Modeling after Minnesota: Achieving Positive Results for Students

By Glenace Edwall, Psy. D., Ph.D., Director, Children's Mental Health Division, Minnesota Department of Human Services

Minnesota has experienced a remarkable expansion in identifying emerging mental health challenges in children and youth, providing treatment and supporting success in school. This has been happening over the past six years through an innovative program that unites mental health providers with schools. School-linked mental health (SLMH) has strong roots in demonstrations under federal grants to Minneapolis and other communities, but the 2007 state legislature created a key mechanism to allow mental health providers to move from their clinical settings to schools. Based on the success of the program, the legislature doubled its funding in 2013 to make it available in nearly all Minnesota counties.

Why have mental health services in schools? It's pretty simple. There is a stunning gap between need—one in five children has a diagnosable mental health condition—and access to care. Nationally, as many as 80 percent of children receive no or inadequate treatment for their mental health conditions. In Minnesota, we are above average, reaching perhaps 50 percent of children in need of care. But some children in specific communities, ranging from immigrants and impoverished people in metropolitan areas to remote rural areas, have exceptional barriers to receiving care. For them, care must be made available in the places they enter nearly every day: their schools.

Minnesota's 2007 legislation emerged as a result of a remarkable public-private partnership, which included mental health, education, local school districts, counties and family advocacy organizations, with NAMI Minnesota playing a key role. Managed care health plans also played a key role in both the state Medicaid program and the commercial insurance market. The initial legislative appropriation of $4.75 million per year funded 20 mental health provider organizations that brought services to 165 school districts in 65 of Minnesota's 87 counties, operating in 420 schools and serving a total of more than 18,000 children.

Data-gathering and reporting requirements for grantees were daunting, but were incredibly valuable in demonstrating the effectiveness of the program. More than one-half of the children receiving services had care for the first time, and one-half of those met the criteria for having a serious level of functional impairment. The children seen in SLMH programs were also more likely to have had difficulty accessing community programs; outcome measures showed that both parents and teachers reported that these children got better.

These results were galvanizing for everyone involved. Community agencies recognized their ability to reach children and families who were difficult to reach at their clinic offices. Health plans and counties recognized savings through earlier identification and access to services. School districts found decreased barriers to learning and increased educational time. Most importantly, students benefitted from new skills and strategies to succeed at school and at home.

Armed with this data, both the state agency and advocates approached the 2013 state legislature with requests double the size of the SLMH program. Poignant testimony from youth and families also helped the legislature to add $7.4 million for fiscal year 2014 and $9.8 million per year for 2015-18, allowing $45 million to be allocated for five-year contracts to the growing program.

Currently, we are ready to embark on the second generation of SLMH in Minnesota. Contracts have been completed with 36 agencies, serving 82 (and soon to be 85) of Minnesota's 87 counties. Minnesota has more than 300 school districts, and 257 will be involved, including more than 800 discrete schools and more than 35,000 students. If, as in the first phase of SLMH, one-half of these students have needed but have not received services, we will have closed more than one-third of the gap between estimated need and service provisions.

Perhaps even more important is that the range of providers brought into the program expansion is significant. New providers include a tribal health organization, a bilingual/bicultural provider, and providers serving the state academies for deaf and hard of hearing students, as well as blind and visually impaired students.

Some of the astounding success of Minnesota's SLMH program resides in its financial structure. Agencies with SLMH contracts bill both public and private third parties for clinical services so that the grant funds can be used for students who don't have health care coverage. Funds are also used for ancillary services that are not generally reimbursable, like in-service training, Positive Behavior Intervention and Supports, and outreach to families and communities. Minnesota SLMH has a simple message for other states: School-linked mental health works. Minnesota knows how to make it work, and it produces successful outcomes for students, families and schools.

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