improve Cultural Competence

Survey results indicate that the mental health services network in many communities are not generally prepared to provide culturally competent care in many communities. In addition to the need for culturally competent care planning on behalf of individuals and development of culturally competent services, it is important to identify and address any system-wide barriers that exist for developing and accessing culturally competent services.

Appendix A: Table of Survey Results

Table 1 (page 1 of 3): County reports of current general service capacity (n=78)

	Exceeds demand	Meets demand	Available but limited	Not available
Outpatient Services				
Diagnostic Assessment (OS)	0%	66%	34%	0%
Explanation of Findings (OS)	0%	55%	45%	0%
Psychological Testing (OS)	1%	46%	53%	0%
Neuropsychological Services (OS)	1%	6%	66%	27%
Psychotherapy - Individual (OS)	3%	65%	32%	0%
Psychotherapy - Family (OS)	0%	52%	44%	4%
Psychotherapy - Multi-family (OS)	0%	24%	37%	38%
Psychotherapy - Group (OS)	0%	22%	53%	25%
Psychotropic Medications				
Initial Eval/ Prescribing of Psychotropic Medications (PM)	0%	14%	82%	4%
Medication Management/Evaluation (PM)	0%	15%	81%	4%
Referral to a Mental Health Professional (PM)	1%	59%	38%	1%
Rehabilitative Services				
Children's Therapeutic Services and Supports (CTSS)				
Psychotherapy - Individual (RHB)	0%	65%	33%	1%
Psychotherapy - Family (RHB)	0%	47%	51%	3%
Psychotherapy - Group (RHB)	0%	21%	49%	29%
Skills Training - Individual (RHB)	0%	47%	51%	3%
Skills Training - Family (RHB)	0%	33%	63%	4%
Skills Training - Group (RHB)	0%	20%	53%	27%
Crisis Assistance (RHB)	1%	40%	43%	16%
Mental Health Behavioral Aide (RHB)	0%	7%	31%	63%
Day Treatment (RHB)	0%	28%	44%	28%
Partial Hospitalization Program				
Partial Hospitalization Program (RHB)	0%	12%	31%	57%

Service Category Key: OS: Outpatient Services; PM: Psychotropic Medications; RHB: Rehabilitative Services; CRTS: Children's Residential Treatment Services; EBP: Evidence Based Practices; SS: Support Services; SP: Special Populations; IHPC: Inpatient Hospitalization Psychiatric Care; PS: Physician Services

Table 1 (continued, page 2): County reports of current general service capacity

	Exceeds demand	Meets demand	Available but limited	Not available
Children's Residential Treatment Services				
Young <13 with aggressive/ sexual acting-out issues (CRTS)	0%	7%	77%	17%
Aggressive behaviors (CRTS)	0%	17%	67%	17%
Adolescents with sexual acting out (CRTS)	0%	17%	63%	20%
Adolescents, sexual acting-out behaviors & DD or PDD (CRTS)	0%	13%	47%	40%
Eating disorders (CRTS)	0%	13%	43%	43%
Evidence Based Practices				
Trauma Focused CBT (EBP)	0%	13%	47%	41%
Diagnosis Class: 0-3R (very young children) (EBP)	0%	25%	62%	13%
Trauma Informed Child-Parent Psychotherapy (EBP)	0%	9%	49%	42%
Incredible Years Parenting (EBP)	0%	19%	28%	53%
Attachment Bio-Behavior Catch Up (EBP)	0%	5%	13%	82%
Parent Child Interaction Therapy (EBP)	0%	8%	47%	45%
Support Services				
Respite (SS)	0%	33%	66%	1%
Outreach (SS)	0%	25%	63%	11%
Prevention (SS)	0%	19%	65%	16%
Promotion (SS)	0%	25%	54%	21%
Special Populations				
Transition age services, youth moving to adulthood (SP)	0%	32%	58%	10%
Early Childhood (pre-school) (SP)	1%	61%	38%	0%
Complex needs, multiple diagnosis and chronicity (SP)	0%	8%	65%	27%
Eating Disorders (SP)	0%	13%	48%	39%
Co-occurring Disorders (MH & substance use) (SP)	0%	14%	56%	30%
Autism (SP)	0%	23%	73%	4%
Brain Injuries (SP)	0%	11%	57%	32%
Mental health services offered in schools (SP)	0%	28%	63%	9%
Specialized MH services in juvenile justice settings (SP)	0%	14%	48%	38%

Service Category Key: OS: Outpatient Services; PM: Psychotropic Medications; RHB: Rehabilitative Services; CRTS: Children's Residential Treatment Services; EBP: Evidence Based Practices; SS: Support Services; SP: Special Populations; IHPC: Inpatient Hospitalization Psychiatric Care; PS: Physician Services

Table 1 (continued, page 3): County reports of current general service capacity

	Exceeds demand	Meets demand	Available but limited	Not available
Inpatient Hospitalization Psychiatric Care				
Children's Mobile MH Crisis Response (IHPC)	3%	33%	29%	36%
Inpatient child/youth psychiatry beds (IHPC)	0%	9%	56%	35%
Psychiatrists, inpatient visits (IHPC)	0%	16%	51%	33%
Adequate/ timely discharge planning (IHPC)	0%	18%	49%	33%
Physician Services				
Health and Behavior Assessment/ Intervention (PS)	0%	20%	62%	18%
Integrated Primary Care, Behavioral Health Services (PS)	0%	12%	54%	34%
Psychiatric Consult to Primary Care Providers (PS)	0%	9%	67%	24%
Physician Consult, Evaluation and Management (PS)	0%	14%	64%	21%
Psychiatric Referral (PS)	0%	20%	74%	7%
Psychiatric consult to psychiatrists (PS)	0%	13%	63%	24%
Physicians perform mental health screening (PS)	0%	15%	63%	23%

Service Category Key: OS: Outpatient Services; PM: Psychotropic Medications; RHB: Rehabilitative Services; CRTS: Children's Residential Treatment Services; EBP: Evidence Based Practices; SS: Support Services; SP: Special Populations; IHPC: Inpatient Hospitalization Psychiatric Care; PS: Physician Services

Table 2: Overall HCBS system improvements, percent of counties (n=78)

	Average	1	2	3	4	5
All persons in jurisdiction (regardless of income) were able to access information in order to make informed choices about long-term care	3.3	4%	5%	60%	23%	8%
All persons in jurisdiction (regardless of income) were able to access in-person assistance in order to make informed choices about long-term care	3.3	5%	4%	60%	22%	9%
All persons in jurisdiction (regardless of income) were able to participate in a Long Term Care Consultation, as needed	3.3	4%	5%	57%	22%	12%
The health and support service systems in jurisdiction were culturally competent to adequately meet the needs of families who have diverse cultural backgrounds	3.1	4%	12%	62%	19%	3%
There were communication patterns and referral protocols between health care and long-term care providers in jurisdiction that allow for maximized care coordination	3.2	5%	6%	60%	22%	6%
There was sufficient local workforce to meet the health/LTC industry and market needs in jurisdiction	2.8	16%	13%	52%	13%	6%

*Level of improvement county's HCBS system has achieved around the following statements (1= No improvement, 2=Very little improvement, 3=Some improvement, 4=Medium amount of improvement, and 5= Significant improvement)

Appendix B: Description of Limitations for Top 10 Service Gaps

1. Attachment Bio-Behavior Catch Up - Many counties report that they are unaware of the service or do not have providers trained in Attachment Bio-Behavior Catch Up. Reasons listed include small, rural populations here service providers tend to be more generalists rather than specialists. Services are delayed or provider choices are limited when referred to out of county providers. Lack of insurance coverage, high deductibles and lack of funding were also reported as barriers to the availability of this evidence based practice.

2. Mental Health Behavioral Aide (MHBA) - The most common barrier identified is the lack of providers that deliver MHBA services. While 95% of the reporting counties indicate that Children's Therapeutic Services and Supports (CTSS) certified providers are available in their county, MHBA services are an optional CTSS service. Currently 97 community and 32 school providers are CTSS certified of which 23 and 1 respectively are certified for MHBA services (only 17 of the community agencies currently offer MHBA on a limited basis). In most areas where this service is available, there are wait lists that delay the service and/or limits choice of vendors. Other barriers cited include low wages, difficult work hours and conditions (typically evening and weekend unless working in a school setting) and lack of trained personnel. Counties noted certification standards including clinical supervision for unlicensed persons as burdensome with insufficient reimbursement. This service is often times compared to personal care services (PCA). Interestingly, previous surveys have identified some counties have a surplus in PCA services while this is not the case with MHBA services. Some natural comparisons between the services have been made. It should be noted that MHBA service payment is significantly higher ($24.12-31.47 per hour) than PCA service ($14.78 per hour).

3. Residential Treatment for young, under age 13 with aggressive and/or sexual acting-out issues- Counties most often reported that the service is either not available in their county or limited because of rural location with low numbers of children to support such a program specific to one age category or condition. The number of providers and beds are sparse which may result in service delay or limited choice of vendors. Other barriers include provider concern over safety and liability when working with youth with these issues. Residential program holder's distance from the family was also listed as an obstacle. One county reported that the success rates for this population are so low that it is typically in the best interest of the child to remain with the family.

4. Neuropsychological Services- Counties report the service isn't readily available particularly in the rural locations. Limited service providers, with wait list from six to eight-months, and even longer to obtain the results. Several counties noted that transportation is a major issue since parents must drive from one and a half to three hours for an appointment thus necessitating taking an entire day off from work for one

appointment. In some cases the consumer demand is too low to sustain the development of this service.

5. Parent Child Interaction Therapy (PCIT) – Many counties indicated they do not have this service available. Barriers included geography, small, and rural populations. Others cited limited providers trained in PCIT. Other counties listed parent's ability to get an appointment. Transportation to the service and the amount of time needed for the service is also a challenge for some families. Reimbursement for the service listed as limited. Providers hesitate to get into this intensity of service without better reimbursement or receiving a grant. One county noted that some specialty services can be "brought in" by tele-health but some services aren't readily adaptable such as PCIT. Surprisingly several counties responded that they didn't know what this service is or whether or not it is available. See also Attachment Bio-Behavior Catch Up, and Trauma Informed Child-Parent Psychotherapy (below)

6. Complex Needs with Multiple Diagnosis and Chronicity – Limited providers, lack of training and limited resources. These children's needs are specific and severe and require significant levels of time that are unavailable from many professionals. Services are often fragmented because multiple providers need to be accessed. One county noted that providers need to be more integrated and learn how to do mental health, chemical health, medical and DD better. Better integrative practices and assessments need to be developed and practices that do not cross domains need to be challenged. Funding integrated practices and service coordination continues to be very challenging. A new Minnesota Health Care benefit was passed in 2013 called Clinical Care Consultation. (Upon federal approval a providers who serve a child/youth who has a complex mental illness or a mental illness co-occurring with other conditions will get paid for communicating with other providers and educators about the child's symptoms, strategies for effective interventions and treatment expectations.)

7. Complex Needs with Multiple Diagnosis and Chronicity – Limited providers, lack of training and limited resources. These children's needs are specific and severe and require significant levels of time that are unavailable from many professionals. Services are often fragmented because multiple providers need to be accessed. One county noted that providers need to be more integrated and learn how to do mental health, chemical health, medical and DD better. Better integrative practices and assessments need to be developed and practices that do not cross domains need to be challenged. Funding integrated practices and service coordination continues to be very challenging. A new Minnesota Health Care benefit was passed in 2013 called Clinical Care Consultation. (Upon federal approval a providers who serve a child/youth who has a complex mental illness or a mental illness co-occurring with other conditions will get paid for communicating with other providers and educators about the child's symptoms, strategies for effective interventions and treatment expectations.)

8. Inpatient Child/Youth Psychiatry Beds – Most counties report having no local service providers. Distance to inpatient providers up to 200 miles, taking anywhere

from one to three plus hours travel time. Transportation and the cost of these trips for family members is also burdensome but critical for the child/youth's treatment progress. Locating a provider that accepts young children <12 years of age was noted by several counties. Counties noting inpatient psychiatry beds are available relay that there are often waiting lists that cause a delay in services or limits choice of vendors.

9. Psychiatric Consultations to Primary Care Providers - Many counties reported the lack of psychiatrists in general in across the state that results in lack of professional resources. Several counties pointed to the new psychiatric consultation benefit through the Mayo Clinic. Pediatricians and other primary care providers who prescribe psychotropic medications for children may access child psychiatrists and social workers to function as an integrated team to deliver quality healthcare to their children with mental health needs.

10. Brain Injuries – Among one of the co-morbid conditions included in the survey, brain injury treatment came in tenth overall as the most common barrier to mental health services. There is a lack of professional expertise and human resources to provide services to children/youth that also suffer from a brain injury. Additional factors listed include county geography, causing transportation issues to access specialized services. The respondents reported insufficient demand to sustain locally. Funding is also extremely limited with waiver waiting lists in many areas.

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