Adult Mental Health Grants 2015-2016

Community Supports Administration

November 1, 2016

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Minnesota Department of **Human Services**

Legislative Report

Mental Health Division, Department of Human Services

651-431-2225

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I. Executive summary

Minnesota's mental health services reflect a strong history in county delivered social services, as well as growth of new and innovative medical service options delivered through health insurance. In order to ensure statewide availability of services, while still recognizing a role for strong local partnership, Minnesota has dedicated grant funding to counties and regional initiatives.

This report provides information about the services funded and people served with the grant funded mental health services and programs, including gaps in services, funding and people served by service category, and select service outcomes by grant type.

Mental health services and programs funded through Adult Mental Health Initiatives (AMHI), Community Support Programs (CSP), Housing with Supports (HWS), and Crisis grants increase access to essential mental health services and ensure Minnesotans with serious mental illnesses receive needed services. Through these dollars, individuals with mental health needs are better able to remain in their community to receive care, reducing the need for more acute, costly care, including institutional stays. Adult mental health grant funding goes directly to counties that form the backbone of the mental health service safety net, as well as through AMHI. Initiatives operate as cross-county collaborations, which monitor service needs, participate in joint service planning and provision of care, and cooperatively work together to assess problems and come up with creative solutions.

Service gaps in mental health care widely vary across the state. The top four gaps reported by counties or tribes and the percent that report the service as a service gap are: Inpatient adult psychiatric beds (95.9 percent), psychiatric prescribers (77.2 percent), permanent supportive housing (84.8 percent) and adult Intensive Residential Treatment Services (IRTS) (79.7 percent).

AMHI and CSP grants had $58.7 million allocated in both 2015 and 2016. Actual spending varied slightly due to the unmet needs funding process, which returns underspent funds from the previous calendar year to DHS where it is then re-granted out for special one-time, mental health projects through an application process. The two service categories with the highest amounts of expenditures for 2015 and 2016 were Other CSP Services ($11.3 million and $13.9 million) and Targeted Case Management ($14.0 million and $12.1 million). Considerable amounts of money also went into service categories Assertive Community Treatment ($4.2 million and $3.6 million), Housing Subsidy ($5.0 million and $6.1 million), and Basic Living/Social Skills ($5.1 million and $4.5 million). Counties, initiatives, and tribes identified more than about 17,600 identifiable individuals receiving services in the first half of 2016 and about 10,650 additional unidentifiable individuals (due to the nature of services). Many of the individuals received more than one grant funded service; for example, many individuals received both Basic Living/Social Skill services and Housing Subsidy services. Multiple services can appropriately be accessed to meet the unique needs of each individual.

Demographic information for the AMHI and CSP grants are as follows:

- The largest portion of grant services were between ages 35 to 54 (40.2 percent), followed by ages 20 to 34 (24.4 percent) and ages 55 to 64 (21.4 percent).
- Grant funds served a higher percentage of women (53.7 percent) than men (46.3 percent).
- Grants funds mainly served the highest portion of White individuals (71.6 percent), however reached a higher percentage of minority populations than in Minnesota's general population. For instance, African Americans are 11.8 percent of service recipients, but make up 5.4 percent of the state population. Native Americans receive 4.5 percent of services, but make up one percent of Minnesota's population.

Of the 17,600 individuals with a Minnesota ID receiving services, 3,463 people had reports in the Mental Health Informational System (MHIS). From Jan. to June 2016, these individuals utilized about 7,000 different services, indicating each person received two types of services on average. For this population, state operated institutions only made up 2.2 percent of services received. Residential treatment (including crisis), another high intensity service, made up 12.5 percent of services. Almost all service recipients remained in the community setting, 93.2 percent had a community residential status, 2.0 percent had an institutional or jail status and 4.8 percent had an unknown status.

Funding for HWS remained at $549,955 annually in 2015 and 2016. The majority of funds were used for Housing Subsidy ($340,457 in 2015 an $276,322 allocated in 2016), followed by Other Community Support Program Services ($167,155 in both 2015 and 2016), and General Case Management (approximately 40,000 each year).

State investment into adult crisis services increased substantially from 2015 to 2016 from $4.8 million to $7.5 million. The largest group receiving crisis services are individuals age 18 to 34 (30.2 percent). These same individuals make up 27.5 percent of recipients served by AMHI/CSP funds. Crisis services are delivered to this population at much higher rates. Almost half of all crisis services go to individuals aged 18 to 35, with each age band receiving about 25 percent of services. The most common reasons for crisis referral was suicide attempt (34.4 percent), followed by Psychotic or Delusional Episode, and Depression Episode (16.5 and 12.9 percent respectively). After receiving crisis services, the most common referral was to Adult Day Treatment (72.6 percent).

While these grants have been successful in reaching populations in need, DHS continues to lead efforts to improve the grant funding process, including refining and growing outcomes data via new biannual reporting into MHIS and working with the Human Service Performance Management System efforts, AMHI reform efforts, strengthening crisis standards and increasing Housing with Support services. DHS also recently transitioned to a 2-year budget cycle process and improved application process to ensure funds are managed better while eliminating unnecessary administrative burden on county partners. The new 2-year funding period improves counties' flexibility to address local needs, while still reporting back outcomes to help Minnesotans understand the value of these programs.

II. Legislation

Minnesota Statutes 2015, 245.4661, Subd. 10:

PILOT PROJECTS; ADULT MENTAL HEALTH SERVICES

By November 1, 2016, and biennially thereafter, the commissioner of human services shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section of law. The commissioner shall provide, at a minimum, the following information:

(1) The amount of funding to mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) The amount of funding for other targeted services and the location of services.

III. Introduction

This legislative report describes a network of adult mental health grants: Adult Mental Health Initiatives (AMHI), Community Support Programs (CSP), Housing with Supports (HWS) and Crisis grants, which offer services and supports to adults with serious mental illnesses. Information on these grants will include types of services/programs funded, amounts funded, gaps in services and other targeted services.

IV. Background

A. Grant Funding for Community Mental Health

Minnesota has been in a process of deinstitutionalization mental health care for at least 60 years. As the state hospitals closed, funding was shifted to community-based residential and outpatient services. In 1987, Minnesota passed the Comprehensive Mental Health Act, which establishes basic standards for adult mental health services in Minnesota. The Act is primarily directed at counties, which are designated as the local mental health authorities. As the medical model of mental health care became stronger, private and public health insurance became key payers of mental health services. The list of services reimbursable under Medicare and Medical Assistance have become a key determinant of what services were available to low-income Minnesotans. Yet not all necessary services could be billed through insurance due to uninsured clients or the limited scope of Medicaid billing. This is where mental health grant funding has filled the gaps and played a crucial role in mental health service delivery. To further understand the framework of the mental health system and where these grants fit in, below is an overview of Minnesota's mental health authority.

B. Mental Health Authority

i. State Supervised and County Administered System

Minnesota is a state-supervised public mental health system that is administered by the 87 counties. The Adult Comprehensive Mental Health Act establishes this framework for Minnesota's public mental health system. These agencies/organizations have specific roles and responsibilities within the system:

1. The State Mental Health Authority, the Minnesota Department of Human Services (DHS)
2. The local mental health authority (Minnesota counties)
3. American Indian tribal governments
4. State Medicaid Agency, (DHS)

ii. State Mental Health Authority

Minnesota is a state supervised, county administered system described in the Comprehensive Mental Health Acts. The state's role is to:

- Define and disseminate statewide policy for mental health service delivery
- Monitor compliance with established state and federal policy
- Coordinate development of state and local mental health system plans, including statewide goals and objectives
- Develop new services and new methods of service delivery based on best practices
- Monitor and evaluate the performance of local service delivery systems, by county or region as the unit of analysis
- Develop and disseminate programs, service delivery, and administration standards
- Allocate funds to local systems through grants

- Administer state and federal health care program funds
- Demonstrate the accountability of these systems to the State Legislature and to federal funding sources
- Provide technical assistance to local administrative agencies (Counties, health plans, service providers, AMHI)
- Provide technical assistance to tribal governments and other tribal entities
- Provide policy and technical assistance on a range of mental health program areas and support systems to address the needs of adults.

iii. Local Mental Health Authority

State law assigns the responsibility of day-to-day administration of local community mental health systems to county boards of commissioners. In addition to receiving state mental health grants, counties allocate local county property tax dollars for the provisions of mental health services for adults and children. Counties are also required to maintain a certain level of spending on mental health, referred to as maintenance of effort (MOE). Each county board is responsible for:

- System planning
- Implementing and coordinating programs of service delivery among local providers
- Coordinating client care through case management
- Determining how to allocate locally generated funds and state funds which flow through the county
- Reporting data and information requested by DHS

iv. American Indian Tribal Governments

Tribal governments have a unique legal status. They are sovereign nations under the U.S. Constitution and under federal law. Tribes retain the powers of self-government over their lands and members. As such, they are responsible for administering funding, determining policy, and providing leadership for day-to-day administrative activities.

v. State Medicaid Agency

Medicaid (or Medical Assistance in Minnesota) is funded jointly with state and federal funds. The Centers for Medicare and Medicaid Services (CMS) administers Medicaid nationwide. Federal law requires that there be a designated State Medicaid Agency. In Minnesota, DHS is the designated state agency and is required to develop and adhere to its own administrative "State Plan." As the State Medicaid Authority, DHS manages that state plan.

The adult mental health grants help to provide services at every level of the public mental health system, making them an important funding source for those with serious mental illness.

V. Methodology

Report findings and data come from a variety of sources. First, the 2013-2014 Gaps Analysis Study, completed in July 2015, was used to identify gaps and barriers to providing services. This data was preferred over yearly grant plan application data, due to completeness of answers and greater methodological soundness. DHS contracts with Wilder Research to complete the study using a series of interviews and surveys. This report makes use of the lead agency (county and tribal level) survey responses to service gaps and barriers to receiving services. Responses were rolled up to the AMHI regional level in each regional profile and at a statewide level in the main report.[1]

Adult mental health grant service category expenditures came from three data sources. First, DHS-2895 forms, which allow fiscal hosts to report expenditures by Budgeting, Reporting, and

Accounting for Social Services (BRASS) codes on a quarterly basis. BRASS codes serve as the basis for tracking county social service activity. While this report will primarily make reference to BRASS codes by the service categories, the categories are defined as such because of the use of these reporting codes. Prior to 2016, grant expenditures for AMHI/CSP expenditures could be reported using an integrated 2895 form. This schema allowed some counties to complete a single form for multiple funding streams. In 2016, integrated 2895 reporting was ended, so future funding would delineate CSP and AMHI spending. However, because of integrated reporting in 2015 and the allowance of identical service categories for both funding streams, for the purposes of this report these grants are discussed together.

Second, data was taken from 2016 grant application plans, which detailed plan grant spending for CY 2016. Plan updates were submitted to account for additional funding allocated through the unmet needs application process.

Finally, data from the quarterly Social Expenditure and Grant Reconciliation (SEAGR) report was used to ascertain the total amount of spending in service categories open for grant spending.

Client level data and estimated persons served were gathered from grant applications and quarterly submissions to Department of Human Services, starting in 2016. The grant application requires counties, initiatives, and tribes estimate the number of people served by service category. However, certain service categories are challenging to accurately estimate, including prevention and outreach services. Estimates from all other service categories were compiled. These totals represent a duplicated estimate of people served by the grants. The number is duplicated because the estimates are created by provider and by service, so individuals seen by more than one provider or receiving multiple types of services are counted more than once. Some

[1] Additional information about the Gaps Analysis is available at https://mn.gov/dhs/partners-and-providers/continuing-care/data-measures/gaps-analysis/current-study/.

adjustments were made to this data based upon regional populations if estimates were deemed to be erroneous.[2] Second, quarterly client-level data reports compiled from counties, initiatives, and tribes. Using a data spreadsheet, fiscal hosts reported clients served, including a PMI, SMI, or AMHI number, some demographic data, and BRASS code of services received. Using client ID, the demographic factors of sex, race, ethnicity, and age of service recipients was extracted from MMIS and MHIS data warehouse systems and appended to county/initiative/tribal reports. Additional information about service history for identified clients was extracted from MHIS for the purposes examining service utilization, as well as select characteristics associated with positive outcomes including employment, residential status, and use of high intensity services, such as institutional stays.

There were significant limitations with the client level data collected. As 2016 was the first year of client level data reporting, many fiscal hosts were not collecting client-level data for all services. Additionally, counties have utilized CSP and AMHI funds in a braided manner to make the dollars go further, which made delineation of grant funded and non-grant funded individuals challenging. Client level data likely underestimates the total number of people served, and may entirely miss certain services, such as preventative services, drop in center clients, certain types of crisis services, and other services posing challenges to client data collection. There was variation across counties, initiatives, and tribes in how data was collected, which may give the appearance of vastly different numbers of individuals receiving services. While some difference is expected, dependent upon the types of programs funded (some programs such as Assertive Community Treatment are considerably more expensive than other Community Support programs), much of this difference is attributable to underdeveloped data collection and reporting methods. DHS has ongoing plans and has set milestones to improve data reporting processes through use of MHIS and SSIS in 2017, as well as participating in the Human Services Performance Management System, which will enhance performance outcomes, measures and thresholds for mental health services. This process is informed by the reporters and existing systems of data collection that can be utilized to gather information.

Using 2014 American Communities Survey data, the grant client population was compared to the general population to ascertain how well counties, initiatives, and tribes were reaching population segments. Client level data was also rolled up by service category within each region to ascertain the number of clients served. However, as detailed client level reporting was new in 2016, this number is expected to underreport the number of individuals served. Fiscal hosts continue to work with providers and government staff to improve completeness of data and level of detail. Demographic comparisons of grant clients to Minnesota's population are available on a statewide basis, as well as in the regional profiles.

[2] Region 4S estimated approximately 10,000 more individuals in one BRASS code, likely due to typographical error so the amount was reduced by about 9,000 individuals. The same BRASS code received an allocation two times the amount on the 2017 application, but only estimated to serve about 600.

Housing with Support (HWS) and Crisis data were taken from 2016 MHIS reports for the first half of the year. Both services were updated significantly in 2016 to collect additional data and require providers submit data. Using payment source, client services funded by grant dollars were identified. Outcome measures are based upon MHIS outcome data points of housing, employment, and education. Demographic data was also extracted. HWS also uses Wilder Research's findings in the 2015 Minnesota Homeless Study to compare the populations served to the general MN homeless population. More information is available at http://mnhomeless.org/pdfs/2015-homeless-study-initial-findings-fact-sheet.pdf.

VI. Service Gaps and Barriers

Service gaps and barriers vary across the state from county to county, region to region, and reservation to reservation. To identify service gaps and barriers, both the Gaps Analysis and Grant Application Plans detail shortages and barriers. Currently the grant plans have no systematic method to evaluate the same set of services or barriers, so this data was used to supplement the Gaps Analysis findings. Counties and tribes lead agencies ranked the top service gaps experienced, and also whether the service availability exceeded, met or fell short of demand, or was unavailable.

Table 1 summarizes all service gaps by those services listed as a top gap, and then by the services most often rated as "short of demand" or "unavailable." While some services are rated as short of demand or unavailable by almost all counties, they may not be a top service gaps, suggesting counties found other service shortages more essential. The four services most frequently listed as a top service gap were:

- Inpatient adult psychiatric beds (45.6 percent listed as a top gap, and 94.9 percent listed service as short of demand or unavailable)
- Psychiatric Prescribers (38.0 percent listed as a top gap, and 77.2 percent listed service as short of demand or unavailable)
- Permanent Supportive housing (25.3 percent listed as a top gap, and 84.8 percent listed service as short of demand or unavailable)
- Adult Intensive Residential Treatment Services (IRTS) (21.5 percent listed as a top gap, and 79.7 percent listed service as short of demand or unavailable)

While availability of inpatient beds is the largest service gap, CSP and AMHI funds are not available to pay for that service directly. As identified in the Governor's Task Force report, having adequate options that prevent costly readmission or delays in discharge is a key need in addressing the current crisis in unavailability of in-patient beds. This includes development of services such as IRTS or supportive housing, and these options are frequently supported with CSP and AMHI funds.

In addition to the top gaps, 74 percent or more of respondents identified shortage of services or lack of availability for the following services:

- Mental health court (91.1 percent)
- Non-medical transportation (82.3 percent)
- Respite Care – Out of Home (81.0 percent)
- Respite Care – Crisis (81.0 percent)
- Foster Care (78.5 percent)
- Mental health services offered in adult correction settings (78.5 percent)
- Respite Care – Evenings and Weekend (78.5 percent)
- Respite Care – In home (74.7 percent)
- Partial Hospitalization (74.7 percent)

A full list of service gaps are available in Table 1, and service gaps by region are available in the appendices.

Table 1: Adult Mental Health Service Gaps in Minnesota, 2013-2014

	Top 3 Service Gap	*Exceeds or Meets Demand*	*Short of Demand or Unavailable*	*DK/ unsure*
Inpatient adult psychiatry beds	45.6%	5.1%	94.9%	0.0%
Psychiatric prescribers	38.0%	22.8%	77.2%	0.0%
Permanent Supportive Housing	25.3%	10.1%	84.8%	5.1%
Adult Intensive Residential Treatment Services (IRTS)	21.5%	19.0%	79.7%	1.3%
Crisis Stabilization - residential	15.2%	35.4%	63.3%	1.3%
Complex needs with multiple diagnosis and chronicity	11.4%	11.4%	69.6%	19.0%
Non-Medical Transportation	10.1%	16.5%	82.3%	1.3%
Supported Employment – Individual Placement & Support Model	10.1%	38.0%	58.2%	3.8%
Neuropsychological Services	8.9%	25.3%	73.4%	1.3%
Medical Transportation	8.9%	35.4%	63.3%	1.3%
Mobile mental health crisis response	8.9%	40.5%	58.2%	1.3%
Integrated Dual Diagnosis Treatment (IDDT)	6.3%	16.5%	70.9%	12.7%
Behavioral Programming	6.3%	21.5%	68.4%	10.1%
Psychiatrists available for inpatient visits	6.3%	20.3%	68.4%	11.4%
Foster Care	5.1%	21.5%	78.5%	0.0%
Medication Management/Evaluation-only psychotropic drugs	5.1%	27.8%	69.6%	2.5%
Psychotherapy - Individual	5.1%	55.7%	44.3%	0.0%
Respite Care - Out of Home	3.8%	16.5%	81.0%	2.5%
Respite Care - In Home	3.8%	19.0%	74.7%	6.3%
Adult Day Treatment	3.8%	29.1%	64.6%	6.3%
Psychiatric Consultations to Primary Care Providers	3.8%	12.7%	54.4%	32.9%
Psychological Testing	3.8%	48.1%	51.9%	0.0%
Diagnostic Assessment	3.8%	53.2%	46.8%	0.0%
Mental Health Rehabilitative Services (ARMHS)	3.8%	62.0%	38.0%	0.0%
Mental Health Court	2.5%	5.1%	91.1%	3.8%
Respite Care - Crisis	2.5%	16.5%	81.0%	2.5%
Mental health services offered in adult correctional settings	2.5%	7.6%	78.5%	13.9%
Partial Hospitalization Program (PHP)	2.5%	17.7%	74.7%	7.6%
Assertive Community Treatment (ACT)	2.5%	24.1%	73.4%	2.5%
Bridges	2.5%	20.3%	69.6%	10.1%
Integrated primary care with behavioral health services	2.5%	8.9%	64.6%	26.6%
Transition age services for youth moving into adulthood	2.5%	38.0%	60.8%	1.3%
Dialectical Behavior Therapy (DBT)	2.5%	48.1%	51.9%	0.0%
Drop-in centers	2.5%	46.8%	51.9%	1.3%
Physician Consultation, Evaluation and Management	2.5%	29.1%	39.2%	31.6%
Certified Peer Specialist (CPS) Services	1.3%	30.4%	65.8%	3.8%

Table 1: Adult Mental Health Service Gaps in Minnesota, 2013-2014 (cont.)

	Top 3 Service Gap	*Exceeds or Meets Demand*	*Short of Demand or Unavailable*	*DK/ unsure*
Projects for Assistance in Transition from Homelessness (PATH)	1.3%	17.7%	64.6%	17.7%
Outreach	1.3%	43.0%	41.8%	15.2%
Adult Protection	1.3%	77.2%	22.8%	0.0%
Respite Care - Evening and Weekend	0.0%	15.2%	78.5%	6.3%
Rehabilitative services for traumatic brain injuries (TBI)	0.0%	19.0%	73.4%	7.6%
Clubhouse model of psychosocial rehabilitation	0.0%	17.7%	70.9%	11.4%
Treatment Services for Autism	0.0%	16.5%	70.9%	12.7%
Residential treatment for adults with eating disorders	0.0%	20.3%	64.6%	15.2%
Consumer-run Services	0.0%	25.3%	63.3%	11.4%
Treatment Services for Eating Disorders	0.0%	29.1%	59.5%	11.4%
Mental Health Services for Veterans	0.0%	30.4%	58.2%	11.4%
Psychotherapy - Group	0.0%	40.5%	57.0%	2.5%
Prevention	0.0%	27.8%	55.7%	16.5%
Residential Habilitation (Supported Living Services)	0.0%	35.4%	53.2%	11.4%
Family Support and Education	0.0%	32.9%	51.9%	15.2%
Health and Behavior Assessment/Intervention	0.0%	17.7%	51.9%	30.4%
Problem gambling services	0.0%	34.2%	51.9%	13.9%
Residential Habilitation (In-Home Family Support)	0.0%	34.2%	49.4%	16.5%
Caregiver/Family Training and Education	0.0%	38.0%	48.1%	13.9%
Independent Living Skills Therapies	0.0%	34.2%	48.1%	17.7%
Prevention/Early Intervention for Behavioral & Cognitive Health	0.0%	21.5%	48.1%	30.4%
Independent Living Skills Training	0.0%	49.4%	48.1%	2.5%
Psychotherapy - Family	0.0%	49.4%	45.6%	5.1%
Caregiver/Family Counseling	0.0%	40.5%	45.6%	13.9%
Psychotherapy - Multi-family	0.0%	22.8%	45.6%	31.6%
Illness Management and Recovery (IMR)	0.0%	44.3%	44.3%	11.4%
Promotion	0.0%	20.3%	40.5%	39.2%
Transitional Supports	0.0%	51.9%	35.4%	12.7%
Physicians that perform mental health screening	0.0%	26.6%	34.2%	39.2%
Explanation of Findings	0.0%	50.6%	31.6%	17.7%
Assistive Technology	0.0%	53.2%	30.4%	16.5%
Case Management	0.0%	73.4%	26.6%	0.0%
Adult Mental Health Targeted Case Management	0.0%	75.9%	24.1%	0.0%
Environmental Accessibility Adaptations	0.0%	58.7%	20.0%	21.3%
Consumer Directed Community Supports	0.0%	70.9%	15.2%	13.9%
Specialized Supplies and Equipment	0.0%	69.6%	13.9%	16.5%

Source: Department of Human Services, 2013-2014, Gaps Analysis, July 2015.

The Gaps Analysis also asked respondents about the largest barriers to providing services. Table 2 lists the statewide top barriers to service by mostly frequently mentioned to least. As with service gaps, barriers to service geographically varied. For instance, outside of the metropolitan counties, geographic location of providers relative to clients and access to transportation was a frequent barrier for service. In the 2016 grant plans, transportation access was heavily emphasized as a barrier to accessing service, including limited access to:

- Last minute transit and volunteer or staff drivers
- Personal transit or vehicles
- Protected transit
- Buses, Taxis and other Public Transit (particularly in rural areas)

This finding makes it unsurprising a significant amount of AMHI/CSP dollars went into Transportation services. In 2015 and 2016, more than 500,000 and 625,000 dollars respectively.

Table 2: Adult Mental Health Barriers to Service in Minnesota, 2013-2014

Barriers to Service	% Counties
Geographic location of providers/distance to service	64%
Access to transportation	57%
Lack of service availability on short notice or during crisis	42%
Long waiting times for services/providers	42%
Lack of housing	34%
Capacity to access service/navigate system	12%
Long waiting lists for waiver(s)	12%
Eligibility restrictions (i.e., qualifying criteria)	10%
Stigma	8%
Costs of service (e.g., high co-pays)	5%
Lack of interest in available services	4%
Cultural responsiveness of service providers	4%
Caregiver and/or family issues	3%
Inconvenient service hours (e.g., limited weekend or evening hours)	3%
Lack of awareness of available services	3%
Requirements to prove eligibility (e.g., completing paperwork, etc.)	3%
Lack of psychiatry services	1%
Lack of subsidized housing or for felons	1%

Source: Department of Human Services, 2013-2014, Gaps Analysis, July 2015.

Barriers to service frequently went beyond the services being unavailable (although long waiting periods for services was a problem across the state). The absence of specific service components created significant barriers for both housing and employment services. Across the state more than 34 percent of lead agencies in the Gaps analysis mentioned there was a lack of housing available.

Based upon grant applications, this shortage is driven by:

- Shortage of affordable housing
- Low vacancy rates
- Landlords willing to rent to the target population (background checks and other eligibility requirements)
- Shortage of rental assistance programs
- Availability of supported housing living arrangements

Similarly, employment services were limited by:

- Available jobs – both for supported employment and non-supported employment
- Employers willing to employ the target population (background checks and other eligibility requirements)
- Vocational training program availability
- Ongoing employment supportive services

Additional information about regional barriers to providing services are available in regional profiles in the Appendix B, including both the Gaps Analysis findings by region and additional information from the regions about barriers.

VII. Adult Mental Health Initiatives and Community Support Program Grants

A. Background

i. Adult Mental Health Initiatives

With the closure of Regional Treatment Centers in the early 1990s, counties were encouraged to develop partnerships with neighboring counties to plan for and develop acute care and community-based mental health treatment for those who had been served by the state hospital. Learning from the success of that approach, legislation was passed in 1996 (M.S. 245.4661) to create and expand grant funding for regional partnerships to continue planning and service expansion efforts to pilot innovative projects. Over time this has resulted in 18 regional county initiatives and the White Earth Nation tribe who have identified as AMHI. Each region ranges in size from single, large county entities in the metro area to regions encompassing up to 18 counties in greater Minnesota. The AMHIs continue to monitor, evaluate, and reconfigure their service models while, at the same time, each county retains its role as the local mental health authority.

The service delivery and administrative design is unique to each AMHI. This approach has allowed small or sparsely populated counties to develop services they would not have the capacity to otherwise. Cross county collaboration also generates creativity in service planning and increased community based services. The AMHIs have been an effective mechanism for regional collaboration to build community-based mental health services in Minnesota. The relationships built and sustained in the AMHIs are key to creating a strong service system. AMHIs have served at least two important purposes: 1) to support collaboration around the infrastructural of mental health services and 2) to promote innovation in the delivery of services. Below are some examples of services and infrastructure building that have been developed within AMHIs:

- Focus on cultural competence, accessible services and better service coordination
- Community education to educate and support citizens and key stakeholders, such as health service providers, law enforcement and court personnel
- Alternative intensive case management models, including Assertive Community Treatment (ACT) teams
- Housing with support options
- Protected transport service for those in crisis
- Prevention Programs
- Mental Health Courts

- Jail Diversion programs

The AMHI structure and funding were designed to give regions flexibility to respond to their unique needs and circumstances. The flexibility of the AMHIs has led to a wide range of participants, organizational structures, funding, and operating practices. For example, AMHIs operate under and number different governing structures including: Service Delivery Authorities, joint powers agreements and memorandums of understanding. Another example is how regions choose to use staff associated with AMHIs. Some regions choose to hire coordinators to help with the administrative, reporting and fiscal work associated with the grants, while others use existing county staff do this work. Information on each AMHI's regional service structure can be found in the Regional Profiles (Appendix b).

The flexibility of AMHI grants have allowed DHS, along with county cooperation, the ability to capture and redistribute funding for identified needs. A few examples of this include:

- Crisis Intervention Training (CIT): A 40-hour program taken by law enforcement to improve responses to people in a mental health crisis.
- Certified Peer Specialist training which allows individuals who have a lived experience of mental illness to be trained as direct service mental health staff.

While each AMHI is strongly encouraged to incorporate evidence-based and research informed practices into their service delivery system, stagnant and reduced funding over the years has made this a challenge. When the initial legislation passed, AMHI's were considered 'Pilot Projects' to provide alternatives or enhance coordination of mental health services. While this has happened to some extent across the regions, many of these dollars have been fully integrated into the base of the region's mental health delivery services.

ii. Community Support Programs

When CSP were established in 1979, it created new and innovative programs including adult day treatment, vocational training, drop-in centers, crisis homes and case management services. CSP grant funding is designed to improve the ability of adults with serious and persistent mental illness to find and maintain competitive employment, handle basic activities of daily living, participate in social activities, set goals and plans and obtain and maintain appropriate living arrangements. These programs and services are not billable through public or private insurance.

CSPs reduce the need for and use of more intensive, costly, or restrictive placements and provide services that are supportive in nature. Examples of these services include, conducting outreach activities such as health and wellness checks, connecting people to resources to meet their basic needs, creating and maintaining social support systems using clubhouses or drop-in centers, finding, securing, and supporting people in their housing; attaining and maintaining financial and medical benefits and assistance finding and maintaining employment.

Per legislation (M.S. 245.4712), only county boards are eligible to apply and receive CSP funding. The counties are then able to grant these dollars out to providers for services.

B. Adult Mental Health (AMHI) & Community Support Program (CSP) Funding

i. Eligible Categories of Spending

There a variety of service categories eligible for grant funding, making up a subset of the Budgeting, Reporting, and Accounting for Social Services (BRASS) codes. The names of the service categories and descriptions of each, as well as additional detail regarding how counties, initiative, and tribes are providing services is provided in Appendix C. Some services are closely aligned with existing Medicaid services, and provide a funding mechanism for addressing the needs of individuals who uninsured or whose coverage does not include those services. Others are focused on the county's coordinating role, such as Targeted Case Management. These services are intended to help address the varied needs an individual may experience, and direct them to the resources that are needed in order to maintain their health in the community.

ii. 2015-2016 AMHI/CSP Spending by Service Type

In 2015 and 2016, CSP and AMHI grant spending was allowed in identical service categories. The Table 3 shows spending across in 2015. As mentioned in methodology, during 2015 it was permissible for counties to report grant expenditures using an AMHI, CSP, or integrated 2895-forms. As such, AMHI expenditures made up 30.0 percent of reports, CSP expenditures made up21.5 percent of reports, and the remaining 48.5 percent was reported on an integrated 2895 form and was a mix of CSP and AMHI funds. It is difficult to discern differences in how AMHI and CSP funds were used in 2015.

The two service categories with the greatest percentage of spending were Other CSP Services and Targeted Case Management, 19.3 percent and 23.9 percent of all dollars respectively. Significant funding was also used for Assertive Community Treatment, Housing Subsidies, Basic Living/Social Skills, and Adult Mobile Crisis Services, receiving 7.2 percent, 8.5 percent, 8.7 percent, and 5.2 percent of all funds respectively. The remaining service categories has spending below 4.6 percent of t received 4.6 percent to as low as 0.0 percent funding (a few thousand dollars).

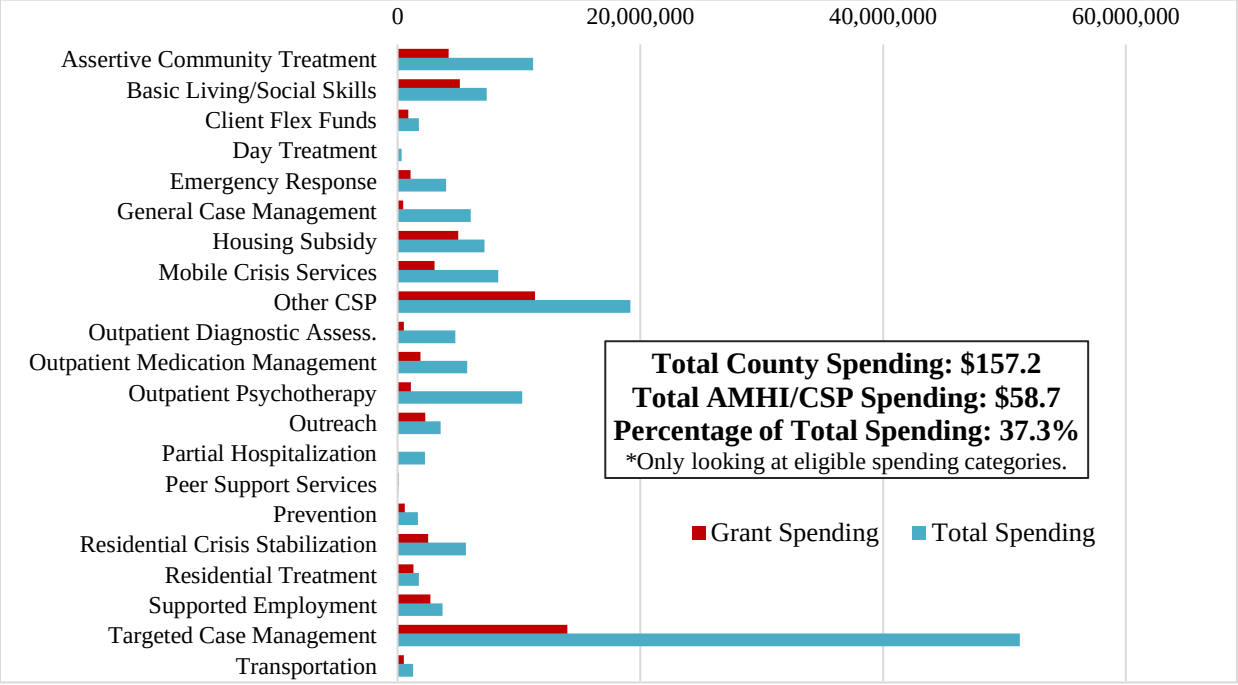
Grant dollars make up a subset of total county/initiative/tribe spending on mental health services. When looking only at spending in service categories eligible for CSP and AMHI grant dollars, *grant spending made up only 37.3 percent of all dollars spent*, the remainder is a mix of county levy dollars and other grant sources. Total spending exceeded $157 million, almost $100 million more than grant funds. Chart 1 shows statewide grant dollar spending by service category as a portion of total county spending (WEN is not included as they do not report expenditures using the 2895 form or SEAGR).

Table 3: Statewide AMHI/CSP Grant Spending by Service, 2015

Service Category	AMHI	CSP	Integrated	Total Spending
	$	$	$	
Adult Day Treatment	$0	$33,031	$6,311	$39,342
Adult Mobile Crisis Services	$1,795,735	$20,517	$1,239,127	$3,055,378
Adult Outpatient Medication Management	$1,540,778	$109,170	$240,547	$1,890,495
Adult Outpatient Psychotherapy	$313,960	$619,680	$156,816	$1,090,456
Adult Residential Crisis Stabilization	$1,064,432	$49,129	$1,394,010	$2,507,571
Adult Residential Treatment	$811,052	$56,381	$427,831	$1,295,264
Assertive Community Treatment	$1,214,480	$1,252,921	$1,747,264	$4,214,666
Basic Living/Social Skills	$2,279,511	$653,843	$2,191,835	$5,125,189
Client Flex Funds	$268,065	$419,708	$197,258	$885,030
Emergency Response Services	$90,982	$367,107	$623,019	$1,081,108
General Case Management	$0	$0	$467,710	$467,710
Housing Subsidy	$1,810,460	$120,033	$3,059,905	$4,990,398
Other CSP Services	$2,060,667	$3,309,860	$5,961,296	$11,331,823
Outpatient Diagnostic Assessment	$19,373	$204,554	$290,863	$514,790
Outreach	$979,746	$788,481	$526,963	$2,295,190
Partial Hospitalization	$0	$2,595	$0	$2,595
Peer Support Services	$25,287	$341	$48,675	$74,303
Prevention	$309,890	$233,275	$64,715	$607,880
Supported Employment	$925,305	$213,736	$1,555,424	$2,694,464
Targeted Case Management	$1,896,251	$3,948,708	$8,155,113	$14,000,072
Transportation	$212,767	$224,323	$65,426	$502,517
Totals	$17,618,739	$12,627,393	$28,420,107	$58,666,240

**Adult Mental Health 2895 Expenditure Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2016. Note: in 2015, grant expenditures could be reported by grant funding type or through an integrated form or reporting for entities receiving more than one grant type. Approximately half of the integrated funds are CSP and half are AMHI.*

Chart 1: Statewide AMHI/CSP Grant Spending as Portion of County Spending, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data. Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Table 4 shows 2016 service category spending according to 2016 grant plan data. Unlike in 2015, funding is fully segregated between CSP and AMHI dollars. Several differences between the funding streams become clear. More than 55.0 percent of CSP funds go into Other CSP Services, however only 6.5 percent of AMHI funds. Targeted Case Management and Housing Subsidies also receive a large amount of CSP funds, 11.3 percent and 13.1 percent respectively. AMHI dollars allocated towards Targeted Case Management is even larger, 27.4 percent or $9.76 million dollars. Overall, AMHI dollars are distributed more evenly across many service categories, with 10 categories receiving 3.8 to 10.4 percent of AMHI funds, and 9 service categories receiving 0.4 to 1.9 percent of funds. However, an important caveat is that county, initiative, and tribe allocations differ vastly from one another. As CSP and AMHI dollars are meant to create a flexible funding scheme to meet county and regional mental health needs, dollars may be targeted in opposite ways between even neighboring counties and regions. For a better understanding of service spending trends, please refer to the Appendices Regional Profiles, which further break down spending by Region and include additional information about how this flexible funding scheme is utilized by each initiative. These profiles also highlight specific programs funded in each region.

Table 4: Statewide AMHI/CSP Allocations by Service, 2016

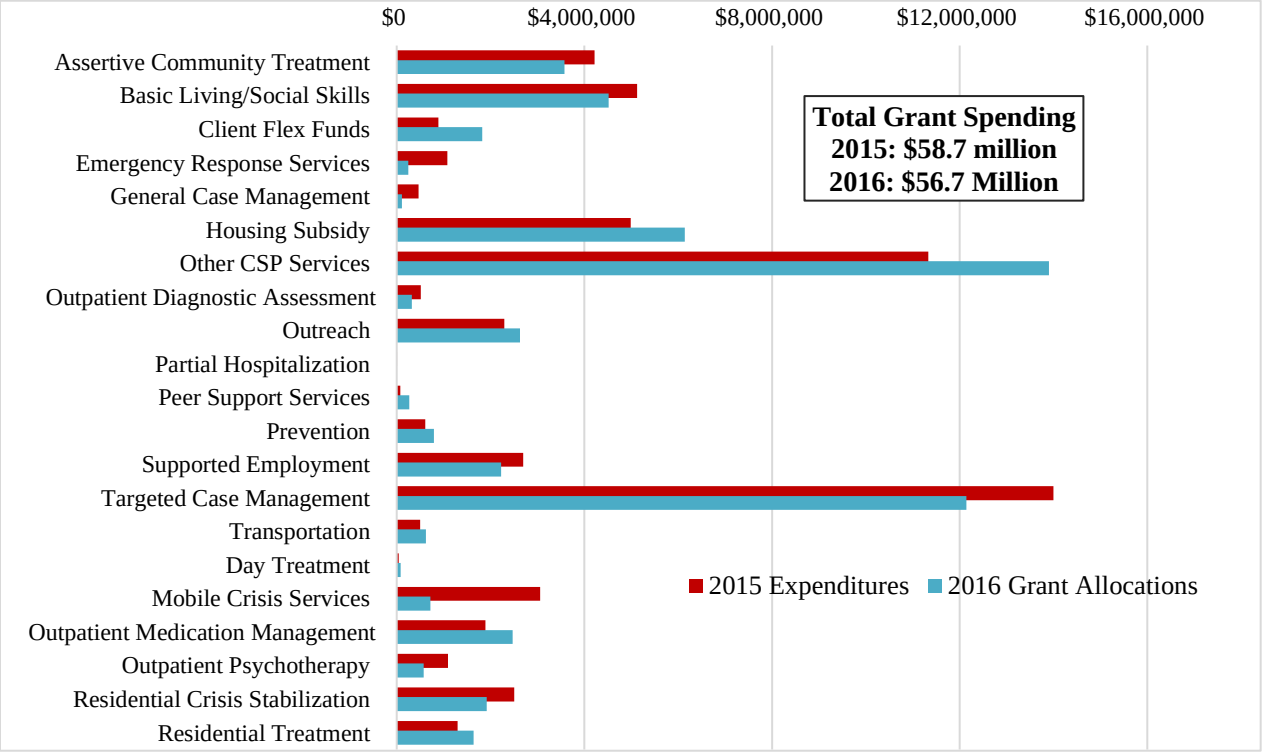
Service Category	CSP *($)*	AMHI *($)*	Total *($)*
Adult Day Treatment	$76,600	$5,000	$81,600
Adult Mobile Crisis Services	$164,800	$554,735	$719,535
Adult Outpatient Medication Management	$201,974	$2,271,580	$2,473,554
Adult Outpatient Psychotherapy	$242,163	$335,679	$577,842
Adult Residential Crisis Stabilization	$63,605	$1,851,662	$1,915,267
Adult Residential Treatment	$15,000	$1,625,439	$1,640,439
Assertive Community Treatment	$0	$3,574,342	$3,574,342
Basic Living/Social Skills	$799,567	$3,718,053	$4,517,620
Client Flex Funds	$117,092	$1,706,571	$1,823,663
Emergency Response Services	$113,141	$135,118	$248,259
General Case Management	$107,304	$0	$107,304
Housing Subsidy	$2,752,701	$3,388,867	$6,141,568
Other CSP Services	$11,579,401	$2,322,919	$13,902,320
Outpatient Diagnostic Assessment/Psych Testing	$176,689	$143,000	$319,689
Outreach	$1,276,071	$1,354,809	$2,630,880
Partial Hospitalization	$0	$0	$0
Peer Support Services	$64,000	$203,003	$267,003
Prevention	$119,149	$670,534	$789,683
Supported Employment	$685,077	$1,538,312	$2,223,389
Targeted Case Management	$2,384,214	$9,758,290	$12,142,504
Transportation	$131,813	$493,444	$625,257
Totals	$21,070,361	$35,651,357	$56,721,718

**Adult Mental Health Grant Application Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2016. Note: Some funding changes occurred after applications submitted, so total funds in this table appear different from allocated funds by about $2.4 million. These funds were allocated through a separate unmet needs application*.

From 2015 to 2016, grant spending among service categories shifted in several notable ways (shown in Chart 2). First, spending in Adult Mobile Crisis Services, Adult Residential Crisis Stabilization, and Emergency Response Service decreased by about $3.8 million at the same time new dedicated crisis grant funding sources were created.

In turn, grant funding increased across many other service categories, including Prevention (29.9 percent), Outreach (14.6 percent), Transportation (24.4 percent), Client Flex Funds (106.1 percent), Peer Support Services (259.3 percent), Other CSP Services (22.7 percent), Housing Subsidies (23.1 percent), Adult Outpatient Medication Management (30.8 percent), Adult Day Treatment (107.4 percent), and Adult Residential Treatment (26.6 percent). Some of this change was also attributable to less grant spending in Outpatient Diagnostic Assessment/Psych Testing (408x), Supported Employment, Assertive Community Treatment, Adult Outpatient Psychotherapy, and Case Management Services (both Targeted and General). Changes from 2015 to 2016 on a regional basis is also available in the Appendices in each regional profile.

Chart 2: Statewide Comparison of AMHI/CSP Grant Spending 2015 to 2016



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

C. Persons Served and Outcomes

i. 2016 Service Recipients

2016 marked a major step forward for the Adult Mental Health Grants in efforts to improve accountability for grant dollars and better track service recipients. While previous grant application cycles asked for estimates of individuals served in the upcoming and previous grant

cycle, the data was often incomplete and inconsistent between reporters. Some tracking occurred in the Mental Health Information System by adding a payment question that included grant funding, however, whether grant funds were state or federal was not indicated.

When completing 2016 grant plans, counties, initiatives, and tribes reported expecting to serve about 38,000 duplicated individuals with CSP funds, and about 62,000 duplicated individuals with AMHI funds.[3] These estimates were in part based upon how many people were served by funding in the previous 2015 grant cycle. Estimates for Prevention and Outreach were excluded as methods to accurately estimate reach varied widely and proved less meaningful. Counts were duplicated both across CSP and AMHI funds (many service recipients benefited from multiple types of services and grant funds), as well as duplicates across multiple types of services as explained in methodology.

While grant plans overestimated the people served, quarterly data reports were expected to underestimate slightly. However, by looking at both the identified recipients and the unidentified recipients, it is possible to gauge an estimate of persons served, on the lower end (see footnote above for further explanation of "true" number served)

In the first half of 2016, fiscal hosts reported out data on over 32,000 identified clients receiving services across 20 service categories. Using client identifiers repeating over multiple quarters and providers, a total of 17,639 unique individuals were identified, with an additional 9,227 unidentified service recipients in quarter 2. *This number underestimates the total number of people served, as it does not include the unidentified service recipients (4,690 in quarter 1 and 9,227 in quarter 2), and also is missing several counties and providers who have not yet begin reporting.* Table 5 provides the breakdown of clients by service category across the state. The services with the highest number of recipients were Other CSP Services, Targeted Case Management, Adult Outpatient Medication Management, Basic Living/Social Services, Housing Subsidies, and Outreach services. Seventy-three percent of recipients received services in one of the six service categories.

In addition to identified service recipients, fiscal hosts reported unidentified client counts for a number services. Unidentified individual counts were provided in instances where either identified client information was unavailable or not yet uniformly collected, for instance

[3] Counties and Initiatives were asked to estimate number of people served per BRASS code per provider in the AMHI/CSP Grant applications and plans. This number is duplicative, because many clients receive services from multiple providers and multiple types of services. For instance, if a person receives Other CSP services from 2 providers, as well as Client Flex Funds and Targeted Case Management Services, then the individual could count as 4 people in the duplicated count. Based upon client specific reporting, most clients receive 1 to 3 services each quarter. Therefore, DHS estimates that grant application counts likely should be reduced by at least half and up to two thirds to represent an accurate estimate of total clients served, 33,000 to 50,000 individuals receiving 100,000 services. Client level data included unique identifiers for about 17,600 clients and 9,000 unidentified individuals. Because this was the first year for counties to report client level data and some counties and providers are missing data, this number likely underreports to total individuals served. The true number would likely fall between 24,000 and 50,000 individuals and will be better ascertained as data reporting improves.

outreach services or for clubhouse and drop-in centers. As the clients are unidentified, these numbers likely include some duplicate individuals. A majority of client level data reported included identifying information, but several counties and initiatives continue to create systems for more efficiently tracking and reporting this data. Please see the regional profiles in the Appendices for additional notes about any missing client level data in counties encountering reporting difficulties. Across the state, about 7 counties did not report any identified client or unidentified client data, so these numbers underestimate the total reach of grant funds.

Table 5: Statewide Recipients of Grant Services by Service Category, Q1-Q2 2016

Service Category	**Jan - June 2016** *Identified Clients*	**Quarter 1 2016** *Unidentified Clients*	**Quarter 2 2016** *Unidentified Clients*
Adult Day Treatment	11	177	701
Adult Mobile Crisis Services	764	-	7
Adult Outpatient Medication Management	1,037	392	2,507
Adult Outpatient Psychotherapy	564	53	435
Adult Residential Crisis Stabilization	303	2,582	2,828
Adult Residential Treatment	428	-	-
Assertive Community Treatment	552	3	3
Basic Living/Social Skills	933	58	163
Client Flex Funds	537	178	357
Emergency Response Services	3	1,669	1,301
General Case Management	165	-	-
Housing Subsidy	1,181	171	155
Other CSP Services	4,993	3	127
Outpatient Diagnostic Assessment/Psych Testing	178	527	1,078
Outreach	849	72	106
Partial Hospitalization	-	-	71
Peer Support Services	39	109	300
Prevention	31	-	121
Supported Employment	437	84	108
Targeted Case Management	4,139	-	-
Transportation	495	39	286
Totals	17,639	6,117	10,654

**Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2016. Note: Estimated reach of Prevention and Outreach harder to ascertain.*

In first quarter, 6,117 unidentified client counts were provided across 15 service categories (See Table 5). This number increased to 10,654 people in second quarter across 18 service categories, which likely encompasses many of same individuals as first quarter, if this data follows a similar pattern as the identified client data.

ii. Demographics

The Adult Mental Health Grant service recipients are similarly demographically to the rest of the state. Several demographic characteristics of age, sex, race, and ethnicity were compared for the AMHI/CSP service recipients and entire population of Minnesota as estimated in the 2014

American Communities Services. Table 6 summarizes the findings and includes any noted difference between the grant recipient population and the total population.

Table 6: Demographic Differences between Statewide AMHI/CSP clients and total population, 2016

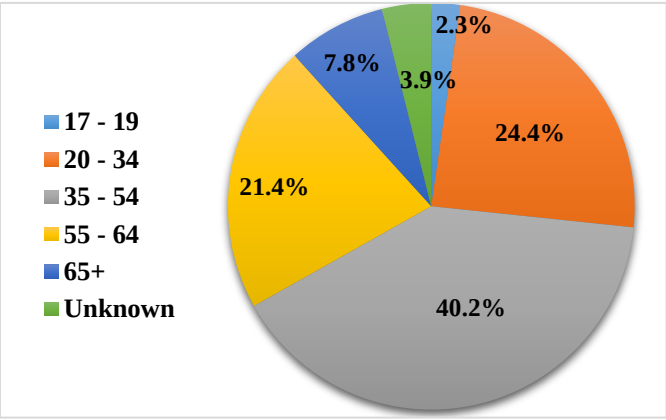
	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)	**15,612**	**4,103,639**	
18 - 19	2.0%	3.6%	*-1.6%*
20 - 34	25.5%	26.6%	*-1.2%*
35 - 54	42.0%	35.5%	*6.5%*
55 - 64	22.4%	16.5%	*5.9%*
65+	8.2%	17.8%	*-9.6%*
Gender			
Male	46.3%	49.2%	*-2.9%*
Female	53.7%	50.8%	*2.9%*
Race			
Asian	2.0%	4.3%	*-2.3%*
Black or African American	11.8%	5.4%	*6.4%*
American Indian or Alaskan Native	4.5%	1.0%	*3.5%*
Multiple Race	2.4%	2.6%	*-0.2%*
Other Race Alone	0.2%	1.5%	*-1.3%*
White	79.2%	85.2%	*-6.0%*
Ethnicity			
Hispanic	2.9%	4.9%	*-2.0%*
Not Hispanic	97.1%	95.1%	*2.0%*

**Data excludes clients without demographic information available and counties which did not provide client level data.*
Source: American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.

Age

Individuals ages 35 to 64 made up a larger share of grant service recipients than portion of the MN population. Individuals ages 35 to 54 made up 42 percent of grant recipients and 35.5 percent of the population (6.5 percentage point difference), and individuals ages 55 to 64 received 22.4 percent of services, despite only being 16.5 percent of the population. Some of this was attributable to the lower representation of individuals over 65 years of age (8.2 percent grant recipients, compared to 17.8 percent of population). Access to Medicare benefits may explains the lower utilization rates. On the other hand, several AMHI/CSP funded services are not covered by Medicare, such as Transportation, Housing Subsidies, and Client Flex Funds, so this difference may be attributed to an unknown cause or suggest older adults are not getting needed services. Individuals ages 18 to 34 were also slightly underrepresented as service recipients, 27.5 percent of clients, but 30.2 percent of the population. Chart 3 shows the state level age breakdown, including individuals are identified, but where age is still unknown (3.9 percent of individuals).

Chart 3: Adult Mental Health AMHI/CSP Grant Service Recipients by Age, Q1-Q2 2016

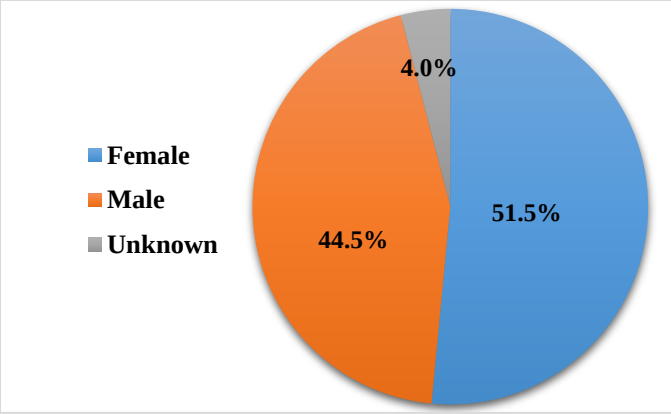


Source: Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016; Medicaid Management Information Systems, Mental Health Information System, 2016.

Gender

Grant funds served a higher percentage of women than men across the entire state, as women were 50.8 percent of the population but were 53.7 percent of recipients. Within regions, however, this trend was occasionally reversed in northern Minnesota. Please review the Appendix B for breakdowns by region that capture such variation. Chart 3 shows the state level gender breakdown, including individuals are identified, but where gender is still unknown (4.0 percent of individuals).

Chart 4: Adult Mental Health AMHI/CSP Grant Service Recipients by Gender, Q1-Q2 2016

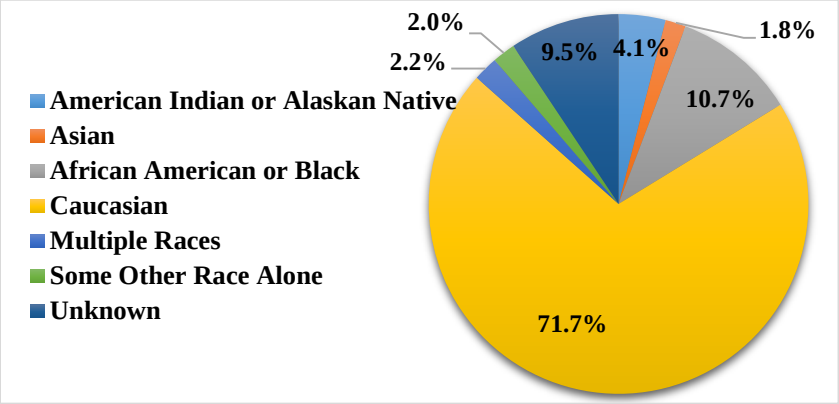


Source: Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016; Medicaid Management Information Systems, Mental Health Information System, 2016.

Race

Grant dollars reach a larger percentage of minority populations than Minnesota's population. For instance, African American individuals are 11.8 percent of service recipients, and 5.4 percent of the state population. Native Americans receive 4.5 percent of services, but make up 1.0 percent of the state's population. Asian individuals receive a lower rate of service than proportion of state population (2.0 percent compared to 4.3 percent of population). Chart 5 shows the state level race breakdown, including individuals are identified, but where race is still unknown (9.5 percent of individuals).

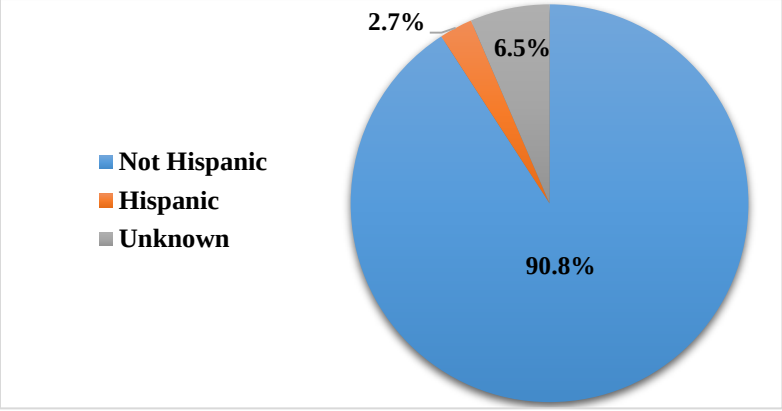
Chart 5: AMHI/CSP Grant Service Recipients by Race, Q1-Q2 2016



Source: Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016; Medicaid Management Information Systems, Mental Health Information System, 2016.

Ethnicity

Chart 6: AMHI/CSP Grant Service Recipients by Hispanic Origins, Q1-Q2 2016



Source: Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016; Medicaid Management Information Systems, Mental Health Information System, 2016.

Individuals of Hispanic origins were slightly under served when compared to the full state population (2.9 percent of service recipients, but 4.9 percent of population). Chart 6 shows the state level Hispanic/non-Hispanic breakdown, including individuals are identified, but where ethnicity is unknown (6.5 percent of individuals).

iii. 2016 AMHI/CSP Recipient Outcomes

The primary goal of CSP and services funded through AMHI, CSP, HWS, and Crisis funds is to reduce institutionalization of severely mentally ill individuals and support individuals so they may stay in the community. A secondary goal is to reduce unnecessary usage of high intensity care, such as institutional stays, when less intense (and often less expensive) care would meet client needs.

Using client level data, 3,463 individuals were identified in the Mental Health Informational System (MHIS) (approximately 25 percent of the total identified client population). There is some evidence this population is in greater need of higher intensity services than the remaining 75 percent of grant service recipients, as MHIS individuals have lower employment rates than individuals appearing in the Medicaid claims data for the same period (19.8 percent compared to 24.1 percent; see tables 7 and 8). This 5 percentage point differences is likely driven by the types of service MHIS covers. MHIS is focused on higher intensity mental health services such as Assertive Community Treatment (ACT), Adult Rehabilitative Mental Health Services (ARMHS), Intensive Residential Treatment Services (IRTS), and Intensive Community Recovery Services (ICRS). Whereas the larger grant recipient population in the Medicaid system has additional claims, but fewer intensive mental health services.

Table 7: Employment status of AMHI/CSP grant service recipients, Jan. – June 2016

Employment Type	***%***
Employed Full-Time	3.3%
Employed Part-Time	16.5%
Unemployed	28.8%
Homemaker	2.0%
Student	1.3%
Retired	2.0%
Disabled	35.0%
Hospital Patient or Resident of Institution	2.9%
Other Reported Classification (volunteers)	1.5%
Sheltered Employment	0.9%
Unknown	5.8%

Source: Department of Human Services, Adult Mental Health Client Level Grant data, 2016; Mental Health Information Systems (MHIS) client level data, 2106. Note: 3,463 grant service recipients also received MHIS reported services in Jan-June 2016 (n=3463)

Table 8: Employment status of AMHI/CSP grant services, Jan. to June 2016

Employment Type	***%***
Unemployed	75.9%
Employed	24.1%

Source: Department of Human Services, Adult Mental Health Client Level Grant data, 2016; Medicaid Management Information Systems (MMIS) client level data, 2106. (n=14,104; 1,920 unknown employment status recipients)

Identified individuals utilized a wide variety of mental health services. In the period of Jan. to June 2016, these individuals utilized almost 7,000 different types of services, suggesting each person averaged 2 programs of treatment, although certain individuals received more than 2 types of care with others receiving only a single service. Most frequent was ARMHS, with over 2,000 individuals receiving this service. Crisis services were also utilized frequently, collectively across Crisis Assessment, Intervention, Stabilization, and Residential services more than 2,460 types of services delivered. High intensity types of care were utilized across the population at lower frequencies. 153 individuals received State-Operated inpatient care (4.7 percent). IRTS and ICRS usage was slightly higher, collectively 411 users (12.5 percent), and ACT has 428 recipients (13.0 percent). See Table 9 for a full summary of service programs of recipients of grant funded services.

The majority of MHIS reported services were paid for through MHCP (71.2 percent). Approximately 2.9 percent of reported services were paid with grant funds only, and 2.9 percent were paid for with a combination of MHCP and grant funds. For remaining individuals, payment source was not known.

Table 9: Statewide Identified Recipients of Grant Services by Service Category, Jan. to July 2016

MHIS Service	Jan - June 2016
Assertive Community Treatment (ACT)	428
Adult Rehabilitative Mental Health Services (ARMHS)	2139
Community Support Program (CSP) services	162
Crisis Assessment	792
Crisis Intervention	806
Crisis Residential	464
Crisis Stabilization	406
Dialectical Behavioral Therapy (DBT)	139
Day Treatment	11
Diagnostic Assessment	167
Housing with Supportive Services	31
Intensive Community Recovery Services (ICRS)	4
Intensive Residential Treatment Services (IRTS)	407
Medication Management	281
Outpatient Psychotherapy	212
Peer Support Services	177
Rule 79 Case Management	167
State-Operated Inpatient	153
Supported Employment	21
Total Services Received	6,967

Source: Department of Human Services, Adult Mental Health Client Level Grant data, 2016; Mental Health Information Systems (MHIS) client level data, 2106. Note: 3,463 grant service recipients also received MHIS reported services in Jan-June 2016 (n=3463); ICRS are no longer operational in Minnesota.

Among MHIS reported AMHI/CSP recipients, the majority of individuals resided in the community (see Table 10). More than seventy percent lived in private residence with 64.9 percent having an independent living and 7.0 percent having a dependent living situation. Approximately 9.4 percent were in residential care or crisis residential, and an additional 1.5 percent in an institutional setting. The remaining individuals had a mix of shelter/homeless, foster care, jail/correctional setting, or other housing status (13.1 percent in total). Unfortunately, residential status is not tracked in Medicaid reporting, so no identical data exists for the broader group of grant recipients.

Table 10: Residential status of AMHI/CSP grant service recipients, Jan. – June 2016

Housing Type	***%***
Homeless/Shelter	4.9%
Foster Care	4.1%
Residential Care	9.0%
Crisis Residential	0.4%
Institutional Setting	1.5%
Jail/Correctional Setting	0.5%
Private Residence - Independent	64.9%
Private Residence - Dependent	7.0%
Other	2.9%
Unknown	4.8%

Source: Department of Human Services, Adult Mental Health Client Level Grant data, 2016; Mental Health Information Systems (MHIS) client level data, 2106. Note: 3,463 grant service recipients also received MHIS reported services in Jan-June 2016 (n=3463)

Table 11: MCHP active enrollment among AMHI/CSP service recipients, Jan. - June 2016

N = 12,403	***n***	***%***
Active MCHP Enrollees	10,941	88.2%
Total member months	62,828	N/A

Source: MMIS Claims data, 2016

From Jan. to June 2016, approximately 12,403 unique individuals were identified with Medicaid expenditure data. During that period, 10,941 AMHI/CSP clients were enrolled in MHCP, with 62,828 member months of service (see Table 11). This does not include the 5,000 individuals without PMI ids. Full expenditure data is available in Table 12. An estimated $137.45 million in payments were made during this period, composed of $131.6 million in Fee-For-Service provider payments and an estimated $34.7 in MCO payments.

Seventy-three percent of expenditures where in seven categories of care:

- Home and Community Service Providers (33.1 percent of all expenditures)
- Hospitals (10.4 percent)
- Pharmacies (9.7 percent)
- Bill Entity for Mental Health (5.9 percent)
- IRTS (4.6 percent)
- County Human Services Agencies (4.3 percent)
- Community Mental Health Center (4.6 percent)

Table 12: MCHP Expenditures for AMHI/CSP Clients with PMI IDs, Jan. to June 2016

	FFS vs Estimated MCO Payment					
	Actual MHCP Payments-Fee for Service and MCO Capitation Payments	**Estimated Payments by MCO (Actual MHCP payment to MCOs was $28,532,973)**	**Total Based on FFS Payments and estimated MCO payments**	**% of Total Spending**	**Avg. Payment for AMHI Clients Enrolled**	**Monthly Per Capita Payment for AMHI clients Enrolled**
Home And Community Srv Provider	$45,510,869	$96,128	$45,606,997	33.1%	$4,168.45	$725.90
Hospital	$11,401,090	$2,974,574	$14,375,664	10.4%	$1,313.93	$228.81
Pharmacy	$5,249,863	$8,081,665	$13,331,528	9.7%	$1,218.49	$212.19
Bill Entity For Mental Health	$4,273,719	$3,889,329	$8,163,049	5.9%	$746.10	$129.93
IRTS	$3,555,277	$2,805,193	$6,360,471	4.6%	$581.34	$101.24
Community Mental Health Center	$2,945,843	$3,355,815	$6,301,658	4.6%	$575.97	$100.30
County Human Services Agency	$5,039,189	$858,222	$5,897,411	4.3%	$539.02	$93.87
Physician	$1,692,120	$3,630,083	$5,322,203	3.9%	$486.45	$84.71
Personal Care Provider	$4,400,909	$321,498	$4,722,407	3.4%	$431.62	$75.16
Chemical Depend Free Standing	$3,812,863	$157,066	$3,969,929	2.9%	$362.85	$63.19
Indian Health Facility	$3,540,548	$7,153	$3,547,701	2.6%	$324.26	$56.47
County Approved Case Manager	$1,774,283	$1,499,408	$3,273,691	2.4%	$299.21	$52.11
Medical Transportation Provider	$841,813	$1,797,734	$2,639,547	1.9%	$241.25	$42.01
Consolidated Provider Organization	$1,026	$2,329,969	$2,330,995	1.7%	$213.05	$37.10
Day Training & Habilitation Center	$2,163,609	$262	$2,163,871	1.6%	$197.78	$34.44
Nursing Facility	$2,055,657	$2,262	$2,057,919	1.5%	$188.09	$32.75
Home Health Agency	$1,294,524	$87,803	$1,382,327	1.0%	$126.34	$22.00
Fed Qual Health Center	$861,992	$389,830	$1,251,822	0.9%	$114.42	$19.92
Medical Supplier	$402,257	$508,840	$911,097	0.7%	$83.27	$14.50
Laboratory, Independent	$314,067	$367,676	$681,742	0.5%	$62.31	$10.85
Dentist	$202,570	$364,838	$567,408	0.4%	$51.86	$9.03
ICF/MR Facility	$467,710		$467,710	0.3%	$42.75	$7.44
Rural Health Clinic	$271,412	$7,882	$279,294	0.2%	$25.53	$4.45
Public Health Nursing Org	$169,751	$58,743	$228,494	0.2%	$20.88	$3.64
Community Health Clinic	$97,398	$108,173	$205,571	0.1%	$18.79	$3.27
Billing Entity For Phys Services	$56,841	$145,978	$202,820	0.1%	$18.54	$3.23
Other Non-Physician		$163,554	$163,554	0.1%	$14.95	$2.60
Optician	$65,243	$93,434	$158,677	0.1%	$14.50	$2.53
Psychologist	$83,781	$64,542	$148,322	0.1%	$13.56	$2.36
Chiropractor	$26,387	$73,003	$99,389	0.1%	$9.08	$1.58
Renal Dialysis Free Standing	$78,255	$17,965	$96,219	0.1%	$8.79	$1.53
Hospice	$80,323	$8,558	$88,881	0.1%	$8.12	$1.41
Regional Services Specialist	$16,134	$69,200	$85,334	0.1%	$7.80	$1.36
Social Worker-Licensed Ind	$38,378	$42,375	$80,753	0.1%	$7.38	$1.29
Approved Day Treatment Center	$41,121	$36,100	$77,221	0.1%	$7.06	$1.23
Ambulatory Surgery Center	$33,568	$24,906	$58,474	0.0%	$5.34	$0.93
Other Non-Traditional		$54,317	$54,317	0.0%	$4.96	$0.86

Table 12: MCHP Expenditures for AMHI/CSP Clients with PMI IDs, Jan. to June 2016 (continued)

	FFS vs Estimated MCO Payment					
	Actual MHCP Payments- Fee for Service and MCO Capitation Payments	**Estimated Payments by MCO (Actual MHCP payment to MCOs was $28,532,973)**	**Total Based on FFS Payments and estimated MCO payments**	**% of Total Spending**	**Avg. Payment for AMHI Clients Enrolled**	**Monthly Per Capita Payment for AMHI clients Enrolled**
Public Health Clinic	$3,931	$45,969	$49,900	0.0%	$4.56	$0.79
School District	$44,325		$44,325	0.0%	$4.05	$0.71
Rehabilitation Agency	$28,093	$15,557	$43,651	0.0%	$3.99	$0.69
Podiatrist	$10,010	$22,337	$32,346	0.0%	$2.96	$0.51
Family Planning Agency	$11,362	$14,707	$26,069	0.0%	$2.38	$0.41
Marriage And Family Therapist	$15,613	$8,590	$24,203	0.0%	$2.21	$0.39
Private Duty Nurse	$11,150	$6,996	$18,146	0.0%	$1.66	$0.29
Cert Registered Nurse Anesth	$5,218	$11,954	$17,172	0.0%	$1.57	$0.27
Optometrist	$5,093	$8,769	$13,862	0.0%	$1.27	$0.22
Nurse Practitioner	$9,636	$3,187	$12,823	0.0%	$1.17	$0.20
Licensed Prof Clin Counselor	$7,809	$4,784	$12,594	0.0%	$1.15	$0.20
Independ Diag Testing Facility	$1,080	$6,115	$7,195	0.0%	$0.66	$0.11
Child And Teen Checkup Clinic		$3,006	$3,006	0.0%	$0.27	$0.05
Audiologist	$1,888	$910	$2,798	0.0%	$0.26	$0.04
Clinical Nurse Specialist	$1,695	$786	$2,480	0.0%	$0.23	$0.04
Registered Physical Therapist	$193	$1,932	$2,125	0.0%	$0.19	$0.03
X-Ray/Diagnostic	$364	$1,235	$1,599	0.0%	$0.15	$0.03
Institution For Mental Disease		$682	$682	0.0%	$0.06	$0.01
Dental Hygienist	$131	$193	$324	0.0%	$0.03	$0.01
Hearing Aid Dispenser	$61	$116	$177	0.0%	$0.02	$0.00
Case Manager(Waiver)		$55	$55	0.0%	$0.01	$0.00
Regional Treatment Center		$0	$0	0.0%	$0.00	$0.00
MCO- Pre-Paid Health Plan Provider	**$28,532,973**					
Total	**$131,551,016**	$34,651,955	$137,669,999		$12,582.94	$2,191.22

VIII. Other Targeted Grant Programs

A. Crisis Services

i. Background

Since the passage of the Comprehensive Adult Mental Health Act, counties must assure mental health crisis services within each county to meet the needs of adults who are experiencing an emotional crisis. Crisis services are required to ensure the safety and assist in the stabilization of the person during the crisis and provide appropriate follow-up and referral appropriate to meet the person's needs. The goal of crisis services is to provide people with the support they need, when they need it, and in the place where they prefer to receive services.

Crisis services are supported by a combination of funding streams that include private insurance, Medicaid/MinnesotaCare reimbursement, and grant funding. Currently, Minnesota is served by a regional network of thirty-one mobile crisis teams spanning across the entire state. Minnesota emphasizes the importance of collaboration between mental health crisis services and other community stakeholders such as law enforcement, hospitals, schools, community mental health providers, medical clinics, and county social services.

In 2015, Minnesota invested $8.6 million for the next biennium into improved crisis services for children and adults. This includes a charge to revise and strengthen service standards, as detailed above. Highlights include:

- Expanding mobile crisis teams across all 87 counties.
- Funding to establish "one number" access. Currently, available technology limits the ability to accurately reroute calls from both cell phones and landlines.
- Phone based consultation for teams serving individuals in crisis who also have co-occurring intellectual disabilities or traumatic brain injuries.
- Defining crisis services as an "emergency service" for the purpose of private insurance coverage. This invokes parity requirements to cover to the same degree as emergency services covered for physical conditions.
- Provides start-up funding to expand crisis residential services for adults.

With this funding, DHS awarded $500,000 for start-up costs to expand Adult Residential Crisis Stabilization (RCS) statewide. These grants provide funds for start-up costs for a 6 bed CRS program in Itasca County and three new IRTS programs which will include RCS beds in Sherburne, Scott and Hennepin counties. We expect that the addition of these 12 beds will be completed by July 1, 2017.

ii. Crisis Funding and Findings

State investment into adult crisis services increased substantially from 2015 to 2016 from $4.8 million to $7.5 (see table 13) to improve crisis center services across the state. At the same time, 2016 brought new data reporting requirements for crisis providers, including both person and service based reporting.

Table 13: Adult Crisis Funding Allocations by Region, 2016

Region	2015 Allocation ($)	2016 Allocation ($)
Total Allocation	*$4,845,170*	*$7,516,289*
Region NW8	$276,110	$589,825
Region 2	$297,622	$303,710
Region 3 North	$262,365	$665,280
BCOW	$293,411	$439,500
Region 5+	$289,802	$370,595
Region 7E	$298,000	$290,000
Region 4S	$300,936	$333,935
CommUNITY	$294,015	$541,150
Anoka	$0	$250,000
Ramsey	$578,000	$579,200
Hennepin	$670,200	$428,075
SW18	$295,215	$699,960
Dakota	$0	$159,730
Carver/Scott	$0	$686,030
SCCBI	$774,380	$443,474
CREST	$245,114	$735,825

Source: Department of Human Services, Grant Allocation Tables, 2016

Table 14 shows the demographics of crisis service recipients for the first half of 2016. More than 1,000 identified individuals received grant funded services across the state.

In Minnesota, individuals ages 18 to 34 are 30.2 percent of the over 18 population, 27.5 percent of AMHI/CSP recipients, but *half of all crisis services go to individuals ages 18 to 35* (see Table 14).

Crisis services were provided to a higher percentage of minority populations, than in Minnesota's population. White individuals received 73.8 percent of crisis services, but were 85.2 percent of the population. By comparison, crisis services served a higher portion of Black or African American, Native American, Native Hawaiian or Pacific Islander, and Other Races than were in the Minnesota Population. Hispanic individuals were served at a greater rate than the state population, 5.1 percent compared to 4.9 percent (whereas AMHI/CSP funds reached this population at a 2.9 percent rate). Only Asian individuals were represented at a lower rate than their MN population proportion (1.4 percent compared 4.3 percent), similar to the AMHI/CSP findings.

Men and women are served at roughly the same rate as the MN population. 1.9 percent of recipients were veterans and 84.1 percent were not veterans with the remaining population's veteran status unknown.

Table 14: Demographic Characteristics of Crisis Recipients, Jan. to June 2016

	Crisis Population (%)
Age (Over 18 Population)	N =1,223
18 to 25	25.8%
26 to 35	23.6%
36 to 45	19.2%
46 to 55	19.2%
56 to 65	9.7%
Over 65	2.5%
Race	
Asian	1.4%
Black or African American	11.6%
Native American	4.5%
Native Hawaiian or Pacific Islander	0.3%
White	73.8%
Other	7.8%
Unknown	0.6%
Veteran	
Not Veteran	84.1%
Veteran	1.9%
Unknown	14.0%
Sex	
Male	49.7%
Female	50.3%
Ethnicity	
Hispanic	5.1%
Not Hispanic	93.3%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016. Note: Remaining percentages are unknown values.

Table 15: Primary Reason for Crisis Referral, Jan. to June 2016

Primary Reason for Referral	*N = 1,154*
Suicide Attempt	34.4%
Self-Injurious Behavior	2.1%
Psychotic or Delusional	16.5%
Depression	12.9%
Anxiety/Panic	11.0%
Other Primary Reason for Intervention	8.6%
Mania	2.6%
Dysregulated Behavior	3.8%
Suicidal Ideation	8.1%

Source: DHS, Mental Health Division, MHIS, 2016. Note: Remaining percentages are unknown values.

The most common reasons for crisis referral was suicide attempt (34.4 percent), followed by Psychotic or Delusional Episode and Depression Episode (16.5 and 12.9 percent respectively). Table 16 includes all primary reasons for crisis referral for the first half of 2016.

Table 16: Referral Source for Crisis Services, Jan. to June 2016

Primary Reason for Referral	*N = 1,154*
Case Manager	2.2%
Child Protection	31.5%
Hospital	7.7%
Law Enforcement	2.0%
Primary Care Physician	0.6%
Probation Officer	1.1%
Residential Treatment or Foster Care Provider	3.2%
School	39.6%
Self, Family, Friend	6.6%
Other Mental Health Agency or Individual	4.8%
Other	0.7%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016. Note: Remaining percentages are unknown values.

Crisis recipients also came from a variety of referral sources. The 2 most common sources were Child Protection (31.5 percent) and School (36.6 percent), together making up more than 65 percent of all referral cases. The high percentage of school based referrals may also help explain the See Table 24 for the full list of crisis service referral sources and their frequency of occurrence.

Table 17: Residential Status of Crisis Services Recipients, Jan - June 2016

Residential Status	*%*
Homeless	4.8%
Residential Care	0.9%
Crisis Residence	1.4%
Institutional Setting	0.2%
Jail/Correction Facility	4.9%
Private Residence - Independent Living	46.6%
Private Residence - Dependent Living	33.4%
Other Residential Status	3.0%
Unknown	4.9%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016.

As Table 25 shows, 17 percent of service recipients came from private residences in either independent or dependent living situations (46.6 and 33.4 percent respectively). A significant portion of individuals also from come Jail/Correctional Settings (4.8 percent), or are homeless (4.9 percent).

Combining recipients with full-time and part-time employment yields an employment rate of 32.5 percent among crisis recipients, 29.5 percent of recipients are unemployed, and the remaining recipients have non-employment status, such as student, homemaker, disabled, or hospital patient (totaling 26.5 percent). Full employment breakdowns are available in Table 18.

Table 18: Employment Status of Crisis Recipients, Jan - June 2016

Employment Status	***%***
Employed Full Time	23.7%
Employed Part Time	8.8%
Looking for Work/Unemployed	29.5%
Homemaker	0.3%
Student	8.1%
Retired	1.7%
Disabled	9.5%
Hospital Patient or Resident of Other Institution	6.6%
Other Reported Classification (Volunteers	0.0%
Sheltered/Non-Competitive Employment	0.0%
Unknown	11.8%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016; N=1154

At the end of the crisis intervention, teams leave clients in the setting they were seen, or make other arrangements for care, called disposition status (referred to here as outcome status).

Table 19: Outcomes of Crisis Intervention, Jan - June 2016

Disposition Status	***%***
Chemical Health Residential Treatment	1.6%
Emergency Department	4.2%
Homeless Shelter	1.6%
Inpatient Psychiatric Unit	23.8%
Jail	4.9%
Remained in Current Residence (Foster Care)	0.9%
Remained in Current Residence (Self or Family)	54.9%
Remained in School	0.5%
Residential Crisis Stabilization	1.4%
Residential Treatment	0.5%
Temporary Treatment (IRTS)	1.9%
Other	3.8%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016; N=1154

The most common outcome is remaining in the current residence (with either self or family), occurring in 54.9 percent of cases. The second greatest outcome was inpatient psychiatric unit care (28.8 percent), followed by the recipient going to jail or an emergency department (4.9 percent and 4.2 percent respectively). Table 19 includes all dispositions of recipients at the end of crisis. After receiving crisis services, referral to additional services are made. Table 20 shows all service referral types. Most common was referral to Adult Day Treatment (72.6 percent).

Table 20: Recipient Service Referrals after Crisis Services, 2016

Service Type	***%***
Unknown	6.8%
Adult Day Treatment	72.6%
Adult Rehabilitative Mental Health Services	8.3%
Assertive Community Treatment	2.3%
Chemical Health Services	1.3%
Children's Therapeutic Services and Supports	1.0%
Crisis Residential	0.5%
Crisis Stabilization	7.2%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016; N=1154

Crisis providers also report general call volume and face-to-face meetings each month as service counts unconnected to particular recipients. Unlike with identified recipients, the services go to a mix of children and adults and may include Medicaid and non-Medicaid recipients. Funding for these centers is also a mix of grant types, county funds, and other payment sources. Despite these limitations, a substantial portion of grant funds supports the centers, so overall statistics are reported below in Table 21 for January to June 2016.

Table 21: Crisis Call Center Call Volume and Call Follow-up, January to August 2016

Call Follow-up Type	***Total (N)***
Total Calls	*23,265*
Provider Referrals	3,730
Phone - No Face to Face	9,540
911 Referral	205
Face to Face 24 Hours	258
Face to Face	3,848
Other	5,684

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016

B. Housing with Supports

i. Background

In 2007 the Governor's Initiative on Mental Health made available yearly grant funding for the development of HWS for persons with serious mental illness. The HWS for Adults with Serious Mental Illness (HSASMI) grants provide supports in permanent supportive housing opportunities for persons occupying about 640 units per year. The HSASMI grants support a range of permanent, lease-base, housing models ranging from single site to scattered site housing projects. In alignment with the housing mission statement, the HSASMI grant housing projects have been selected based upon, and are encouraged to meet, the fidelity standards of the Permanent Supportive Housing Evidence Based Practice (PSH EBP).

The HWS grants were expanded in 2015 in order to increase the opportunities for persons living with serious mental illnesses to have the supportive services and housing needed to access and retain housing. Additionally, these grants support the use of the PSH EBP as the design and assessment standard for the grants, provide training for grantees, and support the state resources needed for oversight of the HSASMI grants and fidelity based evaluation of the grantees.

The PSH models will assure that tenants have access to affordable housing opportunities which are permanent housing. The definition of permanent housing is lease-based, or ownership-based, housing that does not have a pre-defined time limit. The supportive services will be recovery oriented, person-centered, and will demonstrate capacity to provide or link tenants to best practice and evidence-based mental health services. Examples include certified peer specialist delivered services, individual placement and support (IPS) employment services, and critical time intervention (CTI). There are currently 5 HSASMI grantees across Minnesota.

ii. Housing with Supports Funding and Findings

Funding for HWS remained at $549,955 annually in 2015 and 2016. The majority of funds were used for Housing Subsidy ($340,457 in 2015 an $276,322 allocated in 2016), followed by Other Community Support Program Services ($167,155 in both 2015 and 2016), and General Case Management (approximately 40,000 each year). Table 16 provides further detail about grant expenditures and grant plan allocations.

Table 22: Statewide Housing with Supports Grant Plan Allocations, 2016

	Other CSP	Housing Subsidy	Basic Living/Social Skills	Case Management	Total
2015 Total	$167,155	$340,456	$0	$42,300	$549,911
Anoka	$0	141,156	$0	$0	$141,156
CommUnity	$0	102,700	$0	42,300	$145,000
Dakota	$25,100	-	$0	-	$25,100
Ramsey	142,055	$0	$0	$0	$142,055
Region 7E	$0	96,600	$0	$0	$96,600
2016 Total	$167,155	$276,322	$63,178	$43,300	$549,955
Anoka	$0	$78,022	$63,178	$0	$141,200
CommUnity	$0	$101,700	$0	$43,300	$145,000
Dakota	$25,100	$0	$0	$0	$25,100
Ramsey	$142,055	$0	$0	$0	$142,055
Region 7E	$0	$96,600	$0	$0	$96,600

Source: Department of Human Services, 2895 form expenditure data, 2015. Note: Dakota and Ramsey County numbers have been adjusted to reflect total amount paid, 2895 expenditures were not filed in housing form so 2016 grant plan spending used to determine appropriate BRASS code usage for missing expenditures.

In 2016, new reporting requirements through MHIS were enacted that required 6-month status updates for all HWS clients. From January to June 2016, 129 clients were reported as receiving HWS services in the regions receiving grant funds (Dakota had not yet reported data so is excluded).

Young adults ages 18 to 25 received 10.9 percent of HWS services in the first half of 2016 (see Table 23). While young adults make up approximately 12.3 percent of Minnesota's over 18 population, [4] a triennial study on Homelessness conducted by Wilder Research for 2015 found this population is 21.8 percent of the over 18 homeless population.[5] Sixty percent of HWS services went to individuals ages 26 to 55. Statewide, adults make up 53.4 percent of Minnesota's over 18 population, and 63.5 percent of the homeless population. Older adults, who are 55 or older, received 28.7 percent of HWS services, and make up 34.3 percent of Minnesota's over 18 population, and 14.7 percent of the over 18 homeless population.

Half of all HWS services are provided to minority, non-white populations. African Americans receive 37.3 percent of services, Native Americans receive 4.2 percent of services, Asians receive 2.8 percent of services, and multi-racial individuals and individuals of some other race alone collectively receive 5.6 percent of services. While the statewide population is 85.2 white, 5.4 percent African American, and 1.0 percent Native American, Wilder Research found

[4] The age groups for HWS clients are 18 to 25, 26 to 55, and over 55, whereas the statewide and Wilder groups are 18 to 24, 25 to 55, and over 55, which may be the cause of some difference.

[5] Additional information about the 2015 Minnesota Homeless Study from Wilder Research is available at http://mnhomeless.org. Over 18 population rates were calculated based upon counts found here: http://mnhomeless.org/minnesota-homeless-study/detailed-data-counts/2015/All-2015-Homeless-Counts_3-16.pdf?v=2, adjusted to exclude individuals under age 18.

demographics of the homeless population to be quite different. White individuals are only 38 percent of homeless individuals. African Americans were 39 percent of the homeless population, and Native Americans are 8 percent. Individuals who are Asian were 2 percent of the homeless population, and others who were mixed race or another race were 5 percent of the homeless populations. This comparison suggests additional work could be done to reach Native American individuals, but generally, HWS dollars are appropriately serving a majority of minority populations.

Hispanic individuals of any race were 3.8 percent of HWS service recipients, but 7 percent of the homeless population according to Wilder. Additional efforts may be needed to reach this population.

Table 23: Demographic Characteristics of HWS Recipients, Jan. to June 2016

	HWS Population (%)
Age (Over 18 Population)	
18 to 25	10.85%
26 to 35	16.28%
36 to 45	19.38%
46 to 55	24.81%
56 to 65	26.36%
Over 65	2.33%
Veteran Status	
Not Veteran	94.57%
Veteran	5.43%
Sex	
Male	47.29%
Female	52.71%
Race	
Asian	2.82%
Black or African American	37.32%
Native American	4.23%
Multiple Race	2.11%
Other Race Alone	3.52%
White	50.00%
Ethnicity	
Hispanic	3.80%
Not Hispanic	95.35%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016. Note: Remaining percentages are unknown values; N=142.

Table 24 provides employment and non-employment statistics for recipients. Only about a quarter of HWS recipients were employed, with more than half (55.0 percent) looking for work or unemployed. The most common non-workforce status was disabled (almost 15 percent of recipients). Less than four percent of total recipients had the status of student or retired. Wilder Research found that among the homeless population, 30 percent of individuals had any type of employment, with 14 percent of individuals with full-time employment.

Table 24: Employment Status of HWS Recipients, Jan. - June 2016

Employment Status	***%***
Employed Full Time	9.30%
Employed Part Time	17.05%
Looking for Work/Unemployed	55.04%
Student	2.33%
Retired	1.55%
Disabled	14.73%
Hospital Patient or Resident of Other Institution	0.00%
Other Reported Classification (Volunteers)	0.00%
Sheltered/Non-Competitive Employment	0.00%
Unknown	0.00%

Source: Department of Human Services, MHIS data, 2016; N = 142

Table 25: Residential & Educational Attainment Status of HWS Recipients, Jan. - June 2016

Residential Status	***%***
Homeless	2.33%
Residential Care	0.00%
Crisis Residence	0.00%
Institutional Setting	0.78%
Jail/Correction Facility	0.00%
Private Residence - Independent Living	92.25%
Private Residence - Dependent Living	0.78%
Other Residential Status	3.88%
Highest Educational Level Attained	***%***
Grade 5 to 11	7.04%
High School	53.52%
Vocational	7.75%
Some College	21.13%
4 Year Degree	7.04%
Graduate or Professional School	2.11%
Unknown	1.41%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016; N=142

HWS recipients had housing statuses primarily of Independent Living in a Primary Residence (over 92 percent). The remaining 8 percent of recipient had housing varying from Homeless/Shelter, Dependent Living in Private Residence, Institutional Setting, or Other Residential Status (See Table 25).

Recipients' educational attainment varied. About 53 percent of consumers had completed high school, while an additional 21.1 percent had some college. Almost 8 percent had received vocational schooling. About 9 percent had completed a 4-year degree, including a subset that had also gone to professional or graduate school (see Table 25).

About 20 percent of HWS consumers had children (see Table 26). For recipients with children, about 43 percent had the children full-time and 18 percent part-time. Additionally, about 17.2

percent of children in question had special needs (in 41.4 percent of cases it was unknown if the child was special needs or not). Overall, this suggests that about 12.4 percent of HWS services are used to house adults with mental illness and their families.

Table 26: HWS Recipients with Children, Jan. - June 2016

Children Under 18 Years of Age	***%***
Yes	20.42%
No	77.46%
Unknown	2.11%
Parent Live with Children	
Full-time	42.86%
Part-Time	17.86%
Not at All	39.29%
Special Needs Child?	
Yes	17.24%
No	41.38%
Unknown	41.38%

Source: Department of Human Services, Mental Health Division, Mental Health Information System (MHIS) data, 2016; N = 142

IX. Ongoing Initiatives

While these grants have been successful in reaching populations in need, DHS continues to lead efforts to improve the grant funding process. Below are the current projects supporting this work:

A. DHS is currently in the process of developing a more systematic and quantitative data collection for AMHI and CSP grant funding. We are working with counties and providers to use the Mental Health Information System (MHIS) to report all AMHI and CSP grant funding and looking to the Human Service Performance Management System to achieve more accurate expenditure information and client level data. This increased reporting accountability will require DHS to be clearer about the outcomes it expects from the investments of these grants.

B. DHS is currently leading an AMHI reform project to address the purpose and function of AMHI's. Interviews with key stakeholders are ongoing and a workgroup will be starting in 2017 to bring forth recommendations on updating the outdated statute language. In addition, DHS is looking into the role that the DHS mental health program consultants should play in the operation of the AMHIs.

C. Since July of 2016, DHS has held crisis stakeholder meetings to gather input from providers on strengthening the current crisis standards and developing an updated certification process. Implementation for this is scheduled for July 2017. Currently DHS is providing technical assistance to all mobile crisis teams to provide 24/7 coverage by January 2018.

D. With permeant supportive housing listed as top 3 service gap in adult mental health services, DHS is currently in the process of significantly increasing the number of HSASMI grantees from 5 to an additional 6-10 across the state. The additional grantees will start services January 2017.

It is also important to look at the mental health governance structure in order to fully maximize the impact of these grants. Further discussion on this topic should address:

i. Defining the purpose, scope, roles and responsibilities of governing the mental health continuum of care.

ii. Creating clear lines of reporting to the applicable grantees based on authority that are streamlined for efficiency and reduce duplication.

iii. Collect, analyze and act on data to:

1. Identify, develop, implement, fund and evaluate new services driven by local need.
2. Use Continuous Quality Improvement to:
    i. Determine the outcomes and indicators needed to be collected, analyzed and reported.
    ii. Determine the quality improvement structure, methods and strategies used that includes input from individuals and families impacted by mental illnesses.

X. Appendix

A. 2016 Grant Application Detailed Barrier List by Area

Transportation

- Limited last minute transit services
- Limited personal transit
- Limited protected transport
- Limited public transit
- Limited taxis
- Limited volunteer drivers
- No rural area coverage

County Staff

- Limited family/friends access
- Limited staff time
- Limited stakeholder time
- Locating persons w/SMI/SPMI
- Recruitment new positions
- Staff shortage
- Staff turnover

Providers

- High turnover
- Limited family/friends access
- Limited hours of operation
- Limited rural availability
- Long waitlists
- MA/MinnesotaCare payment not accepted
- Not accepting new patients
- PASRR training
- Recruitment - low pay
- Recruitment - qualified applicants
- Recruitment - rural areas
- Shortage of MH providers

Societal/Cultural

- Limited media coverage

- Mental health stigma
- Other Socioeconomic barriers
- Limited public interest in MH
- Limited culturally relevant services
- Limited bilingual staff
- Limited translators
- Limited outreach to diverse communities

Budgetary/Insurance

- Budget shortfalls
- Limited MA/MinnesotaCare coverage
- Loss of grant dollars
- Grant payment not accepted
- High Copays
- Ineligible for state insurance
- MA spenddown/High deductible
- Medicare coverage gaps
- No service coverage
- Time limited coverage
- Transitional insurance gaps

Client level

- Person's symptoms
- Refusal of care
- Knowledge of available services
- Limited/No support system
- Navigating complex system
- Limited phone/internet access

Employment

- Available jobs - General
- Available jobs - Supported Employment
- Background checks
- Employers willing to hire
- Ongoing employment support
- Vocational training

Housing

- Available- affordable housing
- Available- low vacancy rate
- Available- supported housing
- Background checks
- Long waitlists
- Shortage- HUD vouchers
- Shortage- landlords
- Shortage- rental assistance
- Peer Specialist

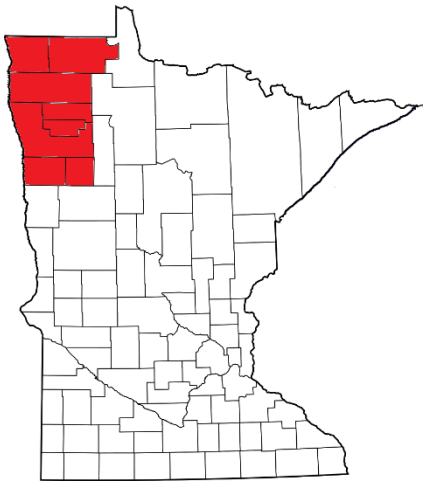
LAC

- Community relationships
- Frequency of meeting
- Limited LAC power
- Limited member training

B. Regional Profiles

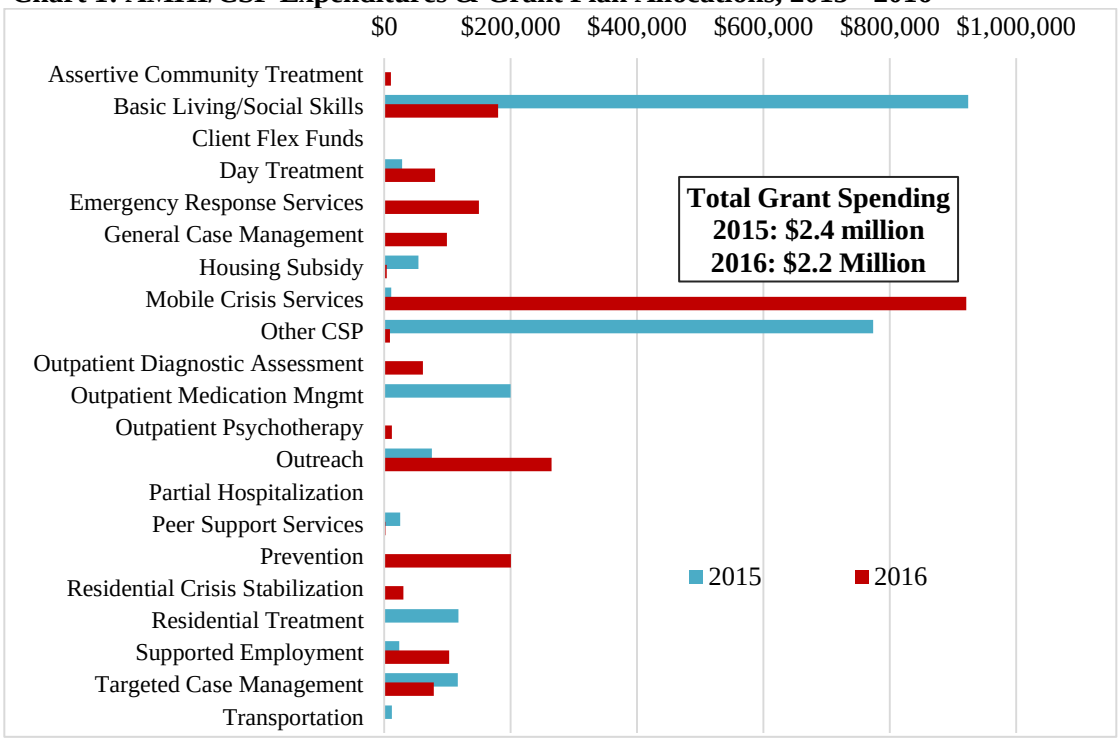
This page is a placeholder for the start of regional profiles in the table of contents. Do not delete. *Regional Profile narrative questions were completed by AMHI initiative representatives. DHS acted in a limited editorial capacity to structure answers in a similar format, remove typographical errors, and enrich answers. Data found in the regional profiles is based upon the same data sets highlighted in the main report. *Note: Not all services and programs described are funded solely by the grants in this report, however funding allows counties, initiatives, and tribes to expand programing and support services in many ways not directly connected to dollars, particularly with the practice of braiding multiple types of funds together.**

Regional Profile: **NW8**



Mental Health Initiative Region 1 is comprised of Kittson, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake, and Roseau Counties (see map), as well as parts of White Earth Nation. In 2016, DHS awarded the region $2.2 million of CSP and AMHI dollars (see Chart 1), as well as $589,825 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 6,040 duplicated individuals across 16 service categories (outreach and prevention not included). In 2015, the region spent $11.3 million across 15 service categories. AMHI/CSP Grant dollars paid 59.2 percent of county expenses in eligible service categories (see Chart 2). Grant dollars were used to fund 5 outside providers with multiple sites and programs, as well as services provided by the county. In the first and second quarter of 2016, the county identified almost 1,026 unique individuals being served across 11 service categories, and an additional 300 unidentified individuals in quarter 1, and 515 individuals in quarter 2.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

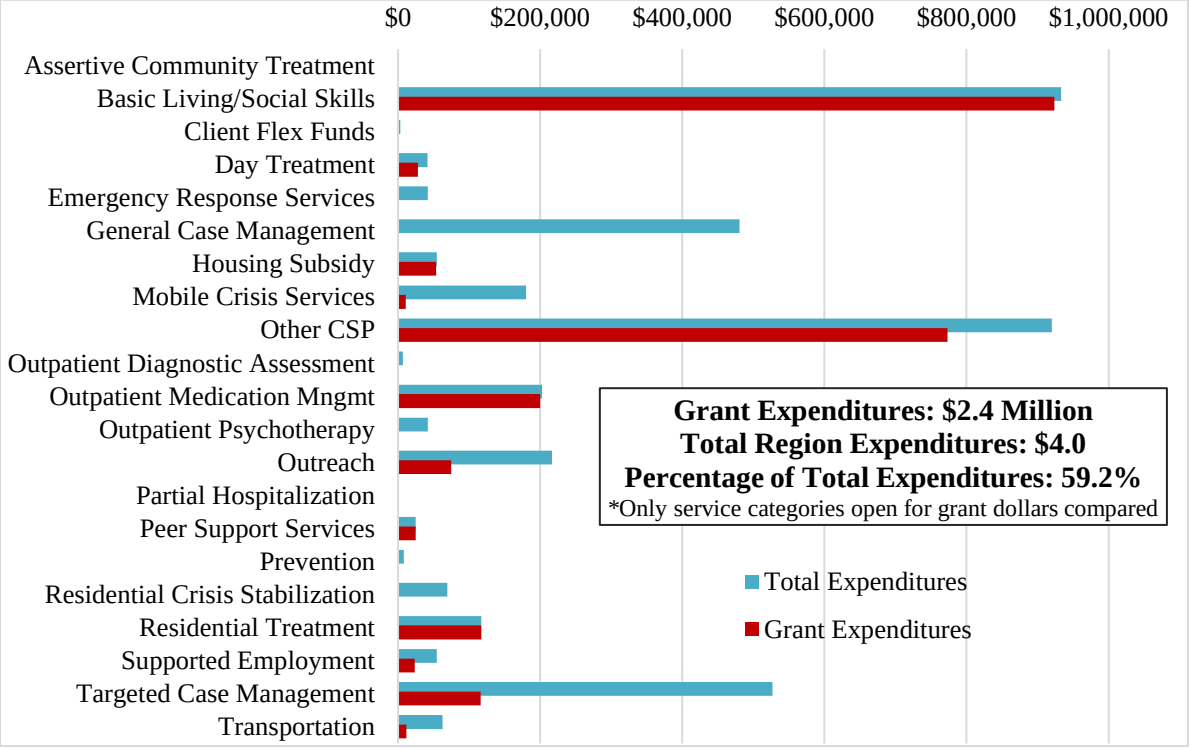
Regional Mental Health Community Needs and Service Structure

The NW 8 Region of MN is comprised of 8 counties, 6 federally designated as rural and 2 federally designated as frontier. There is a predominately Caucasian population of Scandinavian, French and German descent, with Hispanic/Latino ethnicity second and Native American and Multiracial in equal

numbers as third. Western Polk has experienced a rise in the Somali population and in Eastern Polk a growing Russian Orthodox population. Mahnomen County is entirely within the White Earth Nation.

The average county resident is 42 years old, with slightly more men than women (50.2 percent compared to 49.8), also women make up a larger percentage of grant service recipients (63.8 percent). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

In quarters 1 and 2 of 2016, the region provided services to 810 and 832 unique individuals respectively, or 1,026 people over six months. The majority of reported clients received Client Outreach, Other CSP Services, and Basic Living/Social Skill services. Approximately one third of clients received more than one type of service or services from more than one provider each quarter.

Those with co-occurring mental health and chemical health along with those experiencing trauma are rising in service needs. There has also been approximately a 7 percent increase in 2015 for those receiving services between the ages of 25 to 64 years old.

Service Structure

Services are provided through the Counties via flex funds and transportation for crisis services along with contractual arrangements with the Community Mental Health Center (Northwestern Mental Health Center) and two Community clinics that are also designated Critical Access Hospitals (Life Care Roseau

and Sanford Thief River Falls) for direct Community Support Program services, peer recovery specialists, transportation, IRTS, transitional HWS and psychiatry.

Table 1: Demographic Differences between NW8 AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**69361**	
18 - 19	1.7%	3.3%	*-1.6%*
20 - 34	23.8%	22.2%	*1.6%*
35 - 54	40.2%	33.8%	*6.4%*
55 - 64	22.0%	18.0%	*4.0%*
65+	12.3%	22.7%	*-10.4%*
Sex			
Male	36.2%	50.2%	*-14.0%*
Female	63.8%	49.8%	*14.0%*
Race			
Asian	0.6%	0.9%	*-0.3%*
Black or African American	3.0%	0.9%	*2.1%*
Native American	0.0%	3.4%	*-3.4%*
Multiple Race	2.2%	2.4%	*-0.2%*
Other Race Alone	7.8%	1.0%	*6.8%*
White	86.4%	91.4%	*-5.0%*
Ethnicity			
Hispanic	5.7%	3.7%	*2.0%*
Not Hispanic	94.3%	96.3%	*-2.0%*

All counties and mental health providers are contracted with straight Medicaid and the region's PMAPs. The mental health providers (with one still in process) are certified with DHS to provide the Medicaid eligible services along with contracts with commercial health plans. This model of funding allocation has been used since the AMHI's inception due to the rural and frontier nature of the region. The volume of individuals within the region does not support the need for a separate mental health entity in each county and because the workforce is even shorter in this region, trying to hire dedicated staff would lend towards greater competition and barriers to care. The AMHI decided to invest in its mental health continuum of care by allocating financial resources to its area mental health providers who have the clinical and administrative expertise to provide the continuum of care as best allowed based on available workforce, demand and financial resources

Barriers & Challenges to Providing Services

The biggest barriers that arises from the identified gaps is due to the region's geographic location. With 6 rural and 2 frontier counties, economies of scale, accessible workforce and managing financial sustainability are the key factors for the gaps. The strategy taken to provide accessibility is to do as much community based services through CSP, ARMHS and TCM as possible. However, this does not address the full continuum of care needed for some individuals. That means that individuals may need to travel

long distances for receive outpatient or psychiatric care. For higher levels of care they may be non-existent or very hard to access.

The other issue is providing specialty care, while clinically indicated for a person may not be available because there are not enough people for a provider to get that specialization to serve a few. Most providers may have an area of interest tend to be generalists to meet the needs of as many people as possible.

Strategies & Successes to Meeting Community Needs

The NW8 has established a structure to address the gaps and needs of the region. They developed the Systems Workgroup, a working group of the NW8 Governing body, where it is charged in addressing the gaps in the mental health system for the region. The workgroup is using a gap analysis that was completed to determine areas of focus.

Crisis Response Services: The first area was related to crisis response services across the region. In the AMHI's last crisis grant application, a region wide approach was developed to ensure there was coverage of equal service proportion across the entire region. This is in implementation now and will be even further rolled out in the coming months and through the upcoming grant in 2017.

Non-Emergent Transportation: Another area that was addressed and noted in the gaps is around non-emergent transportation. The AMHI through additional funding was able to work on the development of a transportation program for clients to assist them in accessing services where they may need to travel long distances or do not have the means to get the care they need.

Closing Service Gaps: Additionally, each mental health provider is working towards providing services to fill gaps identified. Both the NWMHC and Sanford TRF are moving towards implementing the Behavioral Health Home to address integration with primary care and transitional care. The NWMHC will be working on for 2017 implementing Assertive Community Treatment for those surrounding the larger population centers of Crookston and East Grand Forks and branching out from there. More tele-psychiatry is being established in the coming months to provide greater access.

GAPS ANALYSIS FOR

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 3 or More Counties

- Geographic Location of Providers (100%)
- Lack of Service Availability on Short Notice or During Crisis (75%)
- Access to Transportation (50%)
- Long Waiting Times for Services (38%)

Top Service Gaps

Indicated by 2 or More Counties:

- Permanent Supportive Housing (75%)
- Crisis Stabilization (Residential) (25%)
- Inpatient Adult Psychiatric Beds (25%)
- Psychiatric Prescribers (25%)
- Supported Employment (25%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

Drop-in Centers; Foster Care; MH Courts; Rehabilitative Services for TBI; Residential & Other Treatment Services (Eating Disorders)

Indicated by 7 Counties

Assertive Community Treatment; Behavioral Programming; Clubhouses; Complex Needs w/Multiple Diagnosis & Chronicity; Mobile MH Crisis Response; Non-Medical Transportation; Partial Hospitalization Program; Problem Gambling Services; Respite Care (Crisis; Evenings & Weekends; In Home; Out of Home)

Indicated by 6 Counties

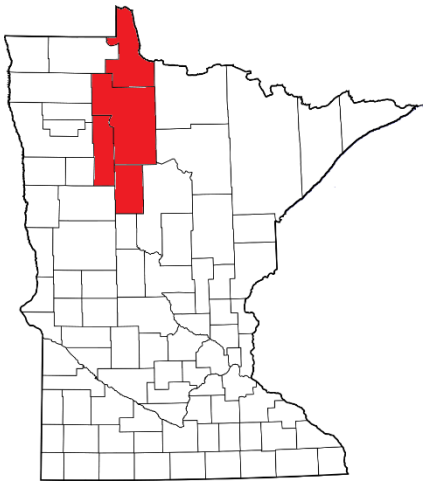
Family Support & Edu; Health & Behavior Assessment; Independent Living Skills Training; Integrated Dual Diagnosis Treatment; Medication Management; Correctional Setting MH Services; Transition Age Services for Youth

Indicated by 5 Counties

Caregiver/Family Counseling & Training & Edu; Consumer-run Services; Independent Living Skills Therapies; Integrated Primary Care w/BH; Promotion; Psychiatric Consults w/PCP; Inpatient Psychiatrists; Psychological Testing; Psychotherapy (Family; Multi-Family); Residential Habilitation (Supported Living Services); Treatment Services for Autism

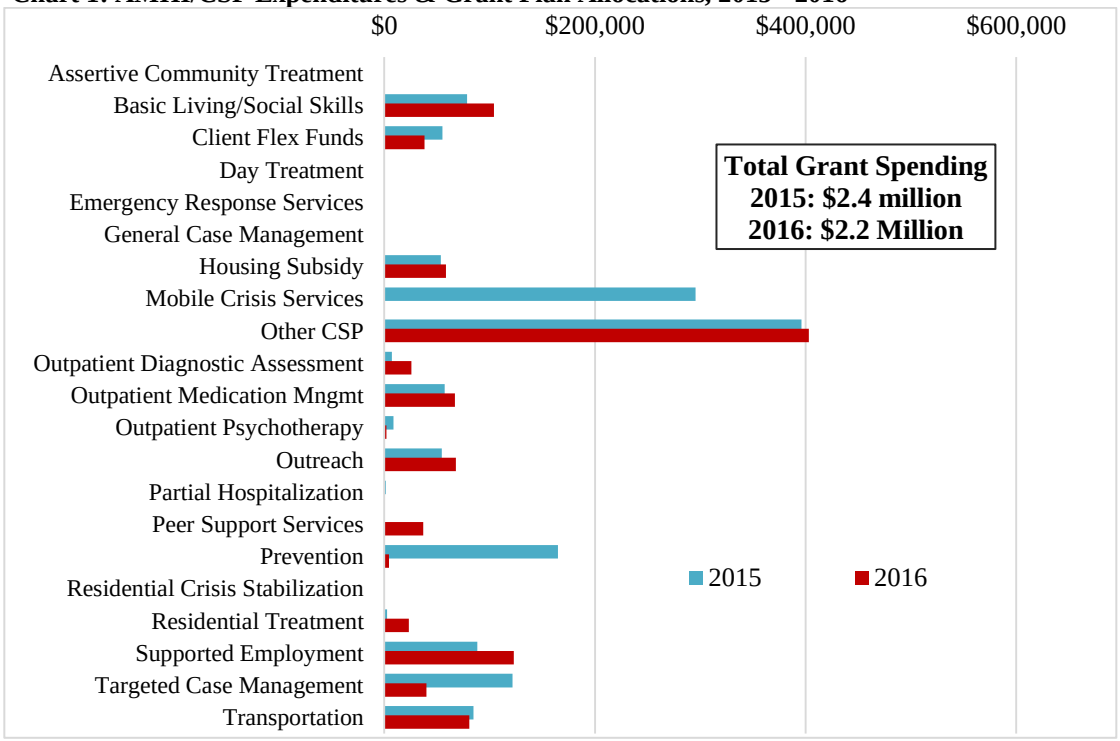
Flexible AMHI Funding: The advantage of the AMHI and NW8's allocation method is that the provider has a pool of funds that are easily available where need arises. There is not a tie of funds to a specific county however data is reported on utilization of services and funds by county so there is transparency. The NW8 is also working on an outcome data collection process to help see if the services provided are delivering the outcomes intended related to increasing employment and meaningful activities and decreasing correctional/incarceration involvement and hospitalization among others.

Regional Profile: **Region 2**



Mental Health Initiative Region 2 is comprised of Beltrami, Clearwater, Hubbard, Lake of the Woods Counties (see map), as well as the Red Lake and part of Leech Lake Tribal Jurisdictions. In 2016, DHS awarded the region $1.07 million of CSP and AMHI dollars (see Chart 1), as well as $303,710 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 1,612 duplicated individuals across 13 service categories (Prevention and Outreach not included). In 2015, the region spent $1.47 million across 17 service categories. AMHI/CSP Grant dollars paid 50.4 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified almost 534 unique individuals being served across 13 service categories, and an additional 59 unidentified individuals.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

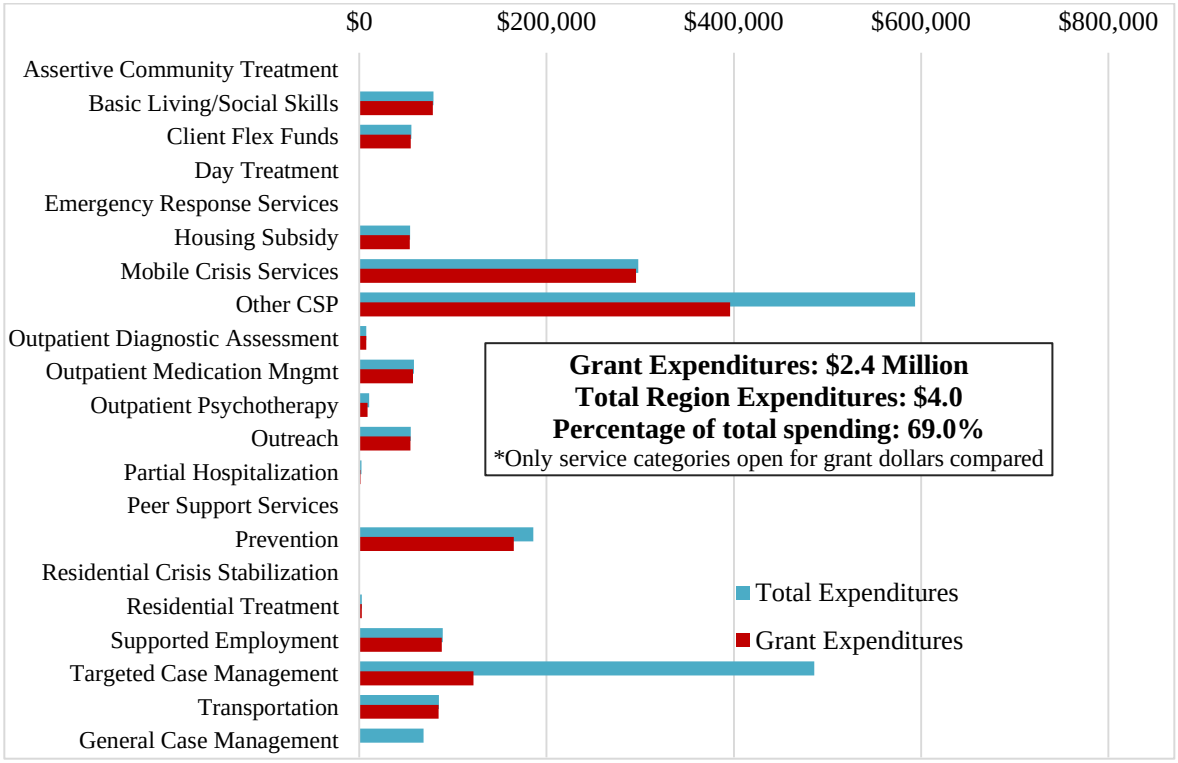
Regional Mental Health Community Needs and Service Structure

Region 2 is a large geographic region with a population of well under 100,000 people. There are parts of three different Indian reservations with Red Lake having the largest American Indian population. Two of the counties in the region are among the poorest counties in the state. Region 2 has large state and federal forests as well as county and tribal lands that do not generate tax revenue to offset the costs of providing service. Region 2 borders Canada. Services on the North West angle are provided by either by water or by

entering Canada and then re-entering the Angle. There is a large American Indian Population in Region two as well as a growing African American population. Both of these populations have high rates of poverty with contribute to a higher demand for services, including mental health and chemical dependency services.

The average county resident is 43.0 years old, with slightly more women than men (50.2 percent compared to 49.8). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1). In quarters 1 and 2 of 2016, the region provided services to 446 and 369 unique individuals respectively, or 534 people over six months. An additional 59 unidentified individuals also received Other CSP services. The majority of reported clients received Adult Mobile Crisis and Other CSP Services.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Service Structure

All four counties provide mental health case management services, and contract with local providers for ARMHS and CSP services through a number of local providers. Region 2 works closely with 3rd party billing to ensure that our local AMHI funds serve as many people as possible. There are contracts with the local mental health center and Upper Mississippi Mental Health Center and they provide emergency mental health transportation services for our region, (often times we are forces to transport people well outside of the region for services which lends itself to challenges when it comes to the continuity of care).

Table 1: Demographic Differences between Region 2 AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**59730**	
18 - 19	19.5%	4.4%	*15.1%*
20 - 34	24.9%	24.5%	*0.4%*
35 - 54	29.3%	30.9%	*-1.6%*
55 - 64	15.9%	18.2%	*-2.3%*
65+	10.5%	22.1%	*-11.6%*
Sex			
Male	47.1%	49.8%	*-2.7%*
Female	52.9%	50.2%	*2.7%*
Race			
Asian	0.7%	0.7%	*0.0%*
Black or African American	2.3%	0.7%	*1.6%*
Native American	0.9%	13.1%	*-12.2%*
Multiple Race	2.3%	3.0%	*-0.7%*
Other Race Alone	22.2%	0.3%	*21.9%*
White	71.4%	82.1%	*-10.7%*
Ethnicity			
Hispanic	1.1%	1.7%	*-0.6%*
Not Hispanic	98.9%	98.3%	*0.6%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Upper Mississippi Mental Health Center and Stellher Human Services work together to provide emergency crisis services within the region. Although we have many challenges the spirt of collaboration and cooperation can overcome or at least mitigate these challenges.

Barriers & Challenges to Providing Services

As stated previously Region 2 is a large rural region spanning approximately 200 miles north to south and nearly a 100 east to west. The size of our region creates *extreme transportation issues*, not only for clients but for service providers as well. These distances have made the provision of *in-home services too costly* for some of our service providers to maintain. We also have some of the highest poverty rates in the state and *limited low income housing*. There is a *significant homeless population* which contribute to the transient nature of much of our population which also makes the provision of ongoing services challenging. Region 2 also has a *large American Indian population but few American Indian service providers*. Local agencies do their best to recruit American Indian service providers but they are a limited commodity. We also do our best to provide culturally appropriate services, however the lack of service providers continues to be a challenge.

The Region also has *no in-patient mental health services* and often have to send people in crisis out of state for services which makes continuity of care an extreme challenge. People often return to the community without the necessary ongoing follow up care which lends itself to returning to a state of crisis.

Finally, there is an *overall lack of service providers at all levels*; from the lack of psychiatrist to the lack of front line staff in our local group care facilities, our region is experiencing the same shortages that the rest of the country is facing, except in our smaller communities the issues are grater due to the lack of available resources.

Strategies & Successes to Meeting Community Needs

In Region 2, many of the resources available in other areas of the state are lacking, collaboration and cooperation is plentiful. Within the local communities, service providers know one another and are willing to work together to solve problems for our local clients. Along with this the region has expanded this collaboration by counties working together to come up with ways to address problem across the entire region.

Emergency Mental Health Transport Program: One example of this collaboration is the Emergency Mental Health Transport program that was developed with Upper Mississippi Mental Health Center. The region identified a region wide issue and worked to integrate a solution. This regional solution has since been looked at and appears that it is being expanded upon throughout the state.

Residential Crisis and IRTS: Region 2 also has extreme shortages in local inpatient mental health care. Beltrami County has taken the lead, with input from other regional counties and tribal partners, in developing residential crisis housing and in the future an IRTS facility that would be available to all four Region 2 counties as well as our tribal partners.

Nurse Scholarship: The region offers a scholarship to a local nurse who will go on to become an advanced practice psychiatric nurse practitioner.

Vehicles for Non-Profits: To address the transportation needs within the region, the initiative works with local partners to purchase vehicles for several local non-profits. These vehicles have since been used by providers to pick up clients and bring them to appointments. This decreased no shows for appointments which in turn has increased billing for these agencies while ensuring that clients can get to their appointments.

GAPS ANALYSIS FOR REGION 2

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 2 or More Counties

- Geographic Location of Providers (100%)
- Lack of Service availability on Short Notice (75%)
- Access to Transportation (50%)

Top Service Gaps

Indicated by 2 or More Counties:

- Inpatient Adult Psychiatry Beds (75%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

Crisis Stabilization – Residential; MH Court; Partial Hospitalization Program; Psychotherapy (Group); Respite (Crisis)

Indicated by 3 Counties

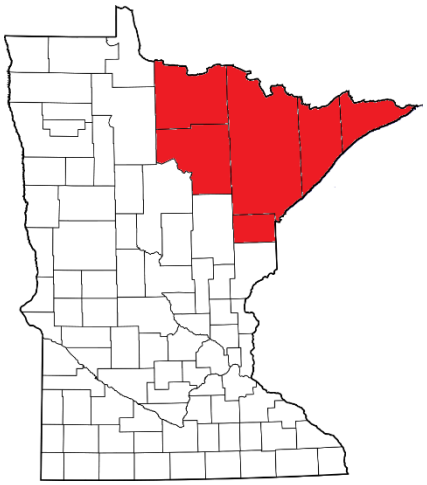
Adult Day Treatment; Adult IRTS; Clubhouse; Dialectical Behavioral Therapy; Drop-in Centers; Foster Care; Integrated Dual Diagnosis Treatment; Neuropsychological Services; Psychotherapy (Multi-Family); Respite Care (Evening & Weekend, In Home, Out of Home)

Indicated by 2 Counties

Assertive Community Treatment; Bridges; Caregiver/Family (Counseling; Training & Edu); Complex Needs w/Multiple Diagnosis & Chronicity; Consumer Run Services; Health & Behavior Assessment/Intervention; Independent Living Skills Therapies; Integrated Primary Care w/BH; Medical Transportation; Medication Management; MH Services for Veterans; Correctional Setting MH Services; Non-Medical Transportation; Physicians that perform MH Screening; Psychiatric Prescribers; Inpatient Psychiatrists; Psychological Testing; Psychotherapy (Family); Rehabilitative Services for TBI; Rehabilitative Habilitation (In-Home Family Support); Residential Treatment (Eating Disorders); Treatment Services (Autism; Eating Disorders)

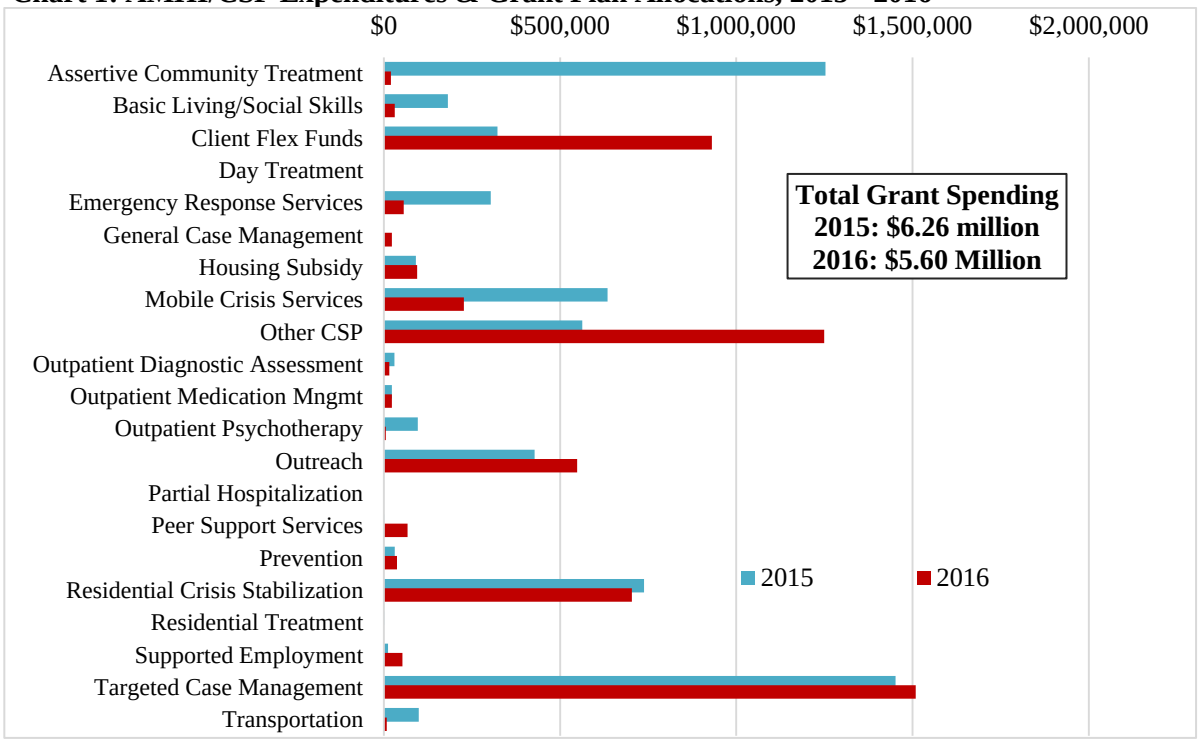
The flexibility allowed with the current AMHI has allowed Region 2 to look at issues and work together to solve these issues. Without these dollars even greater challenges would ensue in meeting the needs within the region.

Regional Profile: **Region 3N**



Mental Health Initiative Region 3N is comprised of Carlton, Cook, Itasca, Koochiching, Lake and St. Louis County (see map), as well as Boise Forte/Nett Lake, Grant Portage, and Fond du Lac Tribal Jurisdictions. In 2016, DHS awarded the region $5.6 million of CSP and AMHI dollars (see Chart 1), as well as $666,280 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 11,323 duplicated individuals across 14 service categories (Prevention and Outreach excluded). In 2015, the region spent $6.26 million across 18 service categories. AMHI/CSP Grant dollars paid 69 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified almost 2,323 unique individuals being served across 16 service categories, and approximately 150 unidentified individuals in each quarter.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



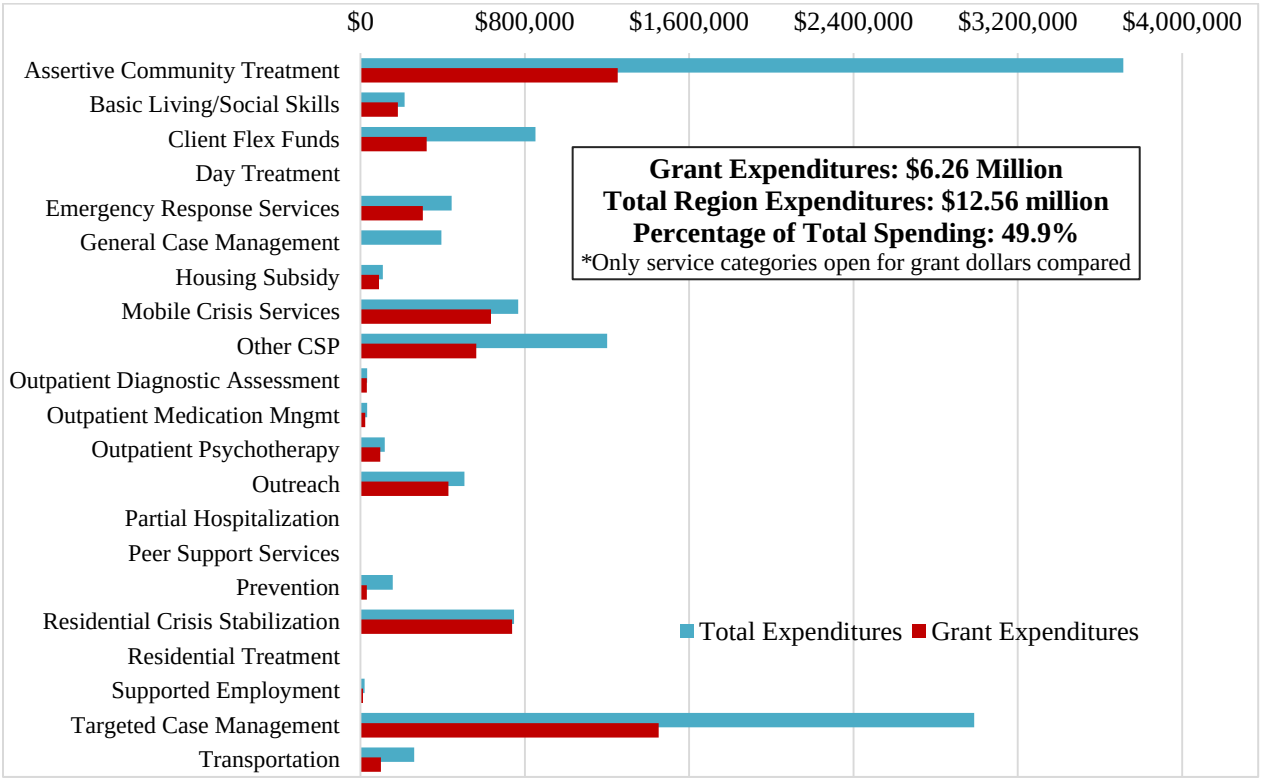
Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

Region 3 is a large, six-county geographic region located in northeastern Minnesota which includes 18,319 square miles (22 percent of the state's land mass) and a population of 310,879.

Each of the Region 3 counties has one to two population centers (larger communities) where most of the health care and human service/social service providers are located. However, a significant percentage of residents live in sparsely populated rural areas outside of these larger communities, with limited or no access to services.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Region 3 counties have some of the lowest population density rates in the state. Minnesota's average population density is 66.6 people per square mile. Of the 87 counties in Minnesota, Cook County ranks 86th (density of 3.6), Koochiching County ranks 85th (density of 4.6), Lake County ranks 83rd (density of 5.3), Aitkin County ranks 79th (density of 8.0), Itasca County ranks 62nd (density of 15.5) and St. Louis County ranks 40th (density of 29.2). While Carlton County's density ranks 32nd (density of 36.8), it is still 50% lower than the state average. Low population density contributes to access barriers including increased windshield time, limited workforce, and transportation barriers. Mental health services are limited and located a significant distance from many rural communities.

The average county resident is 45.6 years old, with slightly more men than women (50.1 percent compared to 49.9). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1). In quarters 1 and 2 of 2016, the region provided services to 1,755 and 1,704 unique individuals respectively, or 2,323 people over six months. An additional 50 unidentified individuals also received Outreach, Other CSP services, and Client Flex Funds. The majority of reported clients received Adult Mobile Crisis, Housing Subsidy, Targeted Case Management, and Other CSP Services.

Table 1: Demographic Differences between Region 3N AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**237453**	
18 - 19	7.0%	4.0%	*3.0%*
20 - 34	21.8%	23.9%	*-2.1%*
35 - 54	38.3%	31.4%	*6.9%*
55 - 64	18.9%	19.0%	*-0.1%*
65+	13.9%	21.6%	*-7.7%*
Sex			
Male	47.2%	50.1%	*-2.9%*
Female	52.8%	49.9%	*2.9%*
Race			
Asian	0.1%	0.8%	*-0.7%*
Black or African American	4.2%	1.3%	*2.9%*
Native American	0.3%	2.7%	*-2.4%*
Multiple Race	2.6%	2.4%	*0.2%*
Other Race Alone	7.6%	0.3%	*7.3%*
White	85.3%	92.6%	*-7.3%*
Ethnicity			
Hispanic	0.9%	1.3%	*-0.4%*
Not Hispanic	99.1%	98.7%	*0.4%*

**Data excludes clients without demographic information available and Koochiching County, which did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

The Lake Superior Chippewa Bands of Bois Forte, Grand Portage and Fond du Lac are full partners in the Region 3 Adult Mental Health Initiative. The Fond du Lac Reservation (4,044 enrolled members) is located in southern St. Louis and Carlton County. The Bois Forte Reservation (3,052 enrolled members) has sites located in Koochiching and St. Louis counties. The Grand Portage Indian Reservation (1,127 enrolled members) is located in Cook County in the extreme northeast part of the state.

Service Structure

The region is served by 3 community mental health providers: Range Mental Health (RMH), Northland Counseling (NC), Human Development Center (HDC) and 2 residential crisis service providers: Birch Tree Center (BTC), Wellstone Center (WC). RMH and BTC have dedicated mobile crisis response teams providing services within a 30-mile radius. Itasca and Koochiching Counties provide mobile crisis response services with support from NC. HDC is developing crisis response services in Carlton, Lake and Cook counties.

There are no community behavioral health hospitals in the region. Growing numbers of individuals in mental health crisis are presenting in local emergency rooms, jails and detox centers in recent years. St. Louis County currently has 3% of the state's population but over 9% of the state's licensed AFC beds for mental health issues or traumatic brain injury. These facilities serve a disproportionate number of clients from outside the region, which strains existing resources.

Barriers & Challenges to Providing Services

The gaps and barriers to service delivery identified by the Gaps Analysis are consistent with Region 3 AMHI and local provider observations.

Region 3 encompasses a very large geographic area with several regional population centers. However, many rural areas are sparsely populated with *limited access to services*. Much of the region is not served by public transportation systems, and *transportation to services* can be a significant barrier for many residents. *Limited workforce and lack of mental health providers* reduces access to services, contributing to long wait times for services and geographic gaps. Many areas of the region have *limited access to cell phone and/or broadband service* required to support telepresence options. Individuals experiencing mental health crises in remote, rural areas of the region are frequently transported to hospitals or facilities in distant communities due to lack of access to local services. *Access to affordable, long-term, supportive housing options* for those with mental health issues is a persistent gap in the regional service delivery continuum.

The three *tribes* within the region have *limited staffing, transportation and technology* (broadband) resources to support crisis response services. In addition to these barriers, the Native American communities have found that mental health services offered within the region may not be culturally appropriate or welcoming to their members. *Telepresence linkages to Native American psychiatrists and other culturally acceptable mental health providers* are being explored, which could positively impact how services are offered and delivered within the region.

Strategies & Successes to Meeting Community Needs

There is a strong history of successful multi-county, multi-provider collaboration within the Arrowhead region, including the Region 3 Adult Mental Health Initiative (R3AMHI), a unique partnership between six counties and three tribes committed to expanding access to mental health services for adults and children in the region and increasing access to culturally appropriate care.

GAPS ANALYSIS FOR REGION 3N

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 3 or More Counties

- Lack of Housing (67%)
- Geographic Location of Providers (67%)
- Access to Transportation (50%)

Top Service Gaps

Indicated by 2 or More Counties:

- Inpatient Adult Psychiatry Beds (50%)
- Adult IRTS (33%)
- Permanent Supportive Housing (33%)
- Inpatient Psychiatrists (33%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

Bridges; Projects for Assistance in Transition from Homelessness; Respite Care (Evening & Weekend, Out of Home)

Indicated by 5 Counties

Adult Day Treatment; Assertive Community Treatment; Family Support & Education; Medication Management; Integrated Dual Diagnosis; Integrated Primary Care w/BH; MH Court; MH Services in a Correctional Setting; Neuropsychological Services; Psychiatric Prescribers; Psychological Testing; Psychotherapy (Family, Group, Individual); Residential Treatment for Adults w/Eating Disorders; Respite Care – In Home

Indicated by 4 Counties

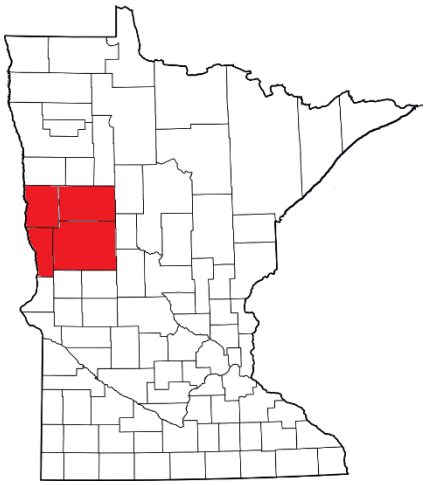
Certified Peer Specialists; Clubhouse; Complex Needs w/Multiple Diagnosis & Chronicity; Foster Care; Illness Management & Recovery; MH Services for Veterans; Prevention; Problem Gambling Services; Rehabilitation Services for TBI; Respite Care (Crisis); Transition Age Services for Youth; Treatment Services for Autism

Mobile Crisis Response Services: Following the closure of the state operated Bridge House program in late 2012, the Region 3 AMHI convened multiple stakeholders to identify and address the need for crisis services within the region. The result of this collaborative endeavor was the opening of Birch Tree Center, a residential crisis response center in Duluth in early 2015 that also houses a mobile crisis response team. Current R3AMHI initiatives include expanding access to mobile crisis response services in underserved areas, expanding access to children's mental health services, promoting integrated behavioral health, and evaluating the current service delivery system to maximize use of available resources and identify and address gaps.

Innovative Service Delivery Models: In a region with very low population density, it will continue to be a challenge to develop and deliver services. Windshield time will always be a consideration in serving individuals in remote areas. Innovative models of service delivery, including technology options, are all emerging as potential solutions to maximize available resources and allow service delivery across a vast, sparsely populated region with a limited workforce.

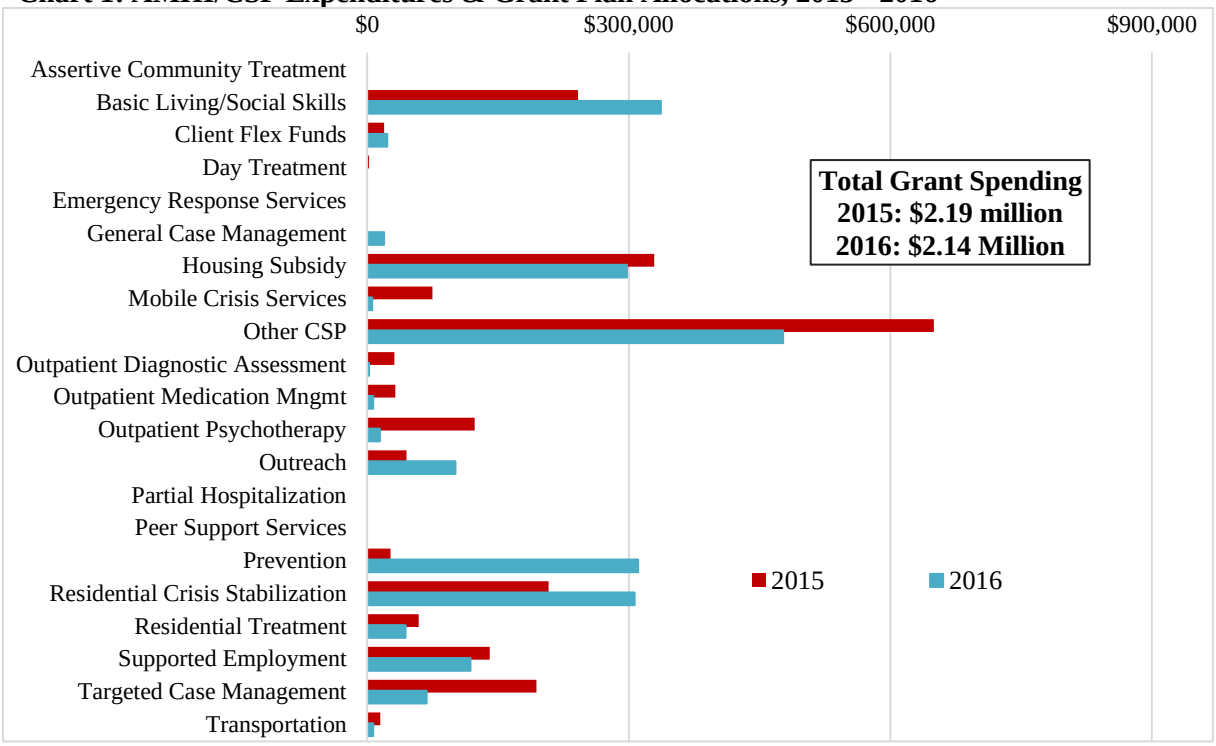
Arrowhead Telepresence Coalition: Multiple initiatives utilizing technology to address issues of distance, transportation and limited providers are underway within Region 3 through the Arrowhead Telepresence Coalition (ATC). This coalition has been piloting initiatives to increase access to mental health services in non-traditional settings including schools, jails and correctional facilities. While broadband issues and other barriers will limit the effective use of telepresence technology in some areas or some applications, initial pilot projects linking providers to jails, schools and rural hospital emergency rooms are demonstrating that technology can reduce barriers due to provider shortages, transportation and distance.

Regional Profile: **BCOW**



Mental Health Initiative Region 4, BCOW, is comprised of Clay, Becker, Otter Tail, and Wilkin Counties (see map). In 2016, DHS awarded the region $2.14 million of CSP and AMHI dollars (see Chart 1), as well as $439,500 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the initiative and counties projected serving more than 2,050 duplicated individuals across 16 service categories (Prevention and Outreach not excluded). In 2015, the region spent $2.19 million across 16 service categories. AMHI/CSP Grant dollars paid 45.5 percent of county expenses in eligible service categories (see Chart 2). Grant dollars were used to fund 13 outside providers, as well as services provided by counties. In the first and second quarter of 2016, the county identified almost 700 unique individuals being served across 11 service categories. Additionally, about 400 unidentified people were served in 2 other service categories.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



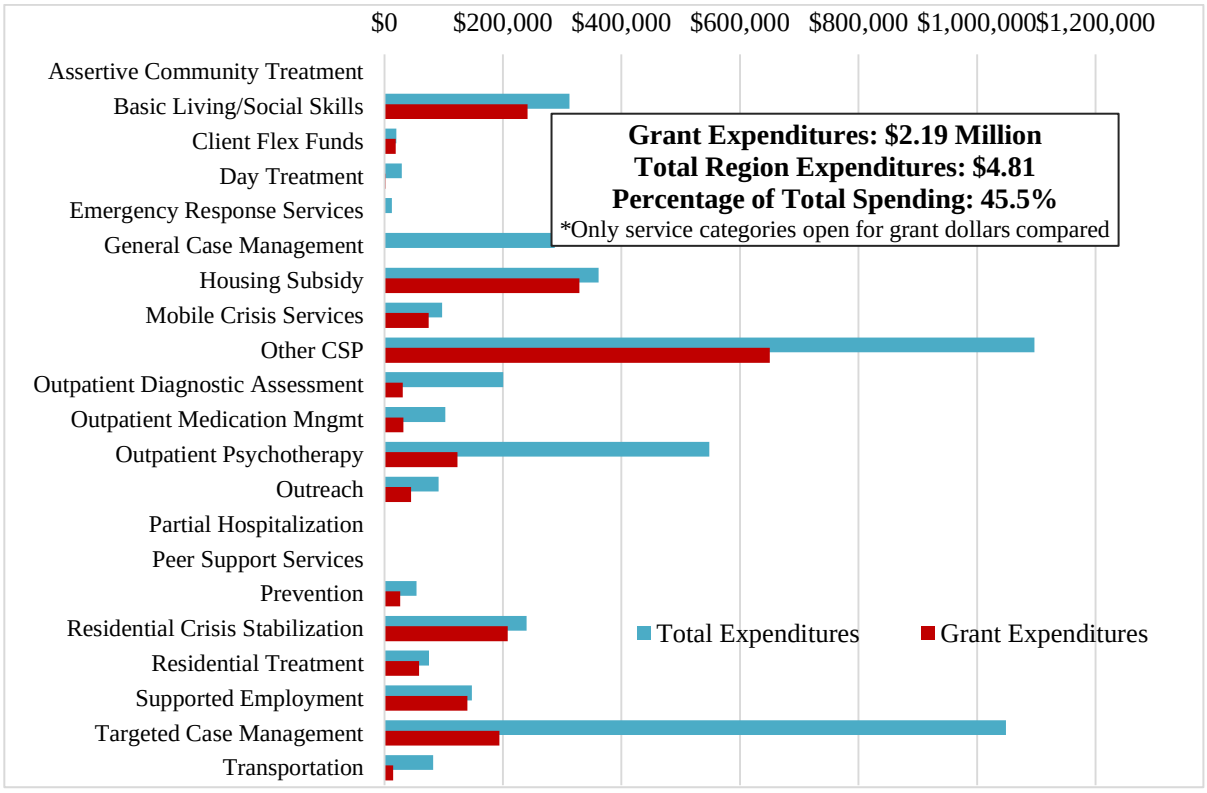
Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

Made up of 4 counties, BCOW has a population of 158,030 over 5,474 square miles, or a population density of 28.87 people per square mile. The average county resident is 40.1 years old, with slightly more woman than men (50.6 percent compared to 49.4). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

In 2016, providers in the region that received the most significant amounts of grant funding included Lakeland Mental Health Center, which will receive more than $677,000 dollars, and additional funds of approximately $240,000 to drop-in centers A Place to Belong, A Place for Friends, and Place for Hope.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

In quarters 1 and 2 of 2016, the region provided services to 546 and 526 unique individuals respectively, or 696 people over six months. An additional 427 and 326 unidentified individuals received services in each respective quarter. The majority of reported clients received Outreach, Targeted Case Management, Housing Subsidy, Basic Living/Social Skill, or Other Community Support Program Services. Approximately half of clients received more than one type of service or services from more than one provider each quarter.

Service Structure

The backbone of region's services structure is around one large community mental health center servicing all four Counties (to varying degrees), with a number of other private and/or non-profit agencies supplementing in some therapeutic treatment service areas.

Table 1: Demographic Differences between BCOW AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**121289**	
18 - 19	1.1%	4.3%	*-3.2%*
20 - 34	21.2%	24.7%	*-3.5%*
35 - 54	42.5%	31.3%	*11.2%*
55 - 64	19.9%	17.4%	*2.5%*
65+	15.2%	22.3%	*-7.1%*
Sex			
Male	36.3%	49.4%	*-13.1%*
Female	63.7%	50.6%	*13.1%*
Race			
Asian	0.7%	0.7%	*0.0%*
Black or African American	4.2%	1.1%	*3.1%*
Native American	0.0%	2.2%	*-2.2%*
Multiple Race	1.6%	2.3%	*-0.7%*
Other Race Alone	6.4%	0.6%	*5.8%*
White	87.1%	93.0%	*-5.9%*
Ethnicity			
Hispanic	4.3%	3.0%	*1.3%*
Not Hispanic	95.7%	97.0%	*-1.3%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

The four county social service agencies and numerous community providers also supplement MH service needs of this region. Available services are largely funded through traditional Minnesota Medical Assistance, State-contracted pre-paid health plans, third-party insurances, or grant funding from various sources.

Coordination of services is accomplished primarily through case management as provided by County agencies and contracted vendors of this service. The BCOW AMHI contracts with or has service agreements in place for Aftercare services, medication management support, enhanced Community Support Program (CSP) services, supported employment, rapid access psychiatry, recovery drop-in centers, residential crisis stabilization & ancillary transportation, Intensive Residential Treatment services not covered by MA, transitional apartments, Bridges housing support, and permanent supported housing.

The BCOW AMHI is structured as follows:

- Executive Committee: meets monthly to provide primary oversight, complete grant planning, oversees the budget.
- Steering Committee: composed of consumers of services & their family members, provides direction to Executive Committee for planning & development of programs to serve adults with mental illness.
- Education Committee: a sub-committee which develops & presents two major training workshops each year.
- Housing Committee: a sub-committee which develops & oversees housing programs & planning.

- Legislative Committee: a sub-committee under development to provide information on Legislative action to Steering, including the development of MMH Crisis Services.
- Other entities contributing to the AMHI include MH providers, Counties, community advocacy organizations, recover/social clubs.

Barriers & Challenges to Providing Services

Barriers to accessing services and supports include:

- Lack of understanding and awareness of service availability;
- Misconceptions or stigma about mental illness;
- Lack of sufficient natural community supports;
- Geographical distances to services & lack of transportation options in our rural communities; difficulty navigating the various service systems & paperwork
- Cost of services & medications
- Lack of adequate
- Affordable housing;
- Need for additional residential crisis stabilization services;
- Challenges serving people with co-occurring disabilities (ex: significant chronic health issues, chronic pain, or substance use disorders);
- Challenges bridging from children to adult services;
- An aging population increasing the need for more geriatric mental health services;
- Lack of available psychiatric beds in community hospitals;
- Difficulty accessing Community Behavioral Health Hospital beds for civilly committed clients;
- Increased complexity of needs & acuity of symptoms in people being served.

Strategies & Successes to Meeting Community Needs

The BCOW Adult Mental Health Initiative was established in 1995 with the following mission: "To develop, support, promote and participate in a comprehensive community mental health system, which will bring together the

GAPS ANALYSIS FOR BCOW

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 2 or More Counties

• Long Waiting Times for Services (100%)
• Access to Transportation (50%)
• Lack of Housing (50%)
• Geographic Location of Providers (50%)

Top Service Gaps

Indicated by 2 or More Counties:

• Adult IRTS (50%)
• Complex Needs w/Multiple Diagnosis & Chronicity (50%)
• Inpatient adult psychiatry beds (50%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

Assertive Community Treatment, Behavioral Programing, Peer Specialists, Crisis Stabilization – residential, Family Support and Education, Foster Care, Mental Health Court, Correctional Setting Mental Health Services, Non-Medical Transportation, Permanent Supportive Housing, Psychiatric Prescribers, TBI Rehab Services, Eating Disorder Residential Treatment, Respite Care – Crisis.

Indicated by 3 Counties

Bridges, Caregiver/Family Counseling & Training, Clubhouses, DBT, Illness Management and Recovery, Independent Living Skills Therapies, Integrated Dual Diagnosis Treatment, Medical Transportation, Medication Management, Neuropsychological Services, Outreach, Partial Hospitalization Program, Prevention (General &Behavioral and Cognitive), Problem Gambling Services, PATH, Inpatient Psychiatrists, Psychotherapy – Group, Residential Habilitation, Respite Care (Evening & Weekend, In Home, Out of Home), Transition Age Services, Eating Disorder Treatment.

necessary programs and services to assist individuals and their families in their management of illness and recovery."

Through a process of regularly scheduled stakeholder meetings, communication, coordination, education and periodic needs assessment, the BCOW AMHI has been able to adapt to the changing mental health service needs as the larger treatment system has evolved over the past 20 years.

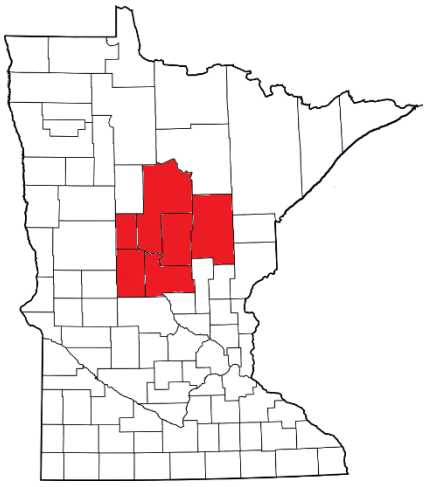
Support Services in the Community: This is accomplished by providing support services to reduce symptoms, enhance stability and support independence in the least restrictive manner possible to maintain community living, and thereby reduce the need for hospital level of care.

Stakeholder Outreach: The BCOW AMHI works to share knowledge of resources across a wide variety of interested stakeholders in an effort to strengthen the service system through coordination of resources, to provide a forum for input by those receiving services, and to promote innovation within our four-county region. Essential services supported by BCOW which have led to positive outcomes are a range of crisis services, aftercare services, recovery drop-in centers, housing supports, supported employment services and community education.

Community Education: The BCOW AMHI workshops, held two times per year bring in over 150 people per workshop to learn new information and to network with others

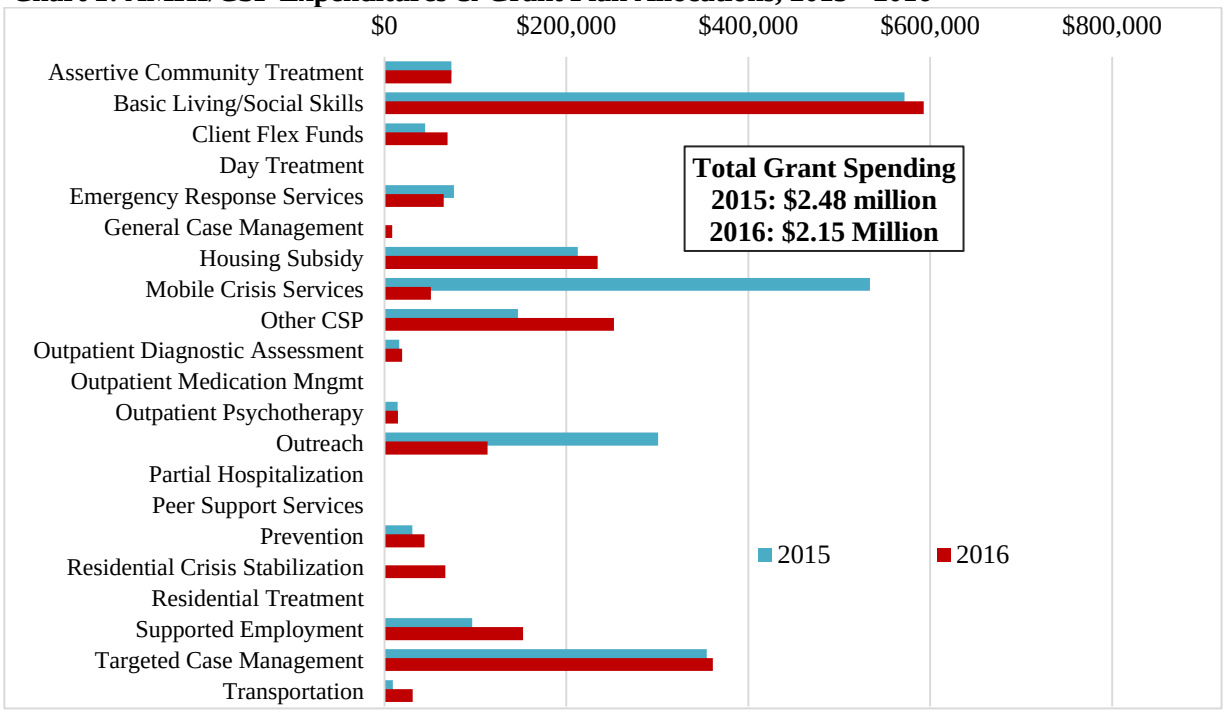
Increasing Doors to Access Services: Additionally, a strength has also been individuals' ability to access support services through a variety of 'doors'; for example clinical therapy leading to case management services referral, or involvement with housing program leading to supported employment referral.

Regional Profile: **Region 5+**



Mental Health Initiative Region 5, Region 5+, is comprised of Aitkin, Cass, Crow Wing, Morrison, Todd, and Wadena County (see map), including parts of the Leech Lake and Mille Lacs Tribal jurisdictions. In 2016, DHS awarded the region $2.15 million of CSP and AMHI dollars (see Chart 1), as well as $370,595 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the initiative and counties projected serving more than 9,878 duplicated individuals across 14 service categories (Prevention and Outreach excluded). In 2015, the region spent $2.48 million across 15 service categories. AMHI/CSP Grant dollars paid 59.3 percent of county expenses in eligible service categories (see Chart 2). Grant dollars were used to fund more than 15 outside providers the largest being Northern Pines Mental Health Center, as well as services provided by counties. In the first and second quarter of 2016, the county identified 605 unique individuals being served across 12 service categories. Additionally, about 1,350 unidentified people were served in 6 other service categories.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



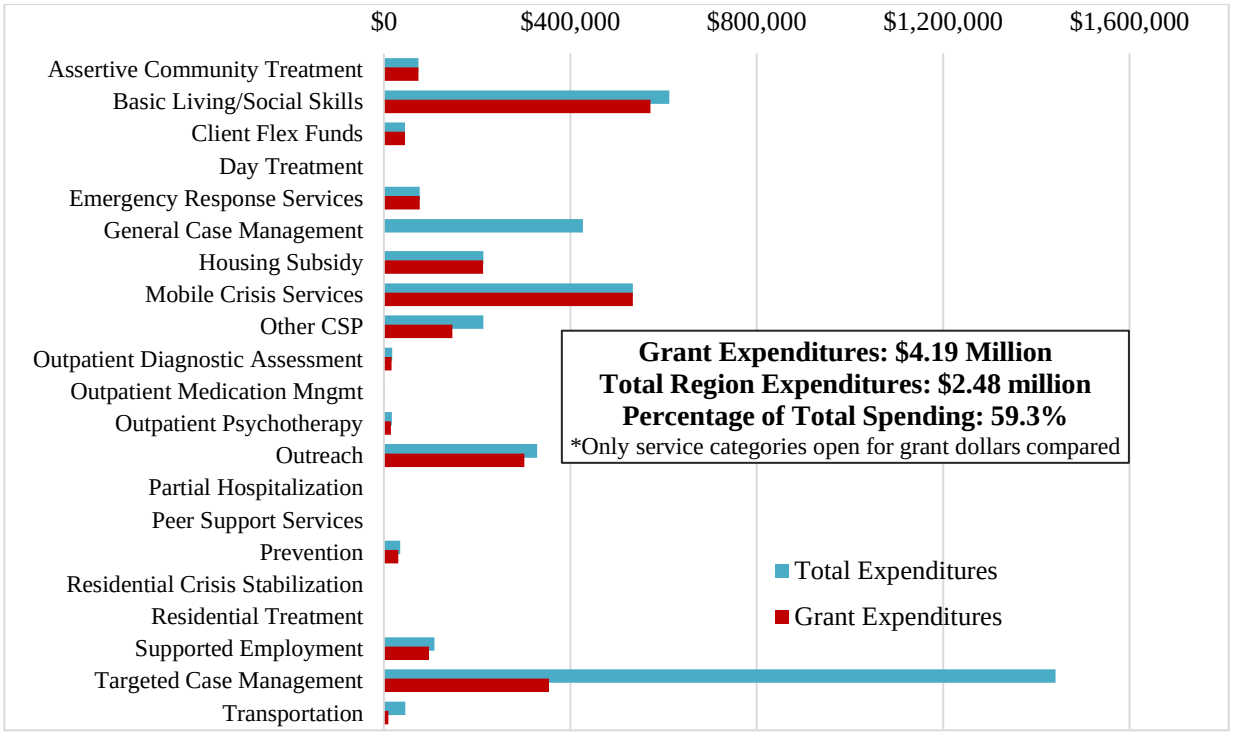
Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

Mental Health Region 5+ has a total population of 182,587. Service areas also include parts of the Leech Lake and Mille Lacs Tribal jurisdictions. This region is largely rural, with many sparsely populated areas. The average county resident is 46.1 years old, with slightly more men than woman (50.1 percent

compared to 49.9). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

In quarters 1 and 2 of 2016, the region provided services to 466 and 488 unique individuals respectively, or 605 people over six months. An additional 1583 and 1352 unidentified individuals received services in each respective quarter. The majority of reported clients received Housing Subsidy, Basic Living/Social Skills, Targeted Case Management, General Case Management, Client Flex Fund, and Other CSP Services. Approximately half of clients received more than one type of service or services from more than one provider each quarter.

Service Structure

Region 5+ has services provided by counties and contracted providers. Services supported by AMHI include:

- RN case management,
- ARHMS,
- Crisis response team,
- ACT team,
- 24/7 Crisis Line,
- Housing Support Services,
- Supported Employment,

- Transportation,
- Residential Crisis Services, and
- Intensive Community Transition Services (ICTS).

Table 1: Demographic Differences between Region 5+ AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**113343**	
18 - 19	1.8%	2.7%	*-0.9%*
20 - 34	22.4%	19.4%	*3.0%*
35 - 54	41.1%	31.4%	*9.7%*
55 - 64	24.9%	19.3%	*5.6%*
65+	9.8%	27.2%	*-17.4%*
Sex			
Male	44.8%	50.1%	*-5.3%*
Female	55.2%	49.9%	*5.3%*
Race			
Asian	1.1%	0.4%	*0.7%*
Black or African American	1.7%	0.6%	*1.1%*
Native American	0.0%	2.9%	*-2.9%*
Multiple Race	1.7%	1.5%	*0.2%*
Other Race Alone	4.5%	0.6%	*3.9%*
White	90.9%	94.0%	*-3.1%*
Ethnicity			
Hispanic	1.9%	2.0%	*-0.1%*
Not Hispanic	98.1%	98.0%	*0.1%*

**Data excludes clients without demographic information available and Morrison county, which did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Other programs not funded by AMHI yet supported include the Youth ACT Team, Outpatient Rule 29 Programs, CTSS, School Linked Mental Health, Discharge Planning, other supportive housing services, access to medical transportation, Certified Peer Specialist and Outpatient Mental Health Services. Services have been designed with providers within the Region 5+ area to meet the needs of each community.

Barriers & Challenges to Providing Services

Some of the barriers within Region 5+ are very unique to this area than other rural areas.

Large Number of Health Care Systems w/Limited Inpatient: Region 5+ currently has 7 different health care systems with seven different hospitals, emergency departments, which require a large amount of travel for providers. Within these seven health care providers, only two have inpatient psychiatric services.

Lack of Child & Geriatric Psychiatric Care Facilities: There are no child or adolescent inpatient psychiatric health care facilities, and one of these two is exclusively for individuals over 55 years old.

Mix of Legal Jurisdictions: There are also more than 30 different law enforcement agencies, six counties, and approximately 50 schools. We also have two tribal jurisdictions where we must provide culturally competent services.

High Civil Commitment Rates: Also from 2014-2015 civil commitments have increased by 50%, and there continues to be few placement options within inpatient psychiatric facilities.

Strategies & Successes to Meeting Community Needs

Civil Commitments: Region continues to seek more opportunities for affordable safe housing, and alternative options to provide services to consumers under civil commitments that are more cost effective.

IRTS: Region 5+ is reviewing applications from community providers to develop more IRTS services in this area Region 5+ would like to continue evaluating the needs within our region and develop services that meet the community needs.

Housing: We continue to look towards alternative housing options to provide community based services as much as possible.

Collaborative Work Across Counties, Providers, & AMHI: All counties within Region 5+ work together to enhance services by meeting monthly to discuss changes, needs, and new ideas to provide the best possible services to our area. Region 5+ has been successful in developing many different service options to meet the needs of consumers. Some of those successes have been *access to rural consumers through transportation options, collaboration with all providers within the area*, and the *development of support of Crisis Services and ICTS program* which connects consumers who are uninsured or under-insured with needed support services. The ICTS program has been a great asset to our Region.

GAPS ANALYSIS FOR REGION 5+

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 2 or More Counties

- Geographic Location of Providers (83%)
- Access to Transportation (50%)
- Long Waiting Times for Providers (50%)
- Lack of Service Availability on Short Notice (33%)

Top Service Gaps

Indicated by 2 or More Counties:

- Inpatient Adult Psychiatry Beds (67%)
- Adult IRTS (33%)
- Neuropsychological Services (33%)
- Psychiatric Prescribers (33%)
- Crisis Stabilization - Residential (33%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

MH Court; MH Services in Correctional Setting; Respite Care (Crisis, Evening & Weekend, In Home, Out of Home)

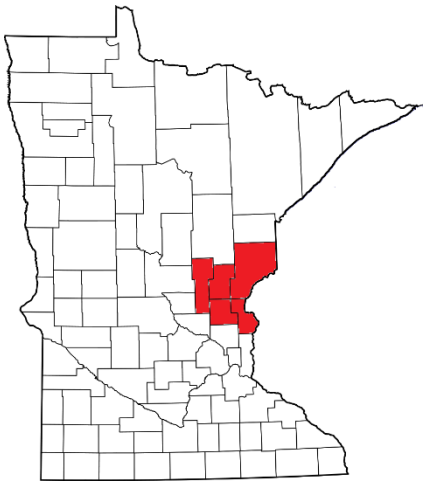
Indicated by 5 Counties

Medication Management; MH Services for Veterans; Partial Hospitalization Program; Permanent Supportive Housing; Prevention/Early Intervention for Behavioral and Cognitive Health; Inpatient Psychiatrists

Indicated by 4 Counties

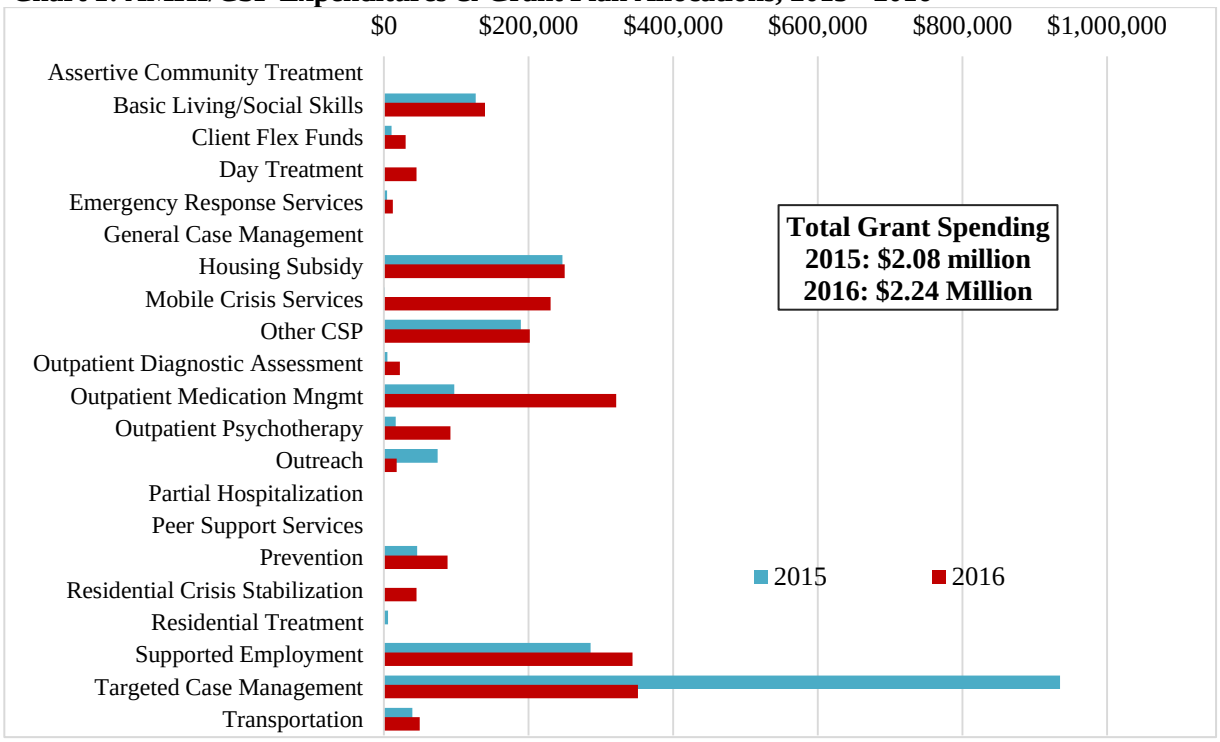
Adult IRTS; Assertive Community Treatment; Behavioral Programming; Bridges; Complex Needs with Multiple Diagnosis and Chronicity; Crisis Stabilization (Residential); Foster Care; Health and Behavior Assessment; Non-Medical Transportation; Prevention; Psychological Testing; Psychotherapy (Multi-Family); Rehabilitative Services for TBI; Treatment Services for Autism; Treatment Services for Eating Disorders

Regional Profile: **Region 7E**



Mental Health Initiative Region 6, Region 7E, is comprised of Chisago, Isanti, Kanabec, Mille Lacs, and Pine County (see map), including part of Mille Lacs Tribal jurisdiction. In 2016, DHS awarded the region $2.15 million of CSP and AMHI dollars (see Chart 1), as well as $290,000 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the initiative and counties projected serving more than 2,955 duplicated individuals across 12 service categories (prevention and outreach excluded). In 2015, the region spent $2.08 million across 15 service categories. AMHI/CSP Grant dollars paid 48.5 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified 832 unique individuals being served across 13 service categories.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016

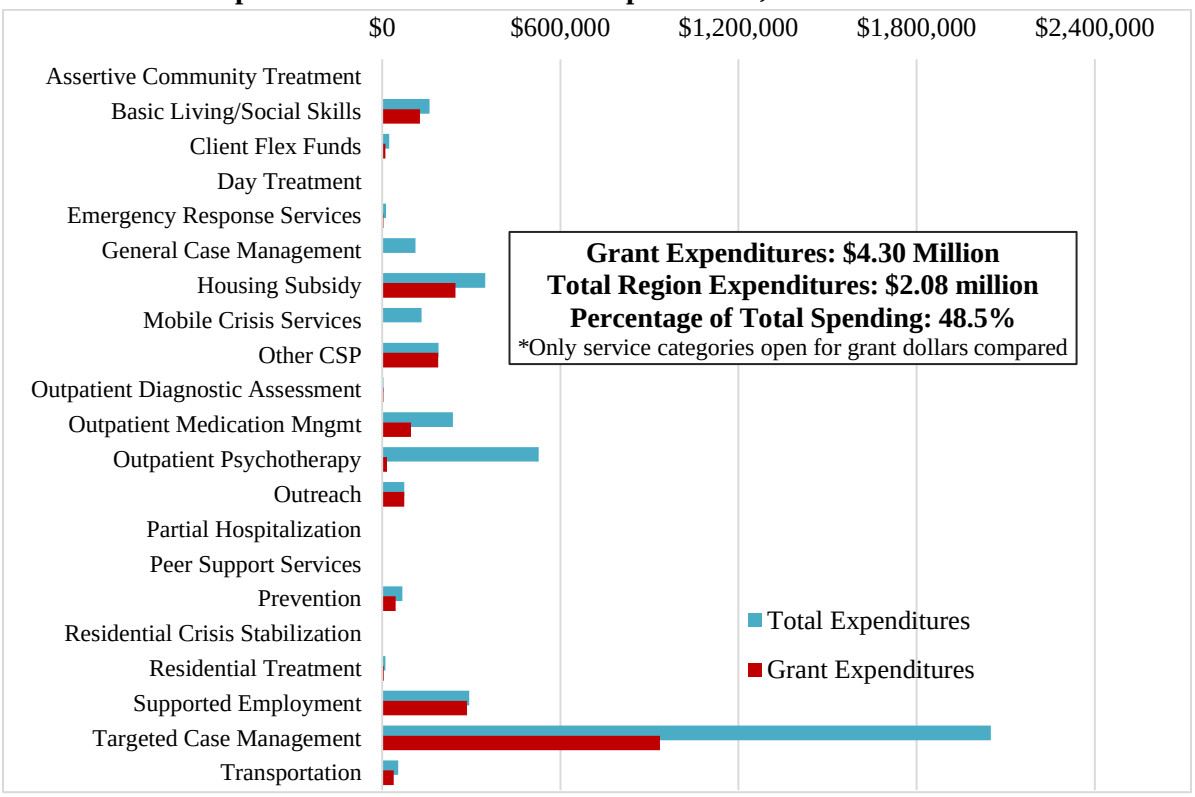


Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

Mental Health Region 7E has a total population of 78,465. Service areas also include parts of the Mille Lacs Tribal jurisdiction. This region is largely rural, with many sparsely populated areas. The average county resident is 42.9 years old, with slightly more women than men (50.2 percent compared to 49.8). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

In quarters 1 and 2 of 2016, the region provided services to 555 and 747 unique individuals respectively, or 832 people over six months. The majority of reported clients received Transportation, Housing Subsidy, Basic Living/Social Skills, Adult Outpatient Medication Management, and Targeted Case Management. Approximately one tenth of clients received more than one type of service or services from more than one provider each quarter.

Service Structure

The service structure in this region is composed of a number of small mental health service providers. After the closure of Riverwood in 2014, a number of smaller local providers have expanded services and new providers have been developed. Some serve the entire region, but many primarily serve clientele in close proximity to the provider due to transportation concerns.

Available services are largely funded through traditional Minnesota Medical Assistance, State-contracted pre-paid health plans, third-party insurance or grant funding from various sources. Some funding is also provided through counties and Region 7E when other sources of funding are not available e.g. those with Medicare or health care policies that do not cover services recommended as medically necessary.

Table 1: Demographic Differences between Region 7E AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**124208**	
18 - 19	4.4%	3.0%	*1.4%*
20 - 34	23.7%	22.5%	*1.2%*
35 - 54	42.4%	37.9%	*4.5%*
55 - 64	21.3%	17.0%	*4.3%*
65+	8.2%	19.6%	*-11.4%*
Sex			
Male	43.4%	51.3%	*-7.9%*
Female	56.6%	48.7%	*7.9%*
Race			
Asian	0.6%	0.6%	*0.0%*
Black or African American	1.9%	1.0%	*0.9%*
Native American	0.0%	1.7%	*-1.7%*
Multiple Race	1.4%	1.8%	*-0.4%*
Other Race Alone	3.2%	0.4%	*2.8%*
White	92.9%	94.4%	*-1.5%*
Ethnicity			
Hispanic	1.3%	1.9%	*-0.6%*
Not Hispanic	98.7%	98.1%	*0.6%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Coordination of services is accomplished primarily through case management as provided by County agencies and contracted vendors of this service.

Region 7E AMHI contracts with or has service agreements in place for supported employment and related transportation, expansion of local dialectical behavior therapy access, medication management and rapid access psychiatry, mobile crisis services and 24/7 access, Bridges housing support, psychiatric beds and the development of permanent supportive housing. In addition, due to the large geographic area the Region contracted for the development of a regional web site to assist residents in accessing mental health related information and resources.

Region 7E activities are facilitated by a Governing Board made up of a voting representative of each of the counties which is typically the supervisor of Adult Mental Health. There is also an adult mental health county case manager regional representative, a regional consumer representative, a regional Director Representative, and the DHS liaison for the region. The meetings are facilitated by a chair which rotates by county annually. The Governing Board meets monthly to provide primary oversight, planning, and oversees the budget. There is a Regional Local Advisory Council with positions for two consumer representatives from each of the five regional counties.

This group meets semi-monthly and is also attended by service providers, the DHS regional liaison and Adult Mental Health Supervisors. The regional Provider Round Table meets on the alternate month from the Regional LAC. These additional groups provide direction to the Governing Board for planning & development of programs to serve adults with mental illness and invite service providers and speakers on topics related to mental health and service delivery. Time limited subcommittees are utilized for specific purposes such as interviewing and selection of positions such as planner and consumer representative, crisis services coordination, and permanent supportive housing development.

Barriers & Challenges to Providing Services

Barriers to accessing services and supports include:

- Lack of understanding and awareness of service availability;
- Misconceptions or stigma about mental illness;
- Lack of sufficient natural community supports;
- Inadequate supply of some service providers such as psychiatry/medication management,
- Geographical distances to services & lack of transportation options in our rural communities;
- Difficulty navigating the various service systems & paperwork;
- Cost of services & medications especially for those with Medicare or commercial insurance that has a limited benefit set;
- Lack of adequate, affordable housing;
- Need for additional residential crisis stabilization services;
- Lack of IRTS or CBHH beds statewide and in the region;
- Inadequate number of psychiatric beds statewide with local psychiatric beds often utilized by persons not from the region so persons from the region in need are often hospitalized miles from family, friends and county case managers;
- Challenges providing services to people with co-occurring disabilities (ex: significant chronic health issues, chronic pain, or substance use disorders);

GAPS ANALYSIS FOR REGION 7E

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 2 or More Counties

• Geographic Location of Providers (80%)
• Access to Transportation (80%)
• Long Waiting Times for Services (40%)
• Lack of Service Availability on Short Notice (40%)

Top Service Gaps

Indicated by 2 or More Counties:

• Psychiatric Prescribers (60%)
• Permanent Supportive Housing (40%)
• Mobile MH Crisis Response (40%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

Adult Day Treatment; Adult IRTS; Assertive Community Treatment; Bridges; Certified Peer Specialist Services; Crisis Stabilization (Residential); Inpatient Adult Psychiatry Beds; Integrated Dual Diagnosis Treatment; Integrated Primary Care w/BH; Medical Transportation; MH Court; Neuropsychological Services; Non-Medical Transportation; Partial Hospitalization Program; Psychotherapy (Family, Group)

Indicated by 4 Counties

Adult Protection; Clubhouses; Consumer-run Services; Dialectical Behavioral Therapy; Drop-in Centers; Family Support &Education; Foster Care; Medication Management; MH Diagnostic Assessment; Physicians that performer MH Screening; Projects for Assistance in Transition from Homelessness; Psychiatric Consultations to PCP; Psychological Testing; Rehabilitative Services for Traumatic Brain Injuries; Respite Care (Crisis, Evenings & Weekends, Out of Home); Treatment Services for Autism

- Challenges bridging from children's to adult services;
- An aging population increasing the need for more geriatric mental health services;
- Difficulty accessing Community Behavioral Health Hospital beds for civilly committed clients;
- Increased county share at state operated facilities when community resources are unavailable;
- Increased complexity of needs & acuity of symptoms in people being served.

Strategies & Successes to Meeting Community Needs

The Region 7E Adult Mental Health Initiative was established in the mid-1990s. It was at this time that deinstitutionalization was occurring. Following the closure of the Moose Lake State Hospital in 1996, funding was made available to counties to develop services for persons with mental ill in the community. Per bylaws, The Region 7E Adult Mental Health Initiative Governing Board exists to plan and develop within the group's geographic jurisdiction, a system of care that will serve the needs of adults with serious and persistent mental illness.

Through a process of regularly scheduled stakeholder meetings, communication, coordination, education and periodic needs assessment, the counties of Region 7E continue to work together to adapt to the changing mental health service needs. This is accomplished by collaboratively planning by Governing Board, Provider Round Table and the Regional Local Advisory Council members for community services to address local needs and reduce the need for hospital level of care.

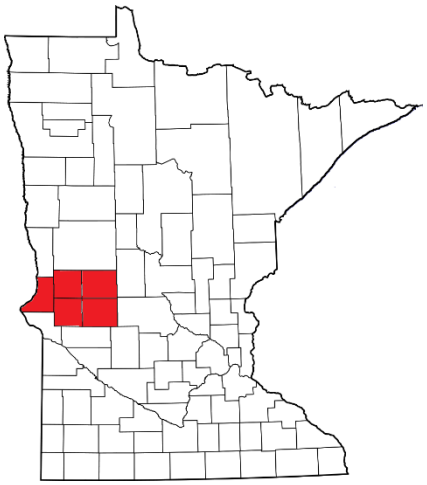
County Collaboration following Riverwood: The regional counties worked together with community service providers to fill in the gap left when Riverwood Centers, the community mental health center, closed in March of 2014. This collaboration has resulted in increased involvement by a wide array of community service providers and an expanded level of communication between providers.

Crisis Mobile Services: An example being crisis mobile services and call services are now provided by a collaboration of four mental health service providers. This partnership did not exist prior to 2014.

AMHI Marketing Campaign: As indicated above, Region 7E has recently developed a regional web site and is in the process of a marketing campaign including billboards to ensure this information is known and accessible.

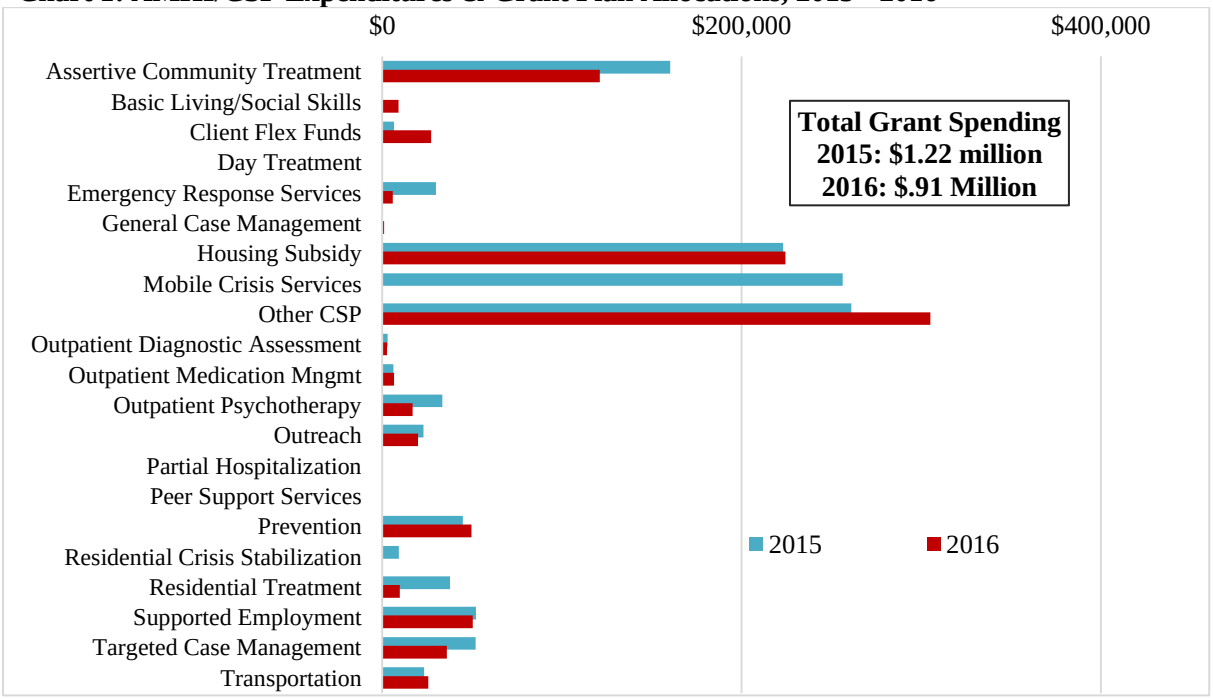
Community Edu & Events: Individual County and the regional LAC bring in speakers and hold forums on mental health related topics and annually gather to attend the legislative day on the hill.

Regional Profile: **Region 4S**



Mental Health Initiative Region 7, Region 4S, is comprised of Douglas, Grant, Pope, Stevens, and Traverse County (see map). In 2016, DHS awarded the region $0.91 million of CSP and AMHI dollars (see Chart 1), as well as $333,950 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the initiative and counties projected serving individuals across 14 service categories (Prevention and Outreach excluded).[6] In 2015, the region spent $2.08 million across 15 service categories. AMHI/CSP Grant dollars paid 44.1 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified 274 unique individuals being served across 8 service categories. An additional 631 unidentified individuals were served in quarter 1 of 2016, and 336 in quarter 2.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

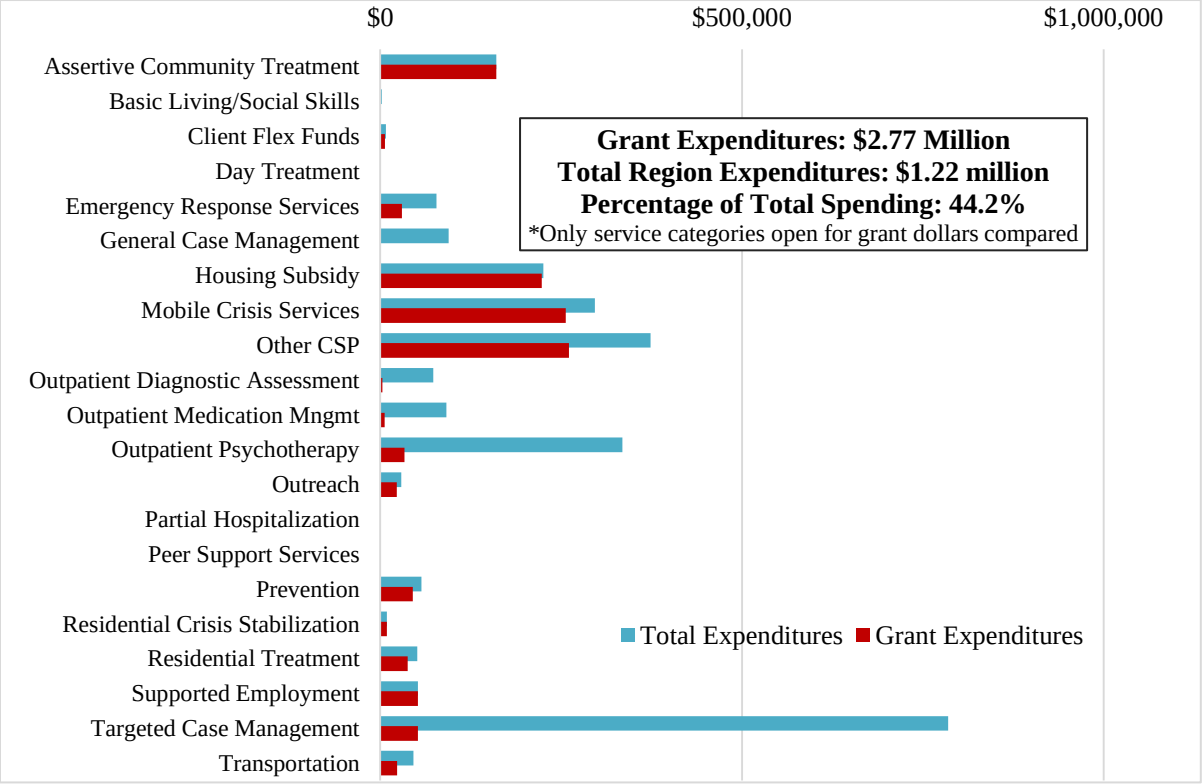
Regional Mental Health Community Needs and Service Structure

Mental Health Region 4S is composed of five rural counties and has a total population of 66,539. Service areas also include parts of the Mille Lacs Tribal jurisdiction. This region is largely rural, with many sparsely populated areas. The average county resident is 43.68 years old, with slightly more women than

[6] Grant estimate exceeded 11,000 duplicated individuals across 14 service categories. Given the size of the region and amount of money, this was deemed to not be a reliable amount so has been adjusted in statewide estimates and is excluded here.

men (50.4 percent compared to 49.6). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

In quarters 1 and 2 of 2016, the region provided services to 198 and 247 unique individuals respectively, or 832 people over six months. The majority of reported clients received Transportation, Housing Subsidy, Basic Living/Social Skills, and Targeted Case Management. Approximately one fourth of clients received more than one type of service or services from more than one provider each quarter.

The region's geography creates barriers for client access and limits service availability to consumers. Uniquely, because there are no psychiatric inpatient services and also emergency rooms do not have behavioral health units or staff, Region 4 South's crisis team responds to needs for mental health assessments. While there is a local CBHH, it cannot be accessed for several years due to long waitlists and commitments.

Service Structure

Each county retains responsibility for providing and contracting for services, as needed. While some counties act as providers, others contract with one of 2 mental health centers or smaller community based providers within the region. Region 4 South Consortium provides ACT and Crisis services to all 5 counties and also covers a variety of other services such as employment program, housing financial support, consumer drop-in centers, and socialization projects. Remaining funds are redirected to counties to address other areas of need.

Table 2: Demographic Differences between Region 4 South AMHI/CSP Clients and Total Population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**52342**	
18 - 19	1.5%	3.5%	*-2.0%*
20 - 34	17.3%	22.1%	*-4.8%*
35 - 54	35.1%	30.3%	*4.8%*
55 - 64	25.7%	17.8%	*7.9%*
65+	20.3%	26.4%	*-6.1%*
Sex			
Male	40.1%	49.6%	*-9.5%*
Female	59.9%	50.4%	*9.5%*
Race			
Asian	0.5%	0.5%	*0.0%*
Black or African American	2.0%	0.5%	*1.5%*
Native American	0.0%	0.7%	*-0.7%*
Multiple Race	0.5%	1.2%	*-0.7%*
Other Race Alone	3.1%	0.4%	*2.7%*
White	93.9%	96.8%	*-2.9%*
Ethnicity			
Hispanic	1.5%	1.7%	*-0.2%*
Not Hispanic	98.5%	98.3%	*0.2%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Flexibility in structure from county to county is prompted by variation in available providers, differing county capacities to serve as a provider, size of county, and number of consumers. For instance, counties with fewer consumers often keep more services at a county provider level. ACT and crisis services are kept at a regional level to maximize consumer numbers, staffing, minimize cost, and promote efficiency.

Barriers & Challenges to Providing Services

Region 4 South faces several persistent barriers to provision of services:

- Lack of affordable, safe housing.
- Lack of transportation or access to transportation services, which affect appointments, employment, and socialization.
- Geographical location of services and providers creates access challenges for many consumers.
- Shortage of psychiatric prescribers, which impacts ability to succeed in certain programs.
- Lack of appointments for medication management services.

Inpatient bed shortages have proven particularly troublesome for the region:

- Statewide shortages have made local shortages even direr and create addition burdens for emergency rooms and law enforcement.

- Consumers are more likely to occupy ER rooms for long periods of time and in turn create longer wait times for patients with other medical emergencies.
- Law enforcement agencies face additional financial and staffing burdens with increased requests to provide security at local hospitals, a reality more likely the longer consumers are kept in emergency room beds without proper psychiatric care.
- Protected transport from the ER to a new facility, after a consumer receives a placement also costs money and staff time.
- Finally, lack of local inpatient beds creates strains on family, friends, and support teams that must travel several hours away to visit consumers, a crucial part of the stabilization process.

Strategies & Successes to Meeting Community Needs

- *Inpatient Beds*: Region 4 South advocates for local inpatient beds in this area, specifically targeting the local CBHH to improve the ability of local county consumers to use existing beds.
- *Medication Management*: Counties have also targeted local clinics, hospitals, and insurance providers to facilitate improved medication management services and better utilize primary care providers who consult with specially trained psychiatric providers.
- *Consortium Organized Discussion & Education*: The five counties utilize the Region 4 South Consortium to develop services and create new programs for unmet needs, particularly when funding or staffing at the county level. The Consortium educates and improves awareness to the county and regional mental health issues, including identified service shortages, barriers, and long-term goals.
- *Mental Health Coalition Task Force*: A recently formed group that brings stakeholders together to address mental health barriers and shortages. Member representatives are from hospitals, clinics, law enforcement, county attorney offices, other mental health provider offices, county jails, insurance companies, DHS, and the regional CBHH. A primary focus has been creating solutions to the shortage of inpatient psychiatric beds.

GAPS ANALYSIS FOR REGION 4S

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 2 or More Counties

- Geographic Location of Providers (60%)
- Access to Transportation (60%)
- Long Waiting Times for Services (60%)
- Lack of Service Availability on Short Notice (40%)

Top Service Gaps

Indicated by 2 or More Counties:

- Psychiatric Prescribers (40%)
- Inpatient Adult Psychiatry Beds (40%)
- Adult Day Treatment (40%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

MH Court; Psychiatric Consultations to PCP

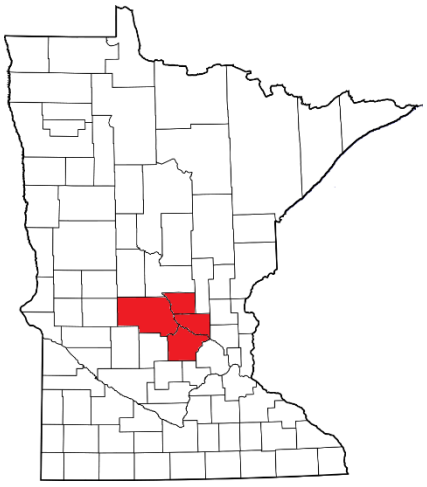
Indicated by 4 Counties

Caregiver/Family Training & Edu; Integrated Primary Care w/BH; Medication Management; Correctional Setting MH Services; Neuropsychological Services; Problem Gambling Services; PATH; Psychiatric Prescribers; Inpatient Psychiatrists; Rehabilitation Services for TBI; Treatment Services for Autism

Indicated by 3 Counties

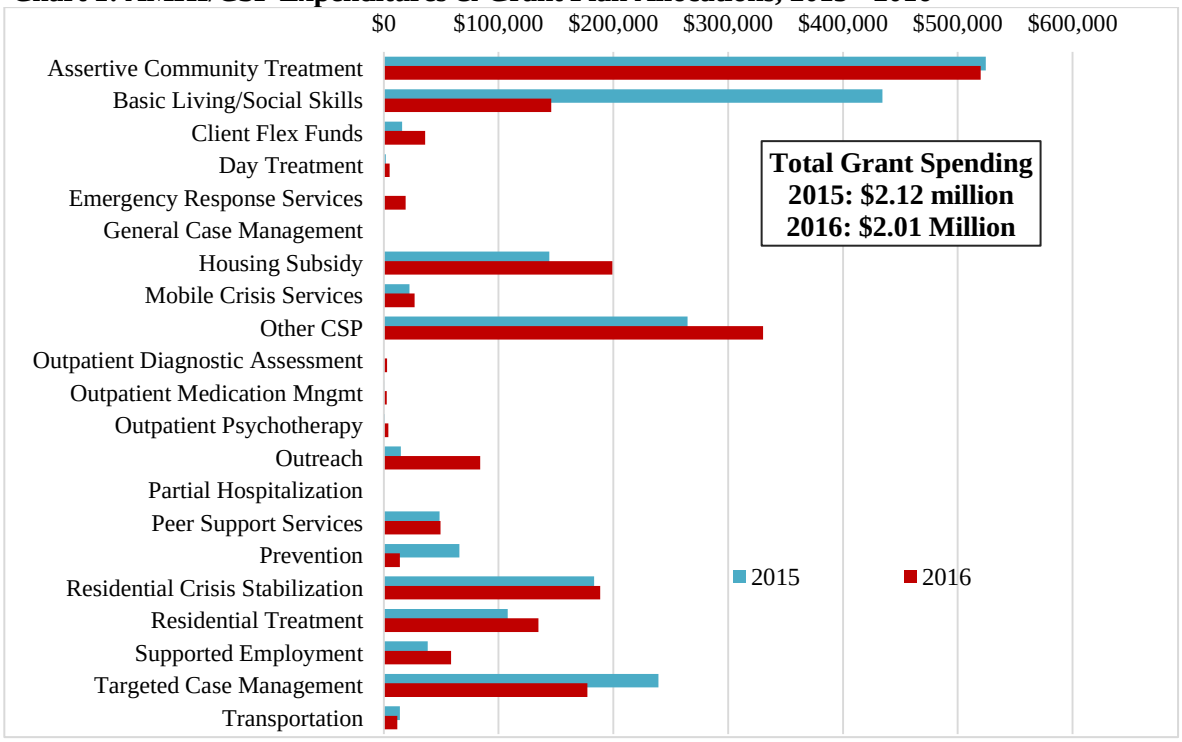
Adult IRTS; Bridges; Caregiver/Family Counseling; Clubhouses; Complex Needs w/Multiple Diagnosis & Chronicity; Crisis Stabilization (Residential); Family Support & Edu; Health & Behavior Assessment; Independent Living Skills Therapies; Integrated Dual Diagnosis Treatment; Medical Transport; MH Diagnostic Assessment; MH Services for Veterans; Non-Medical Transport; Partial Hospitalization Program; Permanent Supportive Housing; Psychotherapy (Individual; Family; Multi-Family); Residential Treatment for Adults with Eating Disorders; Transitional Services for Youth; Treatment Services (Eating Disorders)

Regional Profile: **CommUNITY**



Mental Health Initiative Region 8, CommUNITY, is comprised of Benton, Sherburne, Stearns, and Wright County (see map). In 2016, DHS awarded the region $2.01 million of CSP and AMHI dollars (see Chart 1), as well as $541,150 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the initiative and counties projected serving more than 2,730 duplicated individuals across 17 service categories (Prevention and Outreach excluded). In 2015, the region spent $2.12 million across 17 service categories. AMHI/CSP Grant dollars paid 48.6 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified 621 unique individuals being served across 13 service categories. An additional 95 unidentified individuals received services.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016

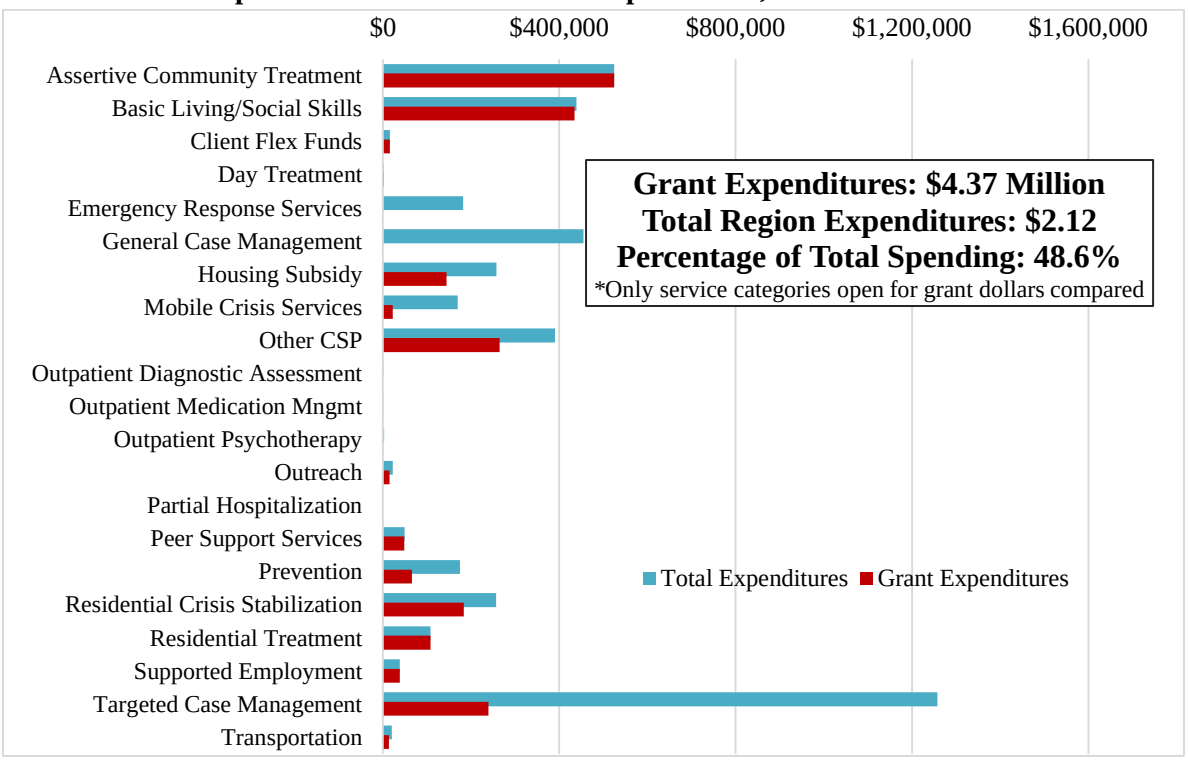


Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

The region covers a land area of over 28,000 square miles which includes more than 60 cities and 70 townships. The cities and townships of this area range from rural farming communities with populations of less than 100 to cities with populations over 60,000. The St Cloud Metropolitan area has a population of over 200,000 and battles with big city issues while more rural parts of the region are primarily agricultural in nature. The region also neighbors the large metropolitan area of Minneapolis/St. Paul.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Another unique feature of the area the CommUNITY Initiative serves includes a growing immigrant/refugee population. Given these features of the region, the CommUNITY Initiative's needs include being able to provide services to fill a variety of needs for a diverse and widespread population. The CommUNITY Initiative also needs to be able to work with a variety of providers who can also provide a diverse number of services and are able to adapt and accommodate the growing diversity within Region 7W. The average county resident is 42.9 years old, with slightly more men than women (50.4 percent compared to 49.6). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

In quarters 1 and 2 of 2016, the region provided services to 396 and 620 unique individuals respectively, or 621 people over six months. The majority of reported clients received Other CSP, Targeted Case Management, Basic Living/Social Skills, Assertive Community Treatment, Adult Residential Crisis Stabilization, and Outreach services. Approximately one tenth of clients received more than one type of service or services from more than one provider each quarter.

Table 2: Demographic Differences between CommUnity AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**210818**	
18 - 19	1.7%	5.0%	*-3.3%*
20 - 34	27.3%	29.6%	*-2.3%*
35 - 54	41.3%	35.5%	*5.8%*
55 - 64	20.9%	14.5%	*6.4%*
65+	8.8%	15.4%	*-6.6%*
Sex			
Male	40.2%	50.4%	*-10.2%*
Female	59.8%	49.6%	*10.2%*
Race			
Asian	1.8%	1.6%	*0.2%*
Black or African American	6.7%	2.9%	*3.8%*
Native American	0.0%	0.4%	*-0.4%*
Multiple Race	2.0%	1.6%	*0.4%*
Other Race Alone	2.0%	0.7%	*1.3%*
White	87.6%	92.8%	*-5.2%*
Ethnicity			
Hispanic	1.6%	2.6%	*-1.0%*
Not Hispanic	98.4%	97.4%	*1.0%*

**Data excludes clients without demographic information available and counties that did not provide client level data (Wright County). American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Service Structure

The community mental health center in the region is Central Minnesota Mental Health Center (CMMHC). CMMHC provides services including individual and family therapy, psychiatry, detox, mobile crisis, crisis beds, IRT, and ACT services. CMMHC provides services in all four of the CommUNITY counties and has offices in three of the four counties to help serve the population closer to their communities.

CommUNITY AMHI provides funding to and/or partners with a variety of providers in the area including CMMHC, Catholic Charities, Rise Inc., Functional Industries, Goodwill-Easter Seals, and St. Cloud HRA. These organizations, like CMMHC, serve the four counties in the initiative, they provide a variety of different services and many have more than one location to better serve the area. The area has a wide variety of mental health services available, however, some services, such as IRTS and psychiatry have long waiting lists. The four counties have a history of working together to tackle gaps in the mental health system.

Barriers & Challenges to Providing Services

The top barriers to services, as reported by the counties within the CommUNITY those highlighted by the Gaps Analysis, such as long wait time for services, and lack of housing. While some of these barriers and

gaps appear to be an outcome of some of the unique features the region the CommUNITY Initiative has, it is important to recognize that these barriers and gaps are not exclusive to the four counties that the CommUNITY serves; but also are frequently reported statewide and nationwide. Nonetheless, the

CommUNITY Initiative has worked at and continues to work at providing services, directly and in collaboration with our providers, to address and improve the barriers and gaps.

Strategies & Successes to Meeting Community Needs

Assertive Community Treatment: The DHS Mental Health Division recently approved a third ACT team for Central Minnesota Mental Health Center (CMMHC) to serve Benton, Stearns, Sherburne and Wright counties. This expansion will allow for closer proximity of the ACT team services for a portion of the CommUNITY Initiative's population.

Intensive Residential Treatment: The region lost an IRT and a CBHH in the past several years. CommUNITY has encouraged providers to consider IRT development and at this time there is a provider exploring this possibility.

Mobile Crisis Team: CMMHC is in the process of changing how our mobile crisis team is staffed and where they are officed. The major barrier to mobile services being more available in our area currently seems to be difficulty finding qualified individuals interested in working on a mobile crisis team. Difficulty hiring staff has been mentioned by many providers in our area and was a major reason listed as to why one of our IRTs closed.

GAPS ANALYSIS FOR COMMUNITY

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 2 or More Counties

- Long Waiting Times for Services (50%)
- Service Availability on Short Notice (50%)
- Lack of Housing (50%)

Top Service Gaps

Indicated by 2 or More Counties:

- Psychiatric Prescribers (75%)
- Inpatient Adult Psychiatry Beds (50%)
- Adult IRTS (50%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

Bridges; Peer Specialists; Clubhouses; Foster Care; Medication Management; MH Court; Mobile MH Crisis Response; Non-Medical Transportation; Permanent Supportive Housing; Rehabilitative Services for TBI; Respite Care (Crisis, Evening & Weekend, In Home, Out of Home); Treatment Services for Autism.

Indicated by 3 Counties

Adult Day Treatment; ACT; Behavioral Programing; Complex Needs w/Multiple Diagnosis & Chronicity; Consumer-run Services; Crisis Stabilization – Residential; Integrated Dual Diagnosis Treatment; Medical Transportation; MH Rehabilitative Services; Veterans MH Services; Correctional Setting MH Services; Partial Hospitalization Program; Prevention; Psychotherapy (Group); Residential Habilitation (In-Home Family Support)

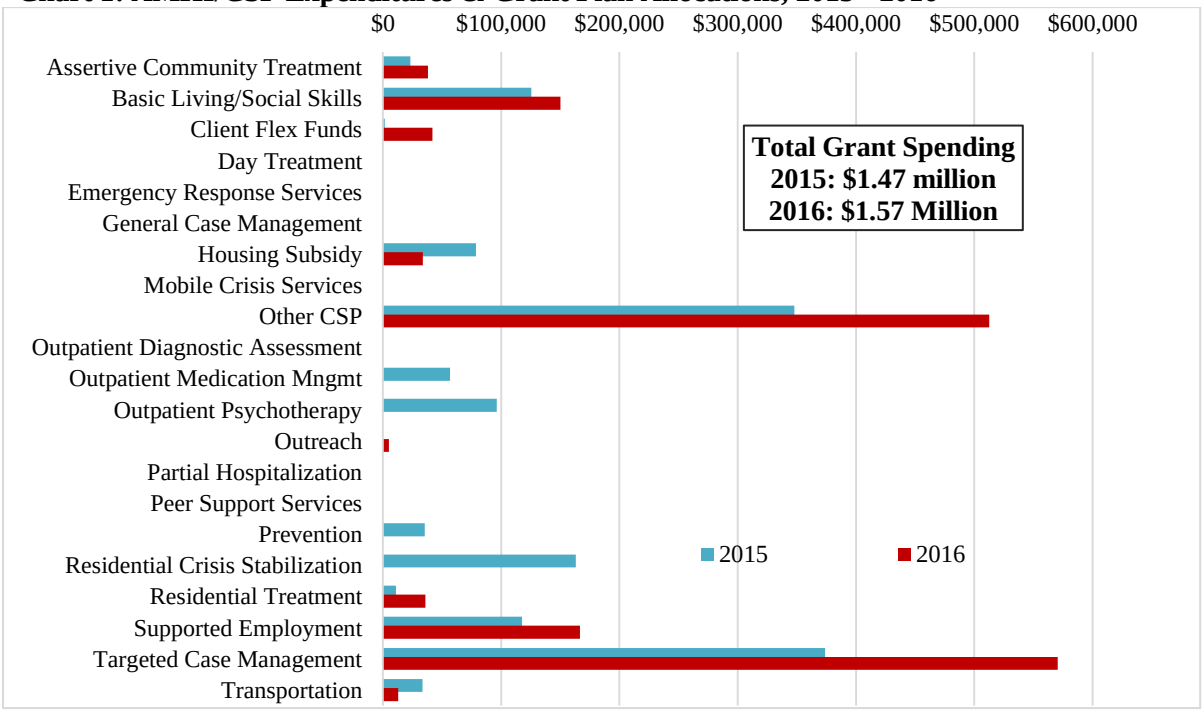
Indicated by 2 Counties

Adult Protection; DBT; Drop-in Centers; Explanation of Findings; Family Support & Edu; Health & Behavior Assessment/Intervention; Illness Management & Recovery; Ind. Living Skills Therapies & Training; Neuropsychological Services; Prevention/Early Intervention for Behavioral & Cognitive Health; PATH; Inpatient Psychiatrists; Psychological Testing; Residential Habilitation (Supported Living Services; Residential Treatment for Eating Disorders; Supported Employment; Transition Age Services for Youth

Regional Profile: **Anoka**

Mental Health Initiative Region 9 is comprised of Anoka County (see map). In 2016, DHS awarded the region $1.57 million of CSP and AMHI dollars (see Chart 1), as well as $250,000 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 5,990 duplicated individuals across 10 service categories (Prevention and Outreach not included). In 2015, the region spent $1.47 million across 13 service categories. AMHI/CSP Grant dollars paid 43.3 percent of county expenses in eligible service categories (see Chart 2). Grant dollars were used to fund more than 7 outside providers, as well as services provided by the county. In the first and second quarter of 2016, the county identified almost 965 unique individuals being served across 5 service categories, and an additional 65 unidentified recipients.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

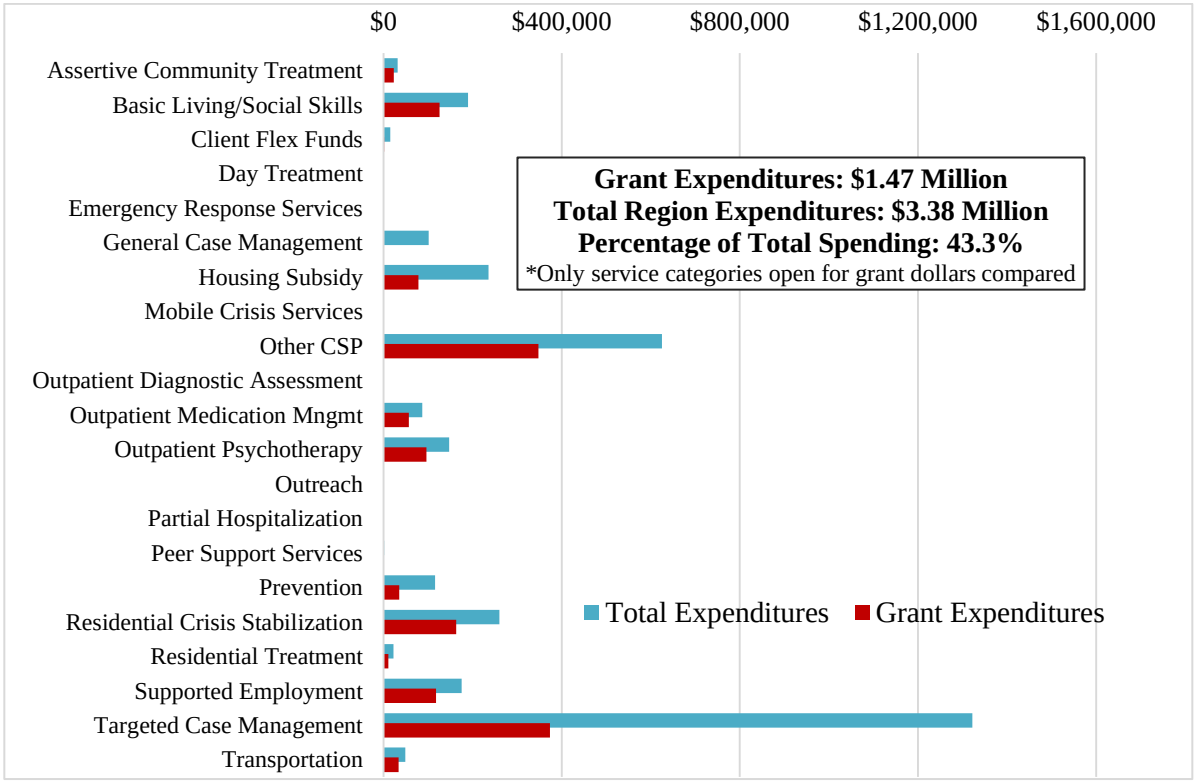
Demographic Characteristics of Anoka

Anoka County, composed of 440 square miles and located in the northwest suburbs of the Twin Cities, is the fourth most populous county in Minnesota. The mix of urban and rural communities poses unique challenges for service delivery. While the median household income, according to Census.gov, is $70,464, there are concentrations of people living in poverty. These tend to follow major transportation thoroughfares, as do jobs located in the county. Diverse ethnic and cultural populations continue to grow in Anoka County. The need for culturally specific services as well as outreach to those in poverty are

identified areas for growth. The average county resident is 37.6 years old, with slightly more women than men who are over 18 (50.4% compared with 49.6%). Table 1 shows County demographics (see Table 1).

In quarters 1 and 2 of 2016, the region provided services to 571 and 905 unique individuals respectively, or 965 people over six months. The majority of reported clients received Targeted Case Management and Other CSP services. Approximately one third of clients received more than one type of service or services from more than one provider each quarter.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

The work of the Adult Mental Health/Children's Mental Health Joint Advisory Council, the Mental Health Director's Network and the Anoka County Mental Wellness Campaign are three committees which actively engage providers and consumers in addressing the needs of the county. Many suggestions given by these committees have been implemented. Targeted case management and adult mental health intake are delivered by county employees, otherwise it has been the practice of the county to rely on community providers to deliver all other mental health services. The Adult Mental Health Intake redesign, initiated in 2014, received an AMC award for their innovation. It was geared to be the right service at the right time as it does not require case management eligibility to access services.

Table 1: Demographic Differences between Anoka AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**251950**	
18 - 19	0.7%	3.1%	*-2.4%*
20 - 34	29.6%	25.4%	*4.2%*
35 - 54	43.7%	40.5%	*3.2%*
55 - 64	19.1%	16.5%	*2.6%*
65+	6.8%	14.4%	*-7.6%*
Sex			
Male	48.5%	49.6%	*-1.1%*
Female	51.5%	50.4%	*1.1%*
Race			
Asian	0.7%	4.0%	*-3.3%*
Black or African American	7.5%	4.8%	*2.7%*
Native American	2.1%	0.6%	*1.5%*
Multiple Race	1.3%	2.8%	*-1.5%*
Other Race Alone	1.9%	1.7%	*0.2%*
White	86.6%	86.2%	*0.4%*
Ethnicity			
Hispanic	2.3%	3.8%	*-1.5%*
Not Hispanic	97.7%	96.2%	*1.5%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Anoka County is fortunate to have a robust and involved mental health provider community. Many of our consumers may never interact with a county case manager but will receive a high level of service from our community providers.

Anoka County is recognized as a national leader when it comes to caring for people. Many of Anoka County's social services and mental health programs have received national recognition for achievement and innovation and have served as models for care.

Barriers & Challenges to Providing Services

While the Gaps analysis highlights accessing services, lack of availability and long waits for services and providers, Anoka County took steps to reduce those barriers in 2015 – 2016 through feedback given by our advisory councils.

The *cost shifts* to the counties remains a struggle. Counties attempt to place people out of the state operated facilities when the client no longer meets medical necessity, however, the infrastructure of community based continuum of care is lacking. This puts a strain on the counties.

Access to psychiatry remains a gap. Providers and consumers report long waiting times for appointments. And providers report that reimbursement for psychiatry and medication management is under-funded and which, in turn, can have an effect on the agency.

Housing, dual diagnosis treatment and recovery, and a partial hospitalization program continue to be challenges. *Transportation and access to transportation* for appointments continues to be a problem across multiple social service programs in Anoka County. We continue to work with our transit to address this barrier and expand transportation options, however, there is not a current public transportation solution at this time.

Strategies & Successes to Meeting Community Needs

In 2013, Anoka County completed a needs assessment for Intensive Residential Treatment Services (IRTS), individualized Community Support Services programs, as well as points of access to mental health to ascertain the processes individuals followed to gain access to mental health. Several outcomes followed the assessment:

Adult Intake Process: A redesigned AMH Intake process, in which a person can be assessed for appropriate services and individuals are connected to referrals and a reduction in dead ends when individuals attempted to obtain needed mental health services.

New IRTS Provider: Through the RFP process Anoka County started a partnership with a new IRTS facility provider in 2014.

Individualized Community Support Services: New program began for non-MA eligible individuals to assist in accessing both health insurance and mental health services.

New Housing Staff: Housing options remain a challenge but and the hire of a new staff person focusing on GRH and mental health housing programs has allowed Anoka County to take inventory of all possible programs and vouchers. This inventory will continue to be evaluated to ensure the homeless, or those in jeopardy of becoming homeless, are given all opportunities to improve their living situation.

Future IPS Model Expansion: Anoka's vocational services provider uses the IPS model of employment and looks forward to expanding referrals to vocational programs from expansion to housing services providers.

Redesigned Website & Jail Diversion: CSP and AMHI dollars have also been spent to redesign the Anoka County Behavioral Health website to be more user friendly, supported a peer support center for those who have co-

GAPS ANALYSIS FOR ANOKA

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

- Capacity to access service/navigate the system
- Lack of service availability on short notice or during crisis
- Long waiting times for services/providers

Top Service Gaps

- Inpatient adult psychiatry beds
- Permanent supportive housing
- Psychiatric prescribers

Other Services Identified as Unavailable or Short of Demand

- Adult Intensive Residential Treatment Services
- Assertive Community Treatment
- Bridges
- Clubhouse Services
- Complex needs with multiple diagnosis and chronicity
- Consumer-run Services
- Crisis Stabilization - residential
- Foster Care
- Integrated Dual Diagnosis Treatment
- Mental Health Court
- Mental Health Rehabilitative Services (ARMHS)
- Mental Health Services for Veterans
- Mental health services offered in adult correctional settings
- Non-Medical Transportation
- Partial Hospitalization Program
- Projects for Assistance in Transition from Homelessness
- Psychotherapy - Individual
- Psychotherapy - Multi-family
- Residential Habilitation
- Respite Care - Crisis
- Respite Care - Out of Home
- Transition age services for youth moving into adulthood
- Transitional Supports

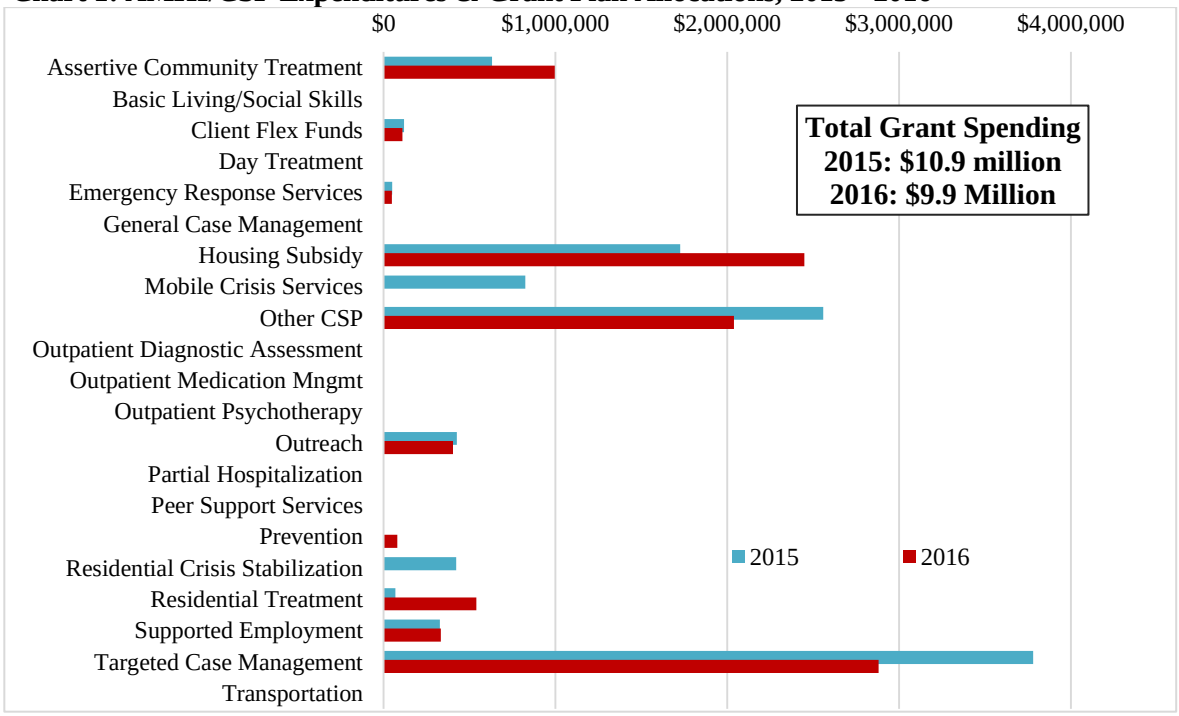
occurring diagnoses and with the initiation of a jail diversion program – designed to help those exiting the jail system connect with mental health resources after they leave.

Anoka County continues to find new and innovative ideas for service delivery, many of which began a few years ago.

Regional Profile: **Ramsey**

Mental Health Initiative Region 10 is comprised of Ramsey County (see map). In 2016, DHS awarded the region $9.9 million of CSP and AMHI dollars (see Chart 1), as well as $579,200 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 8,770 duplicated individuals across 6 service categories (excluding Prevention and Outreach). In 2015, the region spent $9.9 million across 10 service categories. AMHI/CSP Grant dollars paid 39.6 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified almost 1,856 unique individuals being served across 5 service categories. An additional 1,400 unidentified clients were served in two additional service categories.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016

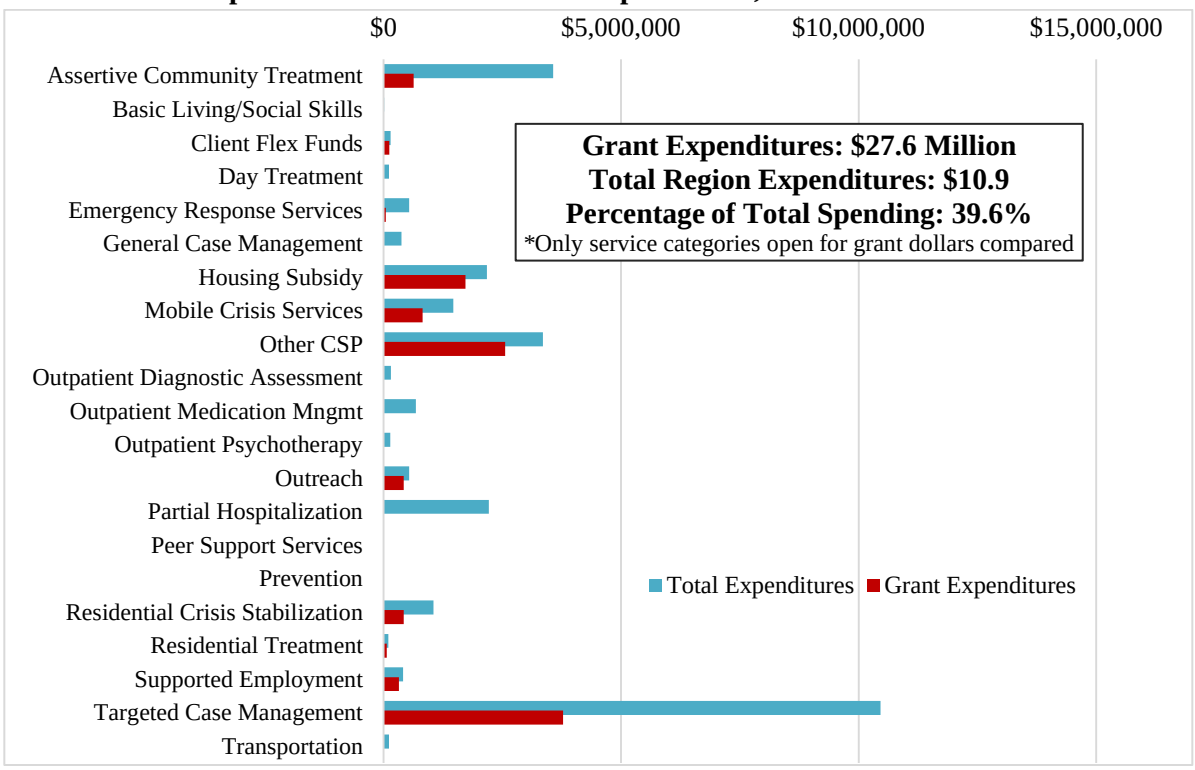


Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

Ramsey County is geographically small, covering only 152.21 square miles. The total population is 532,655 which produces a population density of 3,499 people per square mile. Since the mid-1970s, refugee resettlement and other immigration to Ramsey County has fueled a dramatic change in the human face of the County. Dominated for the past century by Scandinavian and other Western European immigrants and their descendants, Ramsey County has been a welcoming home for the

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

past 30 years to tens of thousands of new Americans from Southeast Asia, Africa, the former Soviet Union, and the Spanish-speaking countries of Central and South America and the Caribbean. Ramsey County is home for a significant number of very new refugees from Burma and a large number of individuals from East Africa as well. These individuals have experienced significant trauma and often don't speak English or have any idea of the concept of "mental health." Addressing the language and cultural barriers with these individuals when they are in a crisis takes significant time and resources and also requires that staff be trained in working across cultures.

The average county resident is 34.6 years old, with slightly more woman than men (51.4 percent compared to 48.6). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1). In quarters 1 and 2 of 2016, the region provided services to 1,856 identified clients over six months, and an additional 1,400 unidentified recipients receiving Outreach and Other CSP services. Clients received Adult Residential Crisis Stabilization, Assertive Community Treatment, Housing Subsidy, Adult Residential Treatment, and Targeted Case Management services.

Service Structure

Ramsey County provides services directly, as well as contracting with community vendors through AMHI funding. County funds are primarily used to support the Community Mental Health Center and Crisis Services which are provided directly. The County also provides TCM and ACT services. AMHI Contracts are in place to administer additional TCM/ACT services, as well as all of our CSP.

Table 2: Demographic Differences between Ramsey AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**399851**	
18 - 19	2.7%	4.1%	*-1.4%*
20 - 34	30.1%	31.4%	*-1.3%*
35 - 54	40.7%	32.5%	*8.2%*
55 - 64	21.0%	15.8%	*5.2%*
65+	5.5%	16.2%	*-10.7%*
Sex			
Male	53.7%	47.8%	*5.9%*
Female	46.3%	52.2%	*-5.9%*
Race			
Asian	5.1%	12.8%	*-7.7%*
Black or African American	25.6%	11.1%	*14.5%*
Native American	1.5%	0.6%	*0.9%*
Multiple Race	8.5%	3.8%	*4.7%*
Other Race Alone	0.0%	1.8%	*-1.8%*
White	59.4%	69.9%	*-10.5%*
Ethnicity			
Hispanic	4.4%	7.3%	*-2.9%*
Not Hispanic	95.6%	92.7%	*2.9%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Contracting decisions are influenced by the desire to offer choice in providers and an array of service types. We give priority to providers who can demonstrate an ability to serve the racially diverse needs of our community.

Barriers & Challenges to Providing Services

Ramsey County is experiencing a chronic *shortage of psychiatry services*. Assistance in the development of community psychiatry capacity (such as loan forgiveness programs, increased reimbursement rates to allow providers to pay prescribers more, etc.) would reduce wait times for individuals.

Continued work is needed to *develop housing options*. Rental vacancy rates are low in all metro county communities, making it difficult to house people even when they have rental subsidies. Individuals with subsidies are also being priced out of their units as landlords increase rents.

Our community is also struggling with how to manage *Rule 20 cases*, as no current services/facilities are not designed to meet people's needs. Similarly, it would be helpful to continue to push legislation to allow for the use of *WIT funding for individuals on the AMRTC wait list*.

Strategies & Successes to Meeting Community Needs

Ramsey County has adopted the strategy and is supported by policy to solicit existing contracts every Five years at a minimum. This practice, along with the recent needs assessment for additional Intensive Residential Treatment Service (IRTS), enhances opportunity for growth, diverse, culturally specific, and comprehensive, client centered services.

Economic & Community Investment: Ramsey County also continues to use resources to support its organizational goals to cultivate economic prosperity and invest in neighborhoods with concentrated financial poverty. As well as County decrease disparities within our service delivery system by 75% by 2030. Contracted providers are expected to contribute to the accomplishment of this goal. Providers are expected to be able to serve people from all backgrounds.

Under the *East Metro Mental Health Crisis Alliance* (Alliance) Ramsey County and Washington County partner to address the needs of individuals at the Urgent Care for Adult Mental Health (Urgent Care). Crisis Services are provided in all of Ramsey and Washington Counties, for a total of 48 cities. The Alliance continues to partner with both Ramsey County and Contracted TCM and ACT case management, as well as local Law Enforcement to develop proactive approaches to intervention.

GAPS ANALYSIS FOR RAMSEY

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

- Cost of Services (high co-pays, etc.)
- Lack of Housing
- Lack of Psychiatric Services

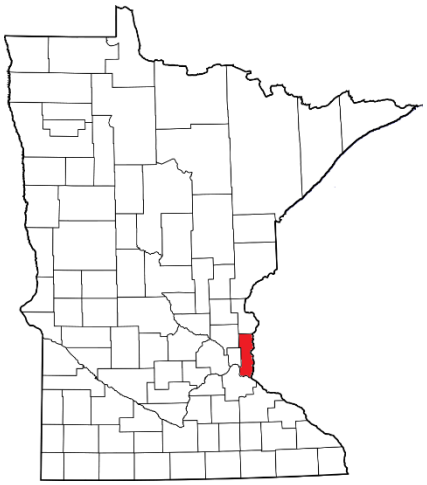
Top Service Gaps

- Permanent Supportive Housing
- Psychiatric Prescribers
- Foster Care

Other Services Identified as Unavailable or Short of Demand

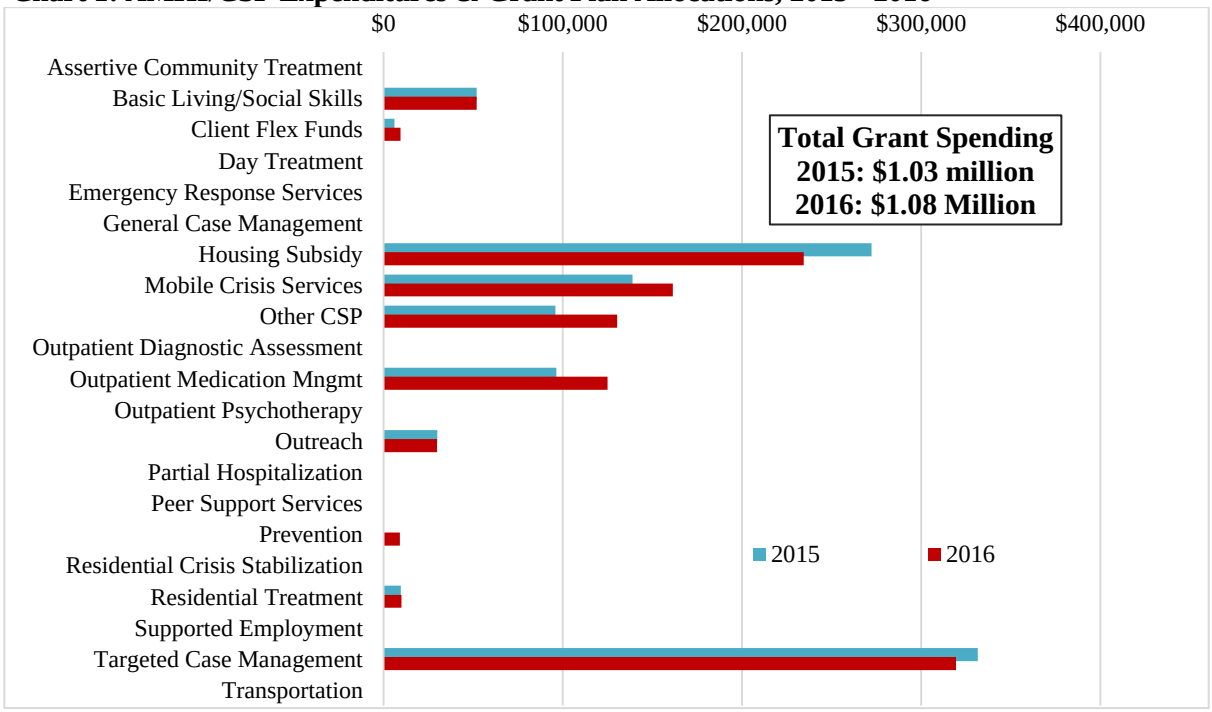
- Adult IRTS
- Assertive Community Treatment
- Assistive Technology
- Behavioral Programing
- Bridges
- Certified Peer Specialists
- Complex needs with multiple diagnosis and chronicity
- Consumer-run Services
- Family Support and Education
- Integrated Primary Care w/BH
- Medication Management
- MH Services for Veterans
- Correctional Setting MH services
- Outreach
- Prevention
- Prevention/Early Intervention for Behavioral & Cognitive Health
- Problem Gambling Services
- Projects for Assistance in Transition from Homelessness
- Promotion
- Psychiatric Consultations with Primary Care
- Supported Employment
- Transition age services for youth moving into adulthood

Regional Profile: **Washington**



Mental Health Initiative Region 11 is comprised of Washington County (see map). In 2016, DHS awarded the region $1.1 million of CSP and AMHI dollars (see Chart 1). In 2016 with AMHI/CSP grant dollars, the county projected serving more than 2,087 duplicated individuals across 10 service categories (Prevention and Outreach not included). In 2015, the region spent $1.03 million across 9 service categories. AMHI/CSP Grant dollars paid 33.7 percent of county expenses in eligible service categories (see Chart 2). Grant dollars were used to fund more than 8 outside providers with, as well as services provided by the county. In the first and second quarter of 2016, the county identified almost 917 unique individuals being served across 6 service categories, and an additional 40 unidentified recipients.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



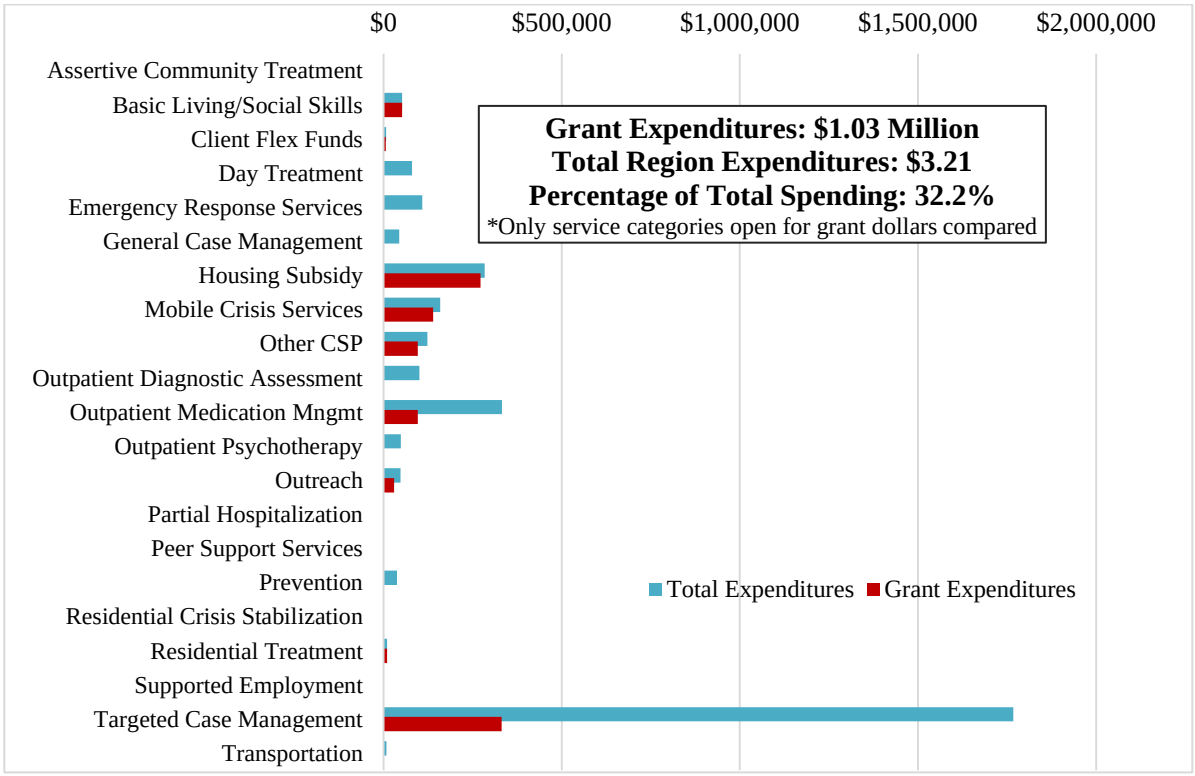
Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Demographic Characteristics of Washington

Washington County has a population of 249,109 over 384.28 square miles, or a population density of 648 people per square mile. As a growing suburban county of the Twin Cities, Washington County is home to 86 percent of residents living in an urban area of the county and 14 percent living in a rural area. The average county resident is 38.7 years old, with slightly more women than men who are over 18 (51 percent compared with 49 percent). Table 1 shows County demographics (see Table 1).

In quarters 1 and 2 of 2016, the region provided services to 714 and 675 unique individuals respectively, or 917 people over six months. The majority of reported clients received Adult Mobile Crisis Services, Housing Subsidies, Basic Living/Social Skill services, Adult Outpatient Medication Management, and Targeted Case Management services. Approximately one third of clients received more than one type of service or services from more than one provider each quarter.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

Median household income in Washington County is $83,545; however, despite higher than average income and home ownership, the struggle to find and maintain affordable housing is still a significant challenge for many in our SPMI and SMI populations. Homelessness in Washington County is often more hidden than in other urban centers in the State as Washington County has no public shelters, leaving those facing a housing crisis with limited options. In 2016, Washington County allotted $234,472 in BRASS Code 443x to provide housing subsidies and supportive housing services.

Adult Mental Health Services in Washington County can best be described as hybridized. The largest area of AMHI grant support includes Adult Mental Health Case Management staff costs for providing direct support to individuals; these services are primarily provided by Washington County staff.

Since the implementation of PMAP services, AMHI/CSP funding for traditional Community Mental Health services has been reduced. For example, Psychiatric Services once primarily provided by the local

Table 1: Demographic Differences between Washington AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**181099**	
18 - 19	3.2%	3.2%	*0.0%*
20 - 34	21.1%	23.3%	*-2.2%*
35 - 54	33.0%	40.4%	*-7.4%*
55 - 64	14.6%	17.3%	*-2.7%*
65+	28.1%	15.8%	*12.3%*
Sex			
Male	40.1%	49.0%	*-8.9%*
Female	59.9%	51.0%	*8.9%*
Race			
Asian	1.7%	5.2%	*-3.5%*
Black or African American	5.9%	3.7%	*2.2%*
Native American	0.2%	0.4%	*-0.2%*
Multiple Race	2.4%	2.5%	*-0.1%*
Other Race Alone	0.7%	0.8%	*-0.1%*
White	89.1%	87.5%	*1.6%*
Ethnicity			
Hispanic	3.2%	3.6%	*-0.4%*
Not Hispanic	96.8%	96.4%	*0.4%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Community Mental Health Center, Canvas Health, Inc., have expanded to a variety of private providers who have the capacity to bill for services through PMAP insurance. This has allowed for diversity of option for consumers and contracted vendors for initiative dollars.

In 2016, major providers in Washington County included Canvas Health, Inc. While the remainder of the AMHI grant is individually contracted with private agencies for services that cannot be reimbursed through managed care. Examples of other contracted services include: community based nursing support for community based medication management, psychiatric care for the uninsured, reimbursement for residential crisis care that cannot be traditionally reimbursed and establishing contracts with private vendors for employment and housing support services. Community based social services that the AMHI grant supports include, housing vouchers, transportation support, and reimbursement for flexible spending for expenses to support individuals in the community.

Barriers & Challenges to Providing Services

Mental Health Services in Washington County have been built upon the rationale of maximizing reimbursable services through managed care or fee for service and then accessing AMHI funds to support services that cannot be reimbursed or are not considered a more traditional social service, such as housing.

Lack of public transportation has historically been a barrier to access services for individuals. Medical transportation options are utilized but are restricted to medical or treatment services; leaving a gap for individuals who are employed, seeking employment or searching for housing. Additionally, many providers only provide services in centrally located areas of the county or have ended services in Washington County due to the increased cost burden of un-reimbursable travel time. An example of this is the limitation on ARMHS services that are provided or ARMHS providers who have withdrawn their services from Washington County. Efforts and planning continue at higher levels of County Government to address this barrier and expand transportation options, however, there is not a current public transportation solution at this time.

In a system built upon reimbursable care, eligibility criteria can be critical prerequisite for services. This is acutely experienced within Mobile Crisis Assessment services as demonstrated by individuals that chose to forego crisis services due to a cost burden related to being under-insured with Medicare or having insurance that does not reimburse crisis services.

Along the continuum of care for crisis services, psychiatric support is critical. There are two hospitals located in Washington County and neither of these community hospitals provide in-patient psychiatric care. Washington County has worked on building a community psychiatric provider network; however, the challenge has been creating a system that can respond when there is a crisis or need for immediate psychiatric care.

Lastly, Washington County has one residential crisis stabilization bed available to the entire county. Recently, our Residential Crisis Stabilization provider applied for a Crisis Services expansion grant through DHS to expand our residential crisis stabilization program to four beds and increase available nursing services. Unfortunately, this proposal was not funded, and, without financial support for capital improvements, services could not be expanded. Without ongoing support for the continuum of crisis services, individuals experiencing a psychiatric crisis escalate to needing more expensive care through

GAPS ANALYSIS FOR WASHINGTON

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service
- Access to Transportation
- Eligibility Restrictions
- Geographic Location of Providers

Top Service Gaps
- Crisis Stabilization - Residential
- Psychiatric Prescribers
- Mobile MH Crisis Response

Other Services Unavailable

Assertive Community Treatment; Certified Peer Specialists; Clubhouses; Consumer-run Services; Drop-in Centers; Health & Behavior Assessment; Inpatient Psychiatry Beds; Integrated Primary Care w/BH; MH Court; Partial Hospitalization Program; Physician Consultation, Evaluation & Management; Physicians Perform MH Screening; Prevention; Prevention/Early Intervention for Behavioral & Cognitive Health; Psychiatric Consultations w/PCP; Inpatient Psychiatrists; Rehabilitative Services for TBI; Residential Treatment (Eating Disorders) Respite Care (Evening & Weekend; In Home); Treatment Services for Autism

Other Services Short of Demand

Adult IRTS; Complex Needs w/Multiple Diagnosis & Chronicity; Explanations of Findings; Foster Care; Medical Transportation; Medication Management; MH Diagnostic Assessment; Correctional Setting MH Services; Neuropsychological Services; Non-Medical Transportation; Outreach; Respite Care (Crisis; Out of Home); Supported Employment; Transition age services for youth; Treatment Services for Eating Disorders

emergency rooms, admission to community hospitals and are not treated in the community in which they live.

Strategies & Successes to Meeting Community Needs

Currently, through AMHI grant planning, several new services are being vetted and considered for implementation within Washington County.

- Employment support services, integral in Olmsted planning, are being reviewed for possible contracts to start in 2017.
- Housing support services will add capacity and support for Adult Mental Health Case Managers in assisting individuals to find stable housing and a landlord mitigation fund is also being considered in 2017.

All of these services have been recognized by the Mental Health Local Advisory Council and Heading Home Washington County as gaps in services in our mental health delivery system.

Crisis Service Expansion: With a strong working relationship with our IRTS and Crisis Stabilization provider, we engaged in grant planning and a crisis delivery system review began long before the Crisis Services Expansion grant was made public. Planning meetings were held to discuss the current need for Residential Crisis Stabilization. Models of care, potential sites and capital improvement plans were reviewed. Allow our plan was not supported by Crisis Services Expansion grant funding; it was a valuable opportunity to recognize and plan to address the shared gaps in services.

The East Metro Crisis Alliance is an example of counties, non-profit organizations, community hospitals and Managed Care organizations coming together to address a regional need and build a service that meets this critical need. Although there continue to be gaps in access to this service, the spirit in which this collaborative effort was built remains in effect. This has resulted the ability to partner with another metro county to share a contract with a private psychiatric provider for individuals who are not insured – bridging a previous gap in service.

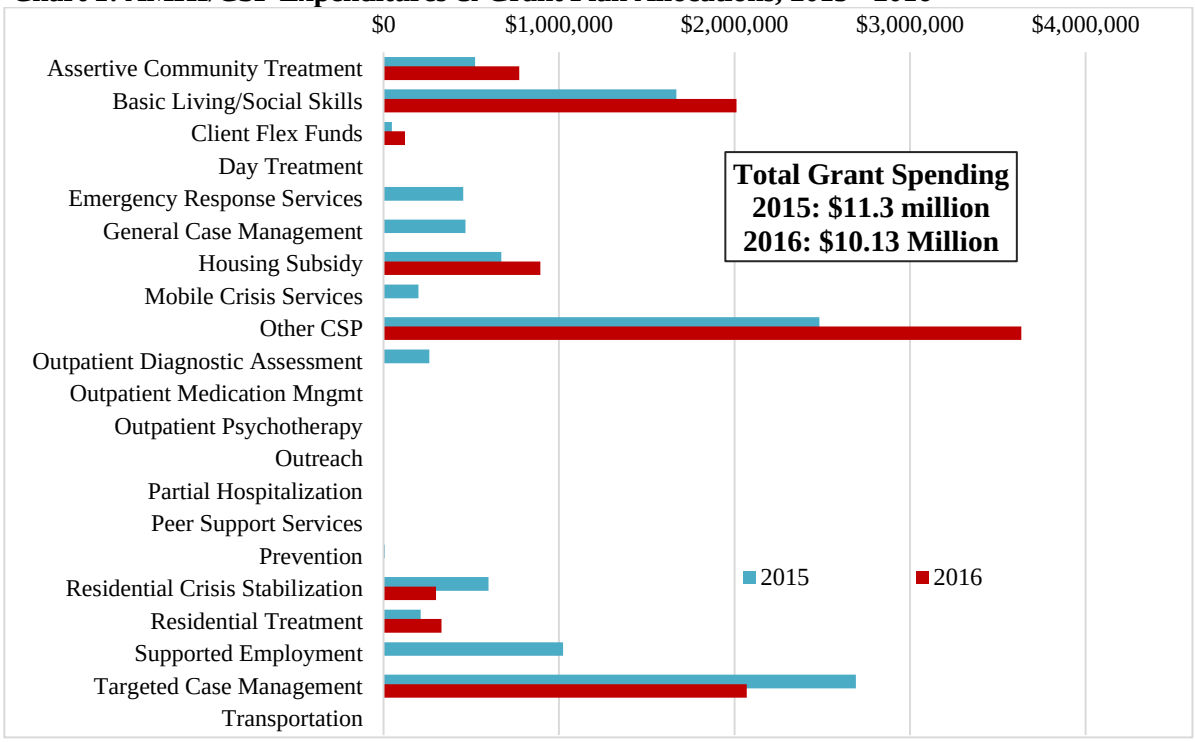
Regional Profile: **Hennepin**

Mental Health Initiative Region 12 is comprised of Hennepin County (see map). In 2016, DHS awarded the region $10.26 million of CSP and AMHI dollars (see Chart 1), as well as $428,075 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 7,431 duplicated individuals across 8 service categories. In 2015, the region spent $11.3 million across 13 service categories. AMHI/CSP Grant dollars paid 30.9 percent of county expenses in eligible service categories (see Chart 2). Grant dollars were used to fund 10 outside providers with multiple sites and programs, as well as services provided by the county. In the first and second quarter of 2016, the county identified almost 2,900 unique individuals being served across 8 service categories.

Demographic Characteristics of Hennepin

Hennepin County is the most populated county in Minnesota with 1.2 million residents and approximately 940,000 adults. At any one time, approximately 6 percent or 56,500 adults in Hennepin County experience a serious mental illness. Hennepin County, as the largest and the most urban and diverse county in the state, has unique needs for a range of distinct populations and communities.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016

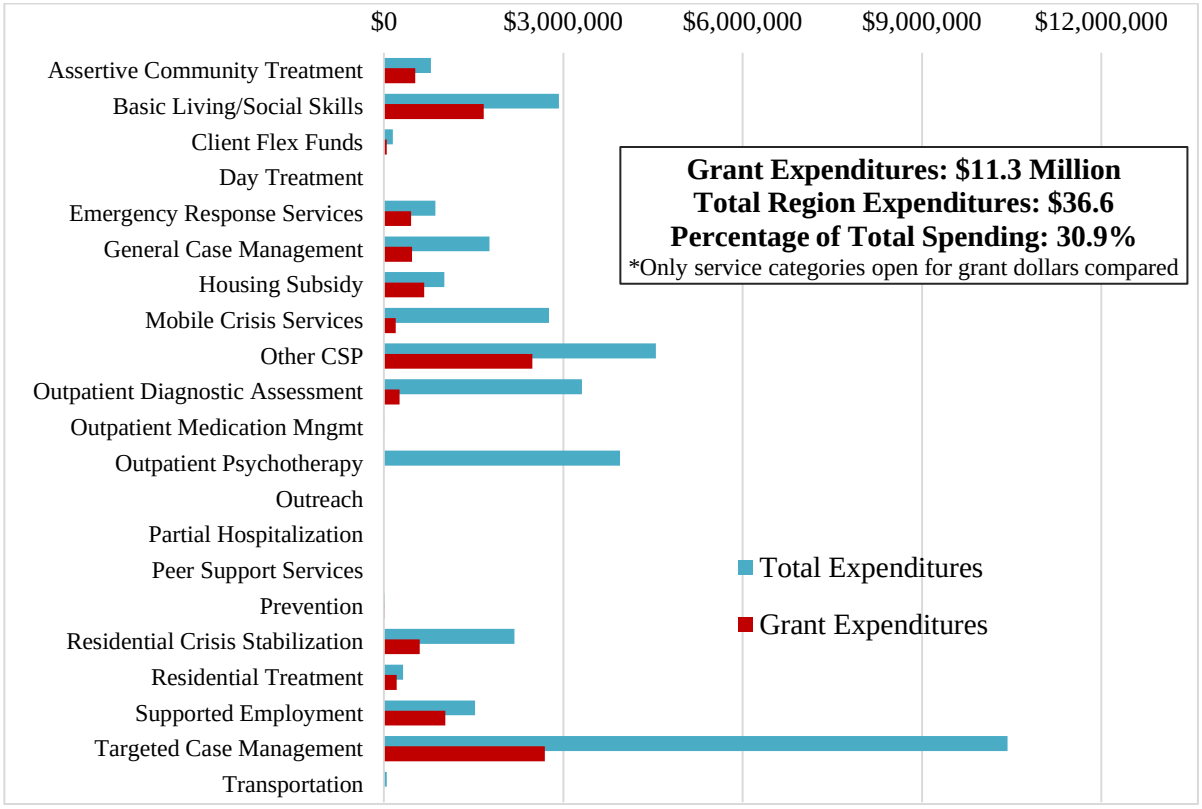


Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

The average county resident is 36.1 years old, with slightly more woman than men (51.3 percent compared to 48.7). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

In quarters 1 and 2 of 2016, the region provided services to 2,637 and 2,418 unique individuals respectively, or 2,899 people over six months. The majority of reported clients received Other CSP Services, Targeted Case Management, Housing Subsidies, Basic Living/Social Skills, and Assertive Community Treatment. Approximately half of clients received more than one type of service or services from more than one provider each quarter.

Chart 2: Hennepin Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

Mental Health Community Needs

Immigrant and Racial/Ethnic Groups: U.S. Census Bureau data shows an increasingly diverse population in Hennepin County, with 12.7% Black/African American, 7.4% Asian 6.9% Latino, 1.2 % Native American. 13.1 % of residents are documented as foreign born. Some of these groups, most notably Black/African Americans, are overrepresented among the homeless and in public mental health services.

Table 1: Demographic Differences between Hennepin AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**<u>918396</u>**	
18 - 19	0.4%	3.2%	*-2.8%*
20 - 34	19.8%	30.5%	*-10.7%*
35 - 54	42.1%	35.3%	*6.8%*
55 - 64	26.5%	15.7%	*10.8%*
65+	11.2%	15.3%	*-4.1%*
Sex			
Male	53.4%	48.7%	*4.7%*
Female	46.6%	51.3%	*-4.7%*
Race			
Asian	2.6%	6.6%	*-4.0%*
Black or African American	31.4%	11.9%	*19.5%*
Native American	0.2%	0.7%	*-0.5%*
Multiple Race	1.4%	3.6%	*-2.2%*
Other Race Alone	2.9%	2.4%	*0.5%*
White	61.4%	74.8%	*-13.4%*
Ethnicity			
Hispanic	2.1%	6.8%	*-4.7%*
Not Hispanic	97.8%	93.2%	*4.6%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

<u>Homeless and Persons in Segregated Settings:</u> Over half of chronic and episodically homeless persons have a serious mental illness and/or a substance use disorder. Hennepin and the entire metropolitan area are experiencing a severe shortage of affordable housing, which limits the options for permanent supportive housing for persons who could otherwise move out of segregated and more restrictive settings.

<u>Transition Age Young Adults:</u> Persons age 16-25 are considered a priority for Hennepin County as their needs for supported education, employment, and coordination with family require more intensive and integrated approaches for intervention and recovery support

<u>Justice Involved Individuals with Serious Mental Illness:</u> Although efforts have been under way for providing assessment and support to persons exiting the jail and workhouse, Hennepin County has identified persons with mental illness with low level offenses as a priority population that will benefit from jail diversion.

Service Structure

The governance and administration for ensuring the service array in MN Statutes 245.466 Subd. 2 is now tacitly shared among the County, health plans, the State, and community providers. Hennepin County administers and monitors some of the core community mental health services, such as CSP, case management/ACT and IRTS, crisis response, and supportive housing programs. Core community services such as CSPs and supportive housing) rely on AMHI and/or County for funding Hennepin County views

State operated/administered programs, managed care organizations, community hospitals, health provider networks, and outpatient clinics as an integral partners in the mental health system of care.

Barriers & Challenges to Providing Services

Hennepin County's large and diverse population requires an increase in capacity for almost every type of mental health service.

The County recognizes that each service type is challenged to ensure availability of culturally specific providers. The most critical gaps in services are noted below:

Medication Prescribers: The County and local hospitals and clinics continue to have a shortage of psychiatrists and Advanced Practice RNs. This impacts access to timely evaluation and treatment; it also affects the capacity of hospitals to offer more inpatient beds.

Housing and Employment: The shortage of affordable housing and tenancy supports is at a crisis level and is a barrier meeting Olmstead Plan goals of moving individuals from segregated settings to more community integrated settings such as permanent supported housing . Similar to housing, employment opportunities and supports also need to be increased.

Crisis residential and IRTS levels of care: Although the county has one crisis residential facility and several IRTS programs, there continues to be waiting lists for these services.

Treatment and Support Providers: The County and its providers continue to experience a shortage of mental health professionals and practitioners including culturally specific staff and staff trained (and compensated adequately) to work with individuals with complex medical and behavioral needs. New service development is now dependent on the ability to hire staff to provide the service.

RTC Beds: A long waiting list for the beds at AMRTC continues, contributing to a bottleneck for persons needing that level of care. Many residents are not receiving appropriate treatment as they wait for a regional treatment bed to become available.

GAPS ANALYSIS FOR HENNEPIN

Lead agencies for counties are asked every two years to provide information on perceived capacity & gaps in the county.

Top Barriers to Service

- Cultural Responsiveness of Service Providers
- Lack of Housing
- Requirements to Prove Eligibility

Top Service Gaps

- Psychiatric Prescribers
- Foster care
- Complex Needs w/Multiple diagnosis & Chronicity

Other Services Unavailable

Consumer-run Services; Crisis Assistance; MH Behavioral Aide; Respite Care (Crisis; Evening & Weekend; In Home; Out of Home); Skills Training (Family; Individual); Transition Services for Youth

Other Services Short of Demand

Adult IRTS; MH Targeted Case Management; Adult Protection; ACT; Assistive Technology; Behavioral Programing; Bridges; Case Management; Certified Peer Specialists; Clubhouses; Crisis Stabilization (Residential); DBT; Drop-in Centers; Explanation of Findings; Family Support & Edu; Illness Management & Recovery; Independent Living Skills Training; Inpatient Psychiatry Beds; Integrated Dual Diagnosis Treatment; Integrated Primary Care w/BH; Medical Transportation; Medication Management; MH Diagnostic Assessment; MH Rehabilitative Services (ARMHS); Veteran MH Services; Correctional Setting MH Services; Non-Medical Transportation; Outreach; Permanent Supportive Housing; Physician Consultation, Evaluation & Management; Rehabilitative Services for TBI; Residential Habilitation (In-Home Family Support; Supported Living); Supported Employment; Transitional Supports; Treatment Services for Autism

Strategies & Successes to Meeting Community Needs

Hennepin County has several long term strategies in place to enhance the mental health service delivery system:

Housing, and Homeless Shelters: The County and community agencies are working to develop a comprehensive housing initiative that will increase the number of available housing units, standardize access to those units, document available housing, and provide tenancy support. We have hired a housing coordinator, developed contracts with several providers, developed policy and procedure and have begun to train providers on the procedures.

Criminal Justice Initiative: The County is currently working with the Department of Community Corrections to improve access to services for citizens with mental health issues who are involved in the criminal justice system. Hennepin has established access to mental health evaluation, medication management, and aftercare coordination for persons with co-occurring disorders at the jail. Jail diversion services and a Forensic ACT team will be added in early 2017.

Managed Care Collaboration: Due to the bifurcated system of payment for mental health services in Hennepin County, a task force has been developed to work with the managed care organizations serving Hennepin County residents. The task force has identified several areas of common concern between managed care and the County and we are looking at ways to work together to share the responsibility for managing the mental health system within Hennepin County.

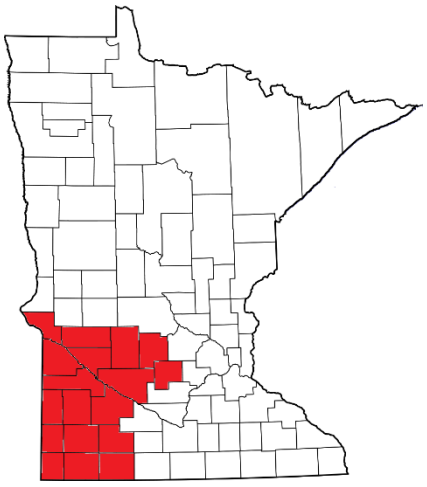
Transition Age Young Adults: Hennepin County developed a pilot project to serve transition age young adults in a more consistent and seamless manner. We have contracted with private TCM providers for dual case management with young adults transitioning from children's TCM. The young adults we transition are those with the most complex issues in out of home care. 90% of the young adults in this program chose to stay with case management as they worked toward recovery.

New Statewide Initiatives: Hennepin County utilizes AMHI/DHS meetings, the LAC, and an internal behavioral health leadership group to stay current with statewide initiatives that are underway. We will be exploring ways to support the First Episode work, Certified Community Behavioral Health Clinics, and Behavioral Health Homes.

Employment: Hennepin County has an Olmstead plan and attention to employment is on the implementation plan. Flexible funding will be essential as the plan is implemented.

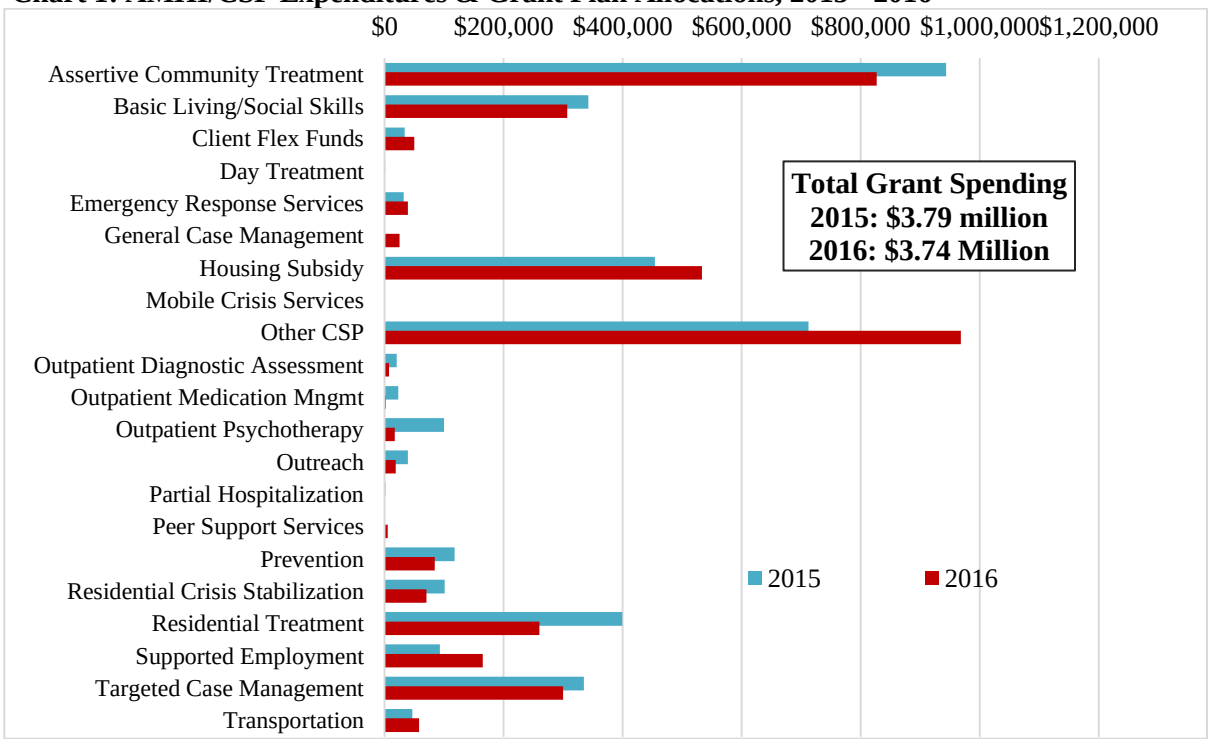
Other New Developments: The County is currently working with community providers to develop three IRTS programs and two crisis residential programs.

Regional Profile: **SW18**



Mental Health Initiative Region 13, SW18, is comprised of: Big Stone, Chippewa, Cottonwood, Jackson, Kandiyohi, Lac qui Parle, Lincoln, Lyon, McLeod, Meeker, Murray, Nobles, Pipestone, Redwood, Renville, Rock, Swift and Yellow Medicine County (see map), and also include the Upper Sioux and Lower Sioux Tribal Jurisdictions. In 2016, DHS awarded the region $3.74 million of CSP and AMHI dollars (see Chart 1), as well as $699,960 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the initiative and counties projected serving more than 4,766 duplicated individuals across 16 service categories (Prevention and Outreach excluded). In 2015, the region spent $3.79 million across 18 service categories. AMHI/CSP Grant dollars paid 32.8 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified 1,198 unique individuals being served across 16 service categories. An additional 300 unidentified individuals received services.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

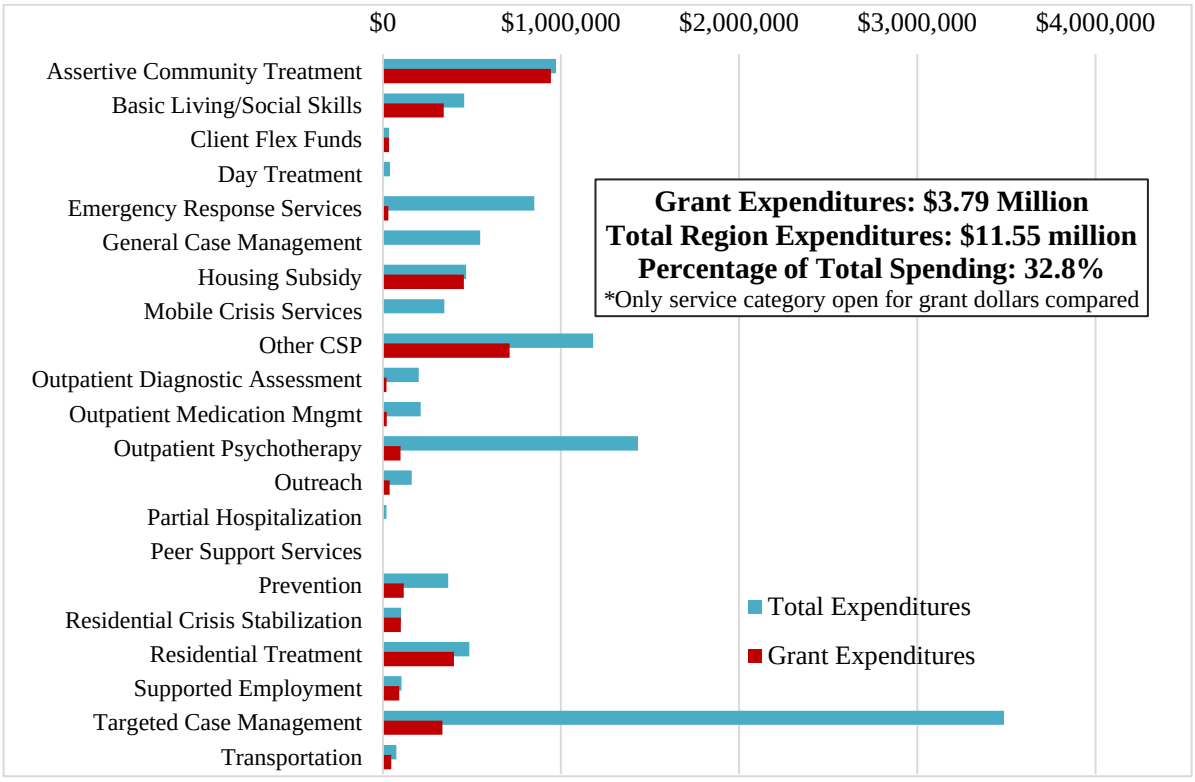
Regional Mental Health Community Needs and Service Structure

The total population for our region is 292,586. Located throughout the region are numerous small municipalities and four with a population greater than 10,000: Willmar (19,638), Hutchinson (14,200), Marshall (13,641), and Worthington (13,090). The majority of mental health resources are located in

these municipalities subsequently becoming regional service hubs. The 18 county area is approximately 17,000 square miles and primarily rural.

There are two Tribal communities in the SW18 region the Upper and Lower Sioux. SMAMHC does not provide services to these communities this has not been without effort. It is of understanding that services are provided internally in these communities with minimal assistance from the counties. There are areas of other ethnic backgrounds in the region such as the Micronesian in Chippewa County, Somalia in Kandiyohi County, as well as Asian and Hispanic in Lyon, Nobles, and Kandiyohi Counties.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

The average county resident is 43.1 years old, with slightly more men than women (50.4 percent compared to 49.6). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

In quarters 1 and 2 of 2016, the region provided services to 970 and 875 unique individuals respectively, or 1,198 people over six months. The majority of reported clients received Other CSP, Targeted Case Management, Assertive Community Treatment, and Adult Residential Crisis Stabilization services. Approximately one third of clients received more than one type of service or services from more than one provider each quarter.

Table 2: Demographic Differences between SW18 AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**213216**	
18 - 19	2.2%	3.2%	*-1.0%*
20 - 34	22.6%	22.1%	*0.5%*
35 - 54	41.5%	32.7%	*8.8%*
55 - 64	20.7%	17.8%	*2.9%*
65+	13.0%	24.2%	*-11.2%*
Sex			
Male	41.0%	49.6%	*-8.6%*
Female	59.0%	50.4%	*8.6%*
Race			
Asian	0.7%	1.5%	*-0.8%*
Black or African American	2.4%	1.4%	*1.0%*
Native American	0.2%	0.8%	*-0.6%*
Multiple Race	0.6%	1.2%	*-0.6%*
Other Race Alone	1.8%	2.1%	*-0.3%*
White	94.3%	93.1%	*1.2%*
Ethnicity			
Hispanic	5.7%	7.0%	*-1.3%*
Not Hispanic	94.3%	93.0%	*1.3%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Service Structure

SMAMHC has shared service contracts with Southwestern, Western and Woodland Centers, the three Regional Mental Health Centers and Prairie Community Services IRT program.

The contracts support Assertive Community Treatment, Adult Rehabilitative Mental Health Services, Intensive Residential Services, and Crisis Stabilization services.

SMAMHC is the provider entity for one of the four Assertive Community Treatment (ACT) team in the region. SMAMHC also operates a smaller Adult Rehabilitative Mental Health Service in Meeker, McLeod and Renville member counties. The program is frequently used as a "step-down" for one of the ACT teams.

Assertive Community Treatment (A.C.T.) Teams

- Southwinds A.C.T. Worthington (Cottonwood, Jackson, Nobles, Pipestone, Rock)
- Buffalo Ridge A.C.T. Marshall (Lincoln, Lyon, Murray, Redwood, Yellow Medicine)
- Tri-Star A.C.T. Cosmos (McLeod, Meeker, Renville)
- Western Plains A.C.T. Willmar/Montevideo (Big Stone, Chippewa, Kandiyohi, Lac Qui Parle, Swift)

Intensive Residential Treatment Services (IRTS)

- Unity House (Worthington): 10 beds (plus 1 Crisis Stabilization)
- Brentwood IRTS (Marshall): 10 beds (plus 1 Crisis Stabilization)

SMAMHC, in partnership with the Kandiyohi Housing and Redevelopment Authority, has approximately 75 housing slots for persons with mental illness. Services are available for those who are frequently not able to access housing assistance through traditional programs, including individuals that are homeless, have felonies, and/or poor rental and/or credit histories.

Each year dollars are allocated and distributed to member counties and partners for additional programs and services. These include:

- Supportive Employment
- Discretionary Funds
- Special Projects (training, support groups)

Barriers & Challenges to Providing Services

Service Shortage for Psychiatric Care

- Adequate and ready access to outpatient psychiatric care
- Access to inpatient psychiatric care and lack of long-term psychiatric care for those who need longer periods for stabilization
- Lack of prompt access to inpatient care on a voluntary basis
- Lack of easy access to Community Behavioral Health Hospitals. The admission criteria are restrictive and prohibitive.
- Services are not closer to consumers' homes.
- Law enforcement time spent in resolving mental health issues including time in emergency rooms and transport.

Housing:

- Housing options
- Housing to meet different acuity levels
- Housing or sex offenders and other criminal histories

GAPS ANALYSIS FOR SW18

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 3 or More Counties

• Geographic Location of Providers (75%)
• Access to Transportation (50%)
• Long Waiting Times for Services (42%)
• Lack of Service Availability on Short Notice (42%)

Top Service Gaps

Indicated by 3 or More Counties:

• Inpatient Adult Psychiatric Beds (42%)
• Psychiatric Prescribers (33%)
• Supported Employment (33%)
• Neuropsychological Services (25%)
• Adult IRTS (25%)

Other Services Identified as Unavailable or Short of Demand

Indicated by 10 Counties

Clubhouses; MH Court; Non-Medical Transportation; Treatment Services for Autism

Indicated by 9 Counties

Correctional Setting MH Services; Respite Care (Crisis)

Indicated by 8 Counties

Certified Peer Specialist Services, Consumer-run Services; Drop-in Centers; Residential Habilitation (In-Home Family Support); Respite Care (Out of Home); Medical Transportation; Projects for Assistance in Transition from Homelessness; Inpatient Psychiatrists; Respite Care (Evenings & Weekends); Treatment Services for Eating Disorders

Indicated by 7 Counties

Adult Day Treatment; Behavioral Programing; Complex Needs w/Multiple Diagnosis & Chronicity; Integrated Dual Diagnosis Treatment; Integrated PC w/BH; Mobile MH Crisis Response; Respite Care (In Home); Residential (Eating Disorders)

- Rule 36 type facility for folks who don't need IRT level of supervision but are not able to get along with less structure than AFC, board and lodge, or apartment with supports.
- Lack of adequate funds to meet emergent housing/crisis housing needs.

- Employment opportunities

Stable, meaningful, and more effective program to obtain employment. Working with Counties and Providers to educate and create a shift in philosophy about competitive employment. IPS in one part of the region has been very successful. Attitudes are changing about the ability to work in a competitive community job--both mental health and vocational providers as well as consumers themselves.

- Transportation for services, employment and social activities

There have been improvements made with transportation programs merging which has allowed for expansion of services.

- Other Areas
    - Consumer Support groups with educational components that are in close proximity to their location with a skilled facilitator
    - Peer mentoring programs

There are some CSP programs in the region who have drop in centers. Certified Peer Specialist training was provided by SMAMHC 2 years ago and ½ of participants are working or volunteer in that capacity. SW18 region did experience a Closure of an IRT facility in April of 2014. The provider indicated issues with staffing and the cost of keeping it open. This has effected the region in not having equal close access to IRT services in the region.

Strategies & Successes to Meeting Community Needs

Since the creation of the initiative it has been considered (and still is) a solid partner in building mental health services in the Southwest 18 counties. This regional design approach has worked in collaborative planning to build a continuum of community based services. The region is a strong provider of ACT, ARMHS, IRTS and housing for people living with mental illness in the SW 18 region:

- ACT services the Statewide average = 111.9 per 10,000 & SW18 = 199.0.
- ARMHS services the Statewide average = 15.9 per 10,000 & SW18 = 21.8
- Adult Residential Crisis Services the Statewide average = 4.7 per 10,000 & SW18 = 6.1.
- Mobile Mental Health Crisis Services the Statewide average = 1.1 per 10,000 & SW18 = 0.9.

Psychiatric Provider Recruitment: Providers are recruiting on an on-going basis. Providers are also, using APRN's and telemedicine to assist in meeting the psychiatry need.

Mobile Crisis Program: Southwestern Mental Health Center was the first to start a mobile crisis program in the region. They developed a framework and are now assisting Western and Woodland Mental Health Centers to adapt the framework to meet the needs in their area.

MH Center Collaboration: SMAMHC not only works closely with the counties but also the mental health centers have been and are integral partners in the services provided and developed in the region. They are the hub of the services provided to counties.

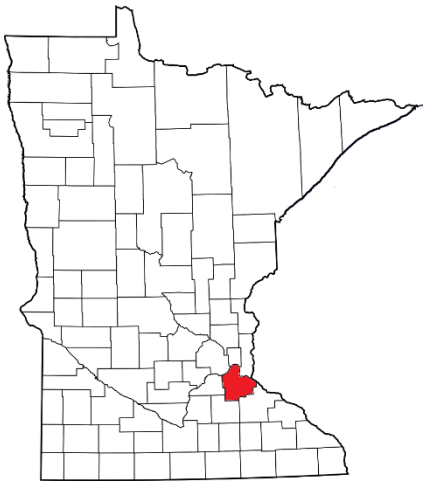
CIT Training: SMAMHC was instrumental in planning and setting up regional CIT trainings. SMAMHC is now working with the Mental Health Centers on continuing to be able to offer training when requests come in from law enforcement and jail administrators.

Housing: As mentioned above we have made progress on the unmet needs. One of areas of growth has been within the housing programs. SMAMHC has well established partnership with Kandiyohi Housing and Redevelop Authority. SMAMHC provides Bridges to Bridges which is a rental assistance program that enables person with serious and persistent mental illness to live in their communities with access to appropriate housing, treatment, support services and income supports through Bridges, Bridges RTC, and HUD Shelter + Care, as well as a SMAMHC funded Bridges to Bridges program. The Shelter Plus Care program is designed to assist person who have experienced chronic homelessness and are living with serious mental illness. SMAMHC has recently received a Housing Support grant from DHS. The grant is designed to provide supportive services for person with severe mental illness who are homeless, or exiting an institution who have complex needs and face high barriers to obtaining or maintaining housing.

The importance of flexibility has allowed the SW18 region to be creative in targeting local needs. Because of the partnerships, smaller and less populated counties have access to services that they would not be able to sustain. SMAMHC's primary goal is a continuum of care providing the "Right Service" at the "Right Time" in the "Right Place". This is achieved though the robust partnerships and collaboration built with the Counties and Providers in the region. The strategic goals SMAMHC continues to work toward include:

- To inspire, provide hope, empowerment and overall wellness.
- Reduce barriers to accessing services.
- Be recovery focused with RESPECT…RECOGNITION and RESPOND to needs in the region.
- Support Evidence Based Practices.
- Seek outcomes though data driven services.
- Advocate for needs and programs in the SW18 region at the State level.

Regional Profile: **Dakota**

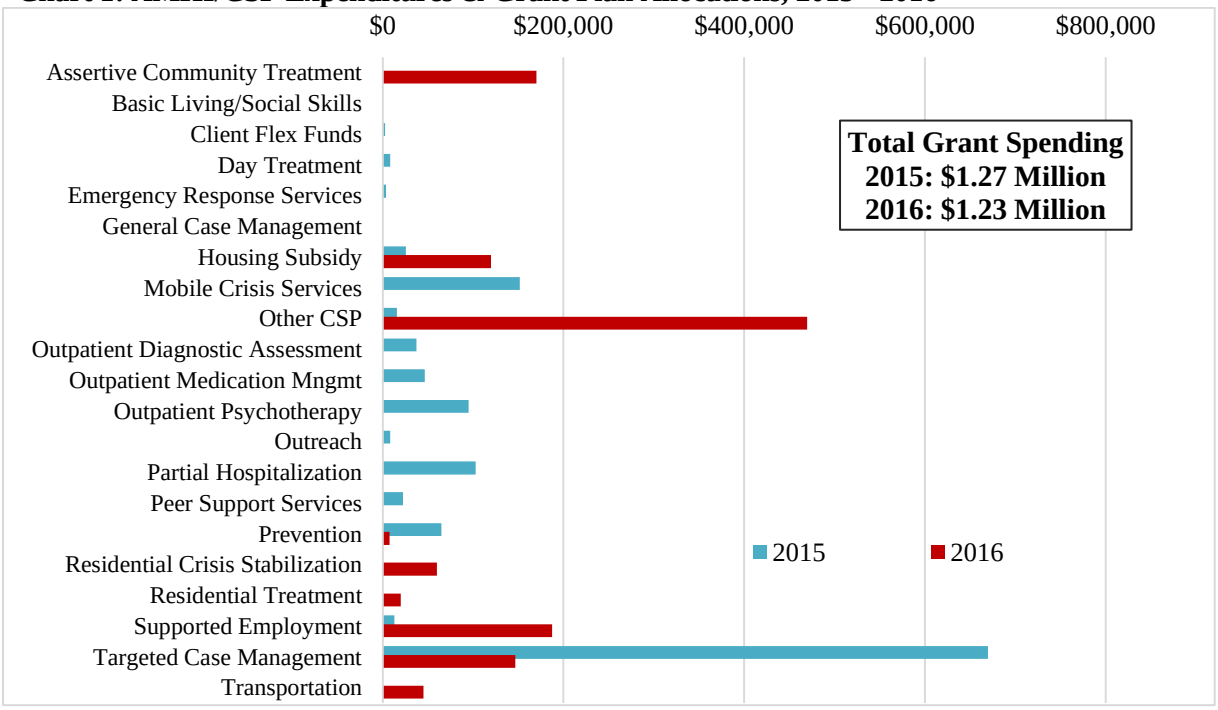


Mental Health Initiative Region 14 is comprised of Dakota County (see map). In 2016, DHS awarded the region $1.23 million of CSP and AMHI dollars (see Chart 1), as well as $159,730 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 794 duplicated individuals across 9 service categories. In 2015, the region spent $1.27 million across 16 service categories (Prevention and Outreach not included). AMHI/CSP Grant dollars paid 19.0 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified almost 366 unique individuals being served across 6 service categories, and about an additional 400 unidentified recipients.

Regional Mental Health Community Needs and Service Structure

Dakota County's 593 square miles are one-third urban, one-third suburban, and one-third rural. Between 2000 and 2010, Dakota County's population increased by 12 percent (reaching 398,552 people in the 2010 U.S. Census), maintaining Dakota County's status as the third most populous county in Minnesota.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016

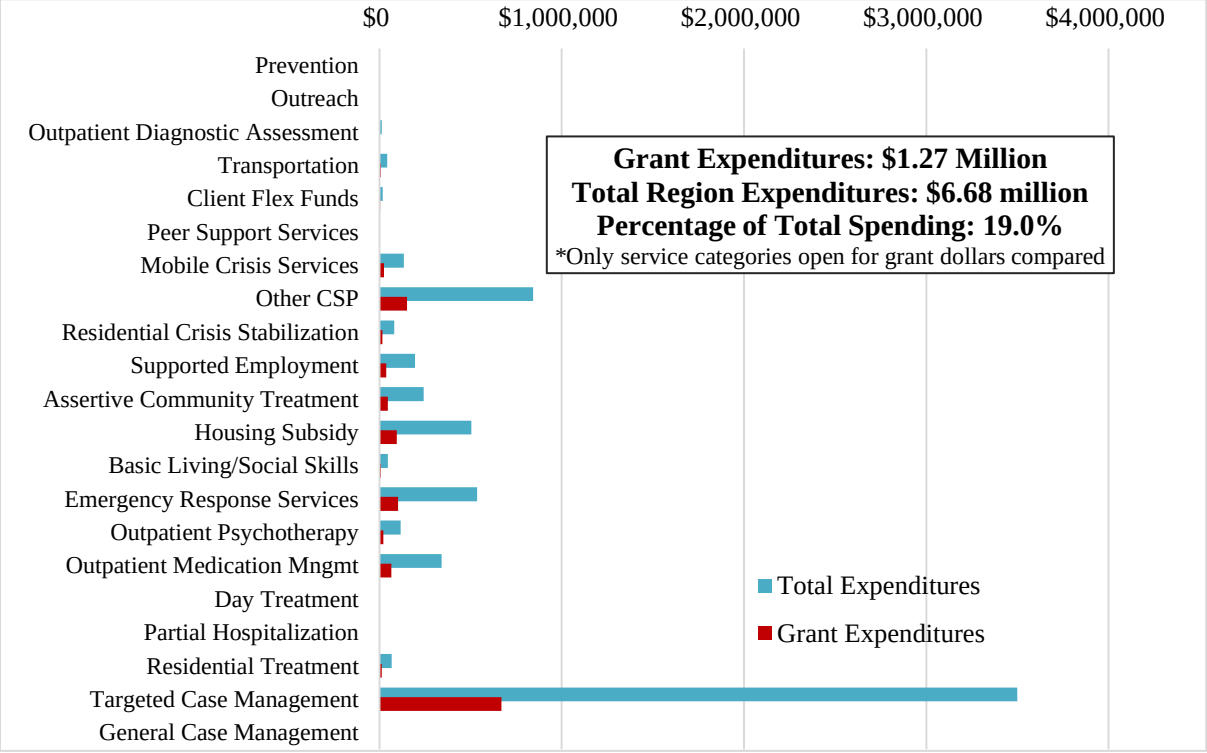


Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Since 2000, Census data show Dakota County's population has become more racially diverse, including both native- and foreign-born populations. In 2010, more than 59,000 people in Dakota County — almost 15 percent of the population —identified themselves in a racial group other than white alone, maintaining

Dakota County as the third-most diverse county in the metropolitan area after Ramsey and Hennepin. The average county resident is 37.3 years old, with slightly more women than men who are over 18 (51.5 percent compared with 48.5 percent).

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Table 1 shows County demographics (see Table 1). In quarters 1 and 2 of 2016, the region provided services to 267 and 255 unique individuals respectively, or 366 people over six months. An additional 336 unidentified individuals received Transportation, Other CSP, and Supported Employment services in quarter 1, and 448 in quarter 2.The majority of reported clients received Targeted Case Management, Other CSP, Adult Residential Crisis Stabilization, and Assertive Community Treatment services.

Dakota County's most recent Community Health Assessment process identified mental health as the top community health issue. Various community and professional groups are organized to address both the crisis and ongoing support needs of adults and youth who are impacted by mental illness and/or substance use disorder (SUD).

Service Structure

Dakota County's mental health system complies with the requirements of the Minnesota Comprehensive Adult Mental Health Services Act. The Act obliges county boards to develop and coordinate a system of affordable and locally available adult mental health services in accordance with Minnesota statutes. Dakota County meets service mandates through direct and purchased service delivery.

Table 2: Demographic Differences between Dakota AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**301908**	
18 - 19	1.6%	3.1%	*-1.5%*
20 - 34	27.9%	25.6%	*2.3%*
35 - 54	35.9%	39.9%	*-4.0%*
55 - 64	19.7%	16.4%	*3.3%*
65+	14.8%	14.9%	*-0.1%*
Sex			
Male	49.7%	48.5%	*1.2%*
Female	50.3%	51.5%	*-1.2%*
Race			
Asian	3.5%	4.5%	*-1.0%*
Black or African American	14.1%	5.1%	*9.0%*
Native American	0.0%	0.3%	*-0.3%*
Multiple Race	0.6%	2.9%	*-2.3%*
Other Race Alone	2.9%	2.7%	*0.2%*
White	78.9%	84.5%	*-5.6%*
Ethnicity			
Hispanic	4.7%	6.3%	*-1.6%*
Not Hispanic	95.3%	93.7%	*1.6%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

The Dakota County Initiative does not fund a community health center; most services are contracted through private providers. Annually, Dakota County's adult mental health Local Advisory Council (LAC) provides the county board a report on the mental health needs of adults residing in the county. County staff works closely with the LAC throughout the year to address service and system needs, gaps and strengths. This ongoing input and discussion informs service and system development.

Barriers & Challenges to Providing Services

- *Need to reduce stigma*, taking a community-based approach that includes working with children in schools, educators, local law enforcement, landlords, employers, and neighbors to promote inclusion of people with mental illness in community life and support earlier access to treatment and support. Efforts to address stigma, include: public awareness campaigns, through the local Public Health Department using the Make It OK and Mental Health First Aid curriculums, as well as Crisis Intervention Training for law enforcement.
- *Need for more community – based supports.* Specifically, in Dakota County there is a need for more individualized housing, employment, and peer supports. There are a number of home- and community-based options within the continuum but capacity in these programs is limited and, for the most part, payment and rate structures don't support growth and sustainability in services. There also is a need more community-based treatment options with broader eligibility and that are available on short-notice.

- *Need for services that respond to the diverse needs, experiences and worldviews* of the residents – In developing and expanding services, it is important to ensure services are flexible, open and culturally responsive, including a more holistic approach to wellness and recovery.
- *Parity in health insurance coverage for mental health and Substance Use Disorder Services* is a significant issue. Many services are covered for people in Minnesota with public health insurance coverage but most private and commercial plans don't have these as covered benefits leaving people with few options to access the right types of treatments and supports.
- *More opportunity for data sharing* to inform approaches to meeting the needs of people who cycle through systems: detox facilities, hospitals, emergency departments, jails, homeless shelters and/or who have repeated contacts with law enforcement. Through the Adult Detention Alternatives Initiative (ADAI) and other system collaborations there is opportunity to use data to develop services and system responses that better address root causes and needs.

Strategies & Successes to Meeting Community Needs

Working Together to Improve Services for People involved in the Criminal Justice System: Dakota County is focused on the needs of adults with mental illness who are involved with law enforcement, Community Corrections and the Dakota County jail. In 2015, the Dakota County Board signed on as a supporter of the national Stepping Up Initiative to reduce the number of adults with mental illness and co-occurring SUD in jails. Dakota County also developed a local Adult Detention Alternatives Initiative (ADAI) focused on expanding integrated services for people with mental health in the jail; reducing the number of people with mental illness who enter the jail; improving the identification of offenders with mental illness; and reducing length of stay for those individuals. In 2016, Dakota County hired a Coordinator for the ADAI and implemented a work plan. Dakota County also joined the White House Data Driven Justice Initiative. AMHI and CSP dollars support the continuum of services that provide alternatives to incarceration.

GAPS ANALYSIS FOR DAKOTA

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

• Eligibility Restrictions
• Lack of Housing
• Lack of Services Available on Short Notice or During Crisis

Top Service Gaps

• Crisis Stabilization - Residential
• Correctional Setting MH Services
• Supported Employment

Other Services Identified as Unavailable or Short of Demand

• Adult IRTS
• Behavioral Programing
• Bridges
• Certified Peer Specialists
• Clubhouse
• Complex needs with multiple diagnosis
• Consumer-run Services
• Foster Care
• Independent Living Skills Therapies & Training
• Inpatient Adult Psychiatry Beds
• Integrated Dual Diagnosis Treatment
• Integrated Primary Care w/BH
• Medical Transportation
• Medication Management
• MH Services for Veterans
• Mobile MH Crisis Response
• Neuropsychological Services
• Non-Medical Transportation
• Outreach
• Partial Hospitalization Program
• Permanent Supportive Housing
• Physicians the Perform MH Screening
• Prevention
• Prev./Early Intervention for Behavioral Health
• PATH
• Psychiatric Prescribers
• Psychiatrists Available for Inpatient Visits
• Rehabilitative Services for TBI
• Residential Habilitation (In Home Support)
• Respite Care (Crisis, Evening & Weekend, In Home, Out of Home)
• Transitional age services for youth
• Transitional Supports
• Treatment Services for Autism

Implementing Minnesota's Olmstead Plan: Dakota County has many efforts underway to improve access to integrated housing, employment, transportation, and education for people of all abilities. Dakota County has led the State in efforts to train the system on person-centered thinking and planning, incorporating these approaches into the case plans and approaches to engagement. At the community level, Dakota County meets monthly with city leadership and staff (administrators, police chiefs, housing code enforcement, and economic development) to create inclusive communities and address service demands on police and emergency medical response. Access to community-based crisis response services continues to be a highly valued service by the local law enforcement and city partners. AMHI and CSP dollars support the continuum of services that enable people to have choice in their housing, employment and community supports.

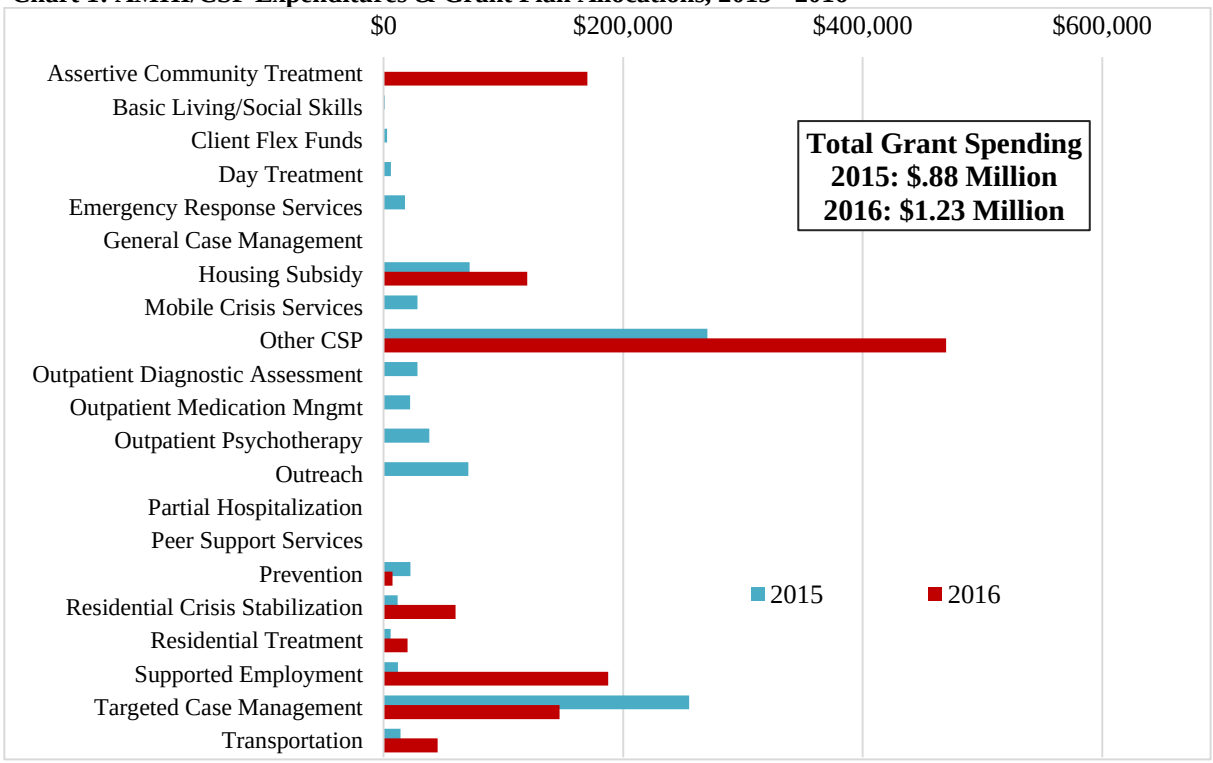
Partnering to Address the Housing Crisis: Access to affordable housing in Dakota County is currently a significant barrier to community living for all low-income populations, especially people with mental illness, criminal histories or other rental barriers. Dakota County's current vacancy rate is less than 1.7%. Dakota County has an active Affordable Housing Coalition that is working on strategies for supporting people in the tight rental market. Dakota County has also been working with community-based organizations to pilot innovative approaches to pairing landlord outreach with tenant support services. AMHI and CSP dollars enable people to secure and maintain community-based housing.

Partnerships with Public Health to Promote Education and Reduce Stigma: In Dakota County, there is a very active partnership between the Public Health and Social Services department to promote mental health education and awareness. The region partners on training activities, using the Mental Health First Aid and Make it Okay curriculums.

Regional Profile: **Scott/Carver**

Mental Health Initiative Region 15, Scott/Carver, is comprised of Scott and Carver County (see map), as well as Shakopee Mdewakanton Sioux Tribal jurisdiction. In 2016, DHS awarded the region $1.23 million of CSP and AMHI dollars (see Chart 1), as well as $686,030 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the initiative and counties projected serving more than 551 duplicated individuals across 10 service categories (Prevention and Outreach excluded). In 2015, the region spent $.88 million across 17 service categories. AMHI/CSP Grant dollars paid 17.1 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified 365 unique individuals being served across 7 service categories.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



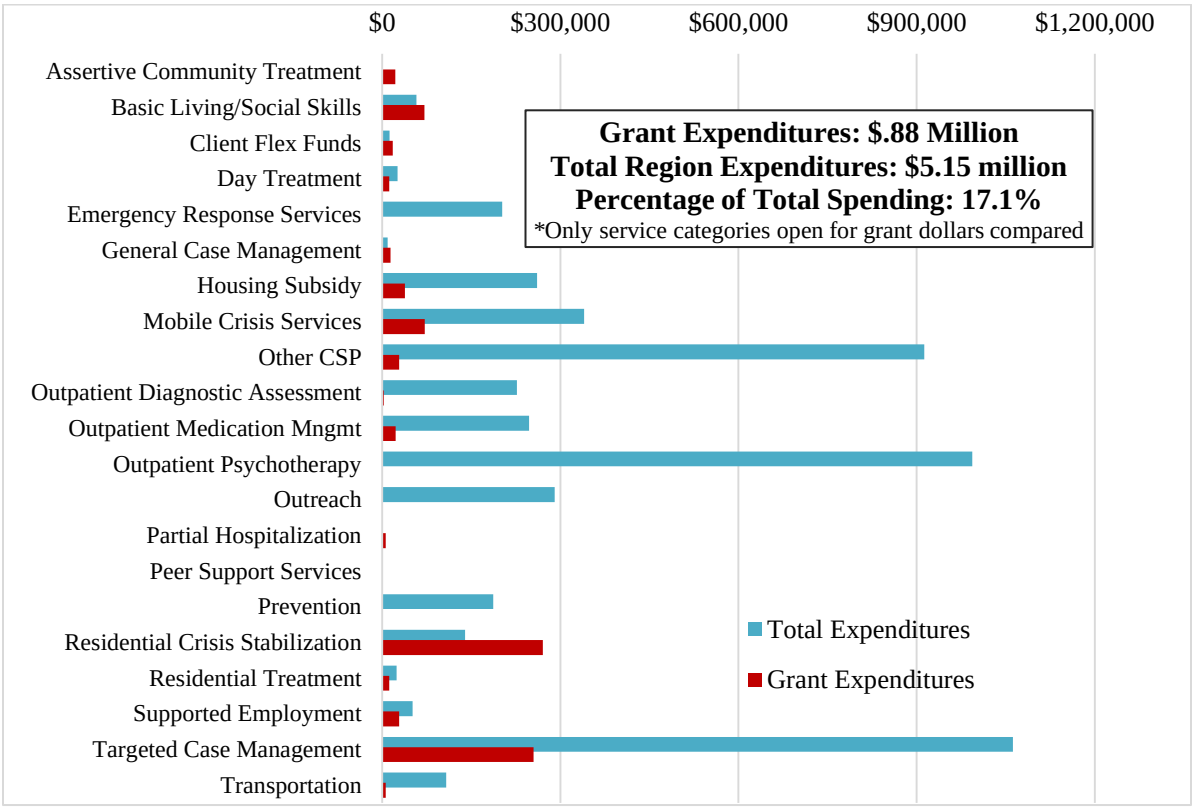
Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

While considered to be part of the Metropolitan service area, Scott and Carver counties both have rural cities. Approximately 89 percent of the population is white. The Mdewakanton Sioux tribe is located in Scott County, and does have a mental health center which tribe members operate. While the group has been active in the Scott County LAC, there is currently not representation on the AMHI. Carver County

expects to experience the highest population and household growth rate in the Metro Region into 2040, with an anticipated 76.9 percent change from 2010 to 2040.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

The average county resident is 36.1 years old, with slightly more women than men (50.7 percent compared to 49.3). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

In quarters 1 and 2 of 2016, the region provided services to 318 and 231 unique individuals respectively, or 365 people over six months. The majority of reported clients received Outreach, Transportation, Client Flex Funds, Other CSP, and Housing Subsidy services. Approximately one fourth of clients received more than one type of service or services from more than one provider each quarter.

Service Structure

A majority of the services within the Scott-Carver AMHI are provided directly by the counties. Scott and Carver County directly provide housing support using grant dollars for damage deposits, ongoing subsidies, application fees, and utilities. The primary funding source for housing subsidies include Section 8, Bridges Program, and HUD Permanent Support Housing (previously known as Shelter plus Care). We continue to have high numbers of people with serious and persistent mental illness who are homeless in both counties. The AMHI also directly provides client outreach services, other CSP services

for services such as Community Support Program activities, and adult mental health case management for those who do not have health insurance or are underinsured.

Table 2: Demographic Differences between Scott/Carver AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**162412**	
18 - 19	1.2%	3.4%	*-2.2%*
20 - 34	25.2%	24.3%	*0.9%*
35 - 54	38.6%	45.3%	*-6.7%*
55 - 64	24.8%	14.5%	*10.3%*
65+	10.2%	12.5%	*-2.3%*
Sex			
Male	45.8%	49.3%	*-3.5%*
Female	54.2%	50.7%	*3.5%*
Race			
Asian	1.8%	4.5%	*-2.7%*
Black or African American	5.7%	2.2%	*3.5%*
Native American	0.0%	0.5%	*-0.5%*
Multiple Race	3.1%	2.5%	*0.6%*
Other Race Alone	3.1%	1.5%	*1.6%*
White	86.3%	88.9%	*-2.6%*
Ethnicity			
Hispanic	0.8%	4.4%	*-3.6%*
Not Hispanic	99.2%	95.6%	*3.6%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Grant funding is used to provide support when there is no other funding source available. Employment services are provided by private agencies using grant dollars to fund services towards gaining competitive employment in the community. ARMHS services are provided through private providers, and Medical Assistance and PMAPS are billed. Grant dollars are only used if there no other funding source.

Barriers & Challenges to Providing Services

Transportation: The top barrier to services in both Scott and Carver Counties is transportation. Some communities in each county have limited to no access to public transportation. This is particularly of concern for those without Medical Assistance, who do not have access to transportation for necessary dental, medical, mental health services.

Inpatient Psychiatric Bed and IRTS Shortage: Currently, the AMHI has no inpatient psychiatric beds and no IRTS or crisis bed facilities within the geographic region. Clinicare is currently pursuing certification to open an IRTS in Carver County, in the city of Victoria. Additionally, Guild Incorporated has been awarded a grant to pursue opening an IRTS in Scott County.

St. Francis Hospital in Scott County has changed their assessment process in the emergency rooms, providing greater access to Allina inpatient mental health beds. In Carver County, the only hospital is

Ridgeview Medical Center. They have experienced an increase in wait times for people who need to be admitted to inpatient mental health units; at times a person will be admitted to the inpatient ICU until a psychiatric bed is located at another hospital.

Psychiatric Providers: Carver County is also experiencing a gap in psychiatric providers in the area, with one of the local providers declining to accept new patients who have Medicare or Medical Assistance plans. Carver County's mental health clinic is seeking to fill an open position for a psychiatric prescriber, with a current wait list for services in place.

Strategies & Successes to Meeting Community Needs

- *IRTS & Hospital Bed Development:* The AMHI has been working towards the development of IRTS and Crisis Bed programs within the geographical region for several years. Carver County anticipates the opening of the IRTS in Victoria soon. The groundwork is being laid for an IRTS and Crisis bed program within Scott County.
- *IPS Employment Services:* Both counties are working to provide Individual Placement and Supportive (IPS) employment services in this region. Guild Incorporated received a grant to provide IPS employment services within Scott County. Carver County has been working towards the development of IPS services and anticipates this service will be provided in 2017.
- *Drug Court:* In the fall of 2016, Scott County started a drug court, which is called Specialty Court, and operates as a problem solving court focusing on individuals with substance abuse issues.
- *Housing with Support:* Carver County Behavioral Health was awarded a grant to provide Housing with Support for Adults with Serious Mental Illness (HSASMI). Scott County has applied for round two of the HSASMI application.
- *Transportation:* Carver County is investigating opportunities to increase transportation options for those without Medical Assistance.

GAPS ANALYSIS FOR SCOTT/CARVER

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by Either County

- Long Waiting Times for Services (100%)
- Geographic Location to Providers (50%)
- Access to Transportation (50%)
- Long Waiting List for Waivers (50%)

Top Service Gaps

Indicated by Either County

- Inpatient Adult Psychiatry Beds (100%)
- Adult IRTS (100%)
- Psychiatric Prescribers (50%)
- Crisis Stabilization - Residential (50%)

Other Services Identified as Unavailable or Short of Demand

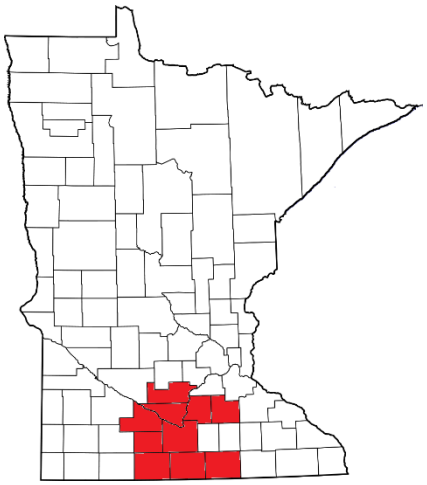
Indicated by Both Counties

Assertive Community Treatment; Certified Peer Specialist Services; Complex Needs w/Multiple Diagnosis & Chronicity; Foster Care; Illness Management & Recovery; Integrated Dual Diagnosis Treatment; Medication Management; MH Court; Mobile MH Crisis Response; Neuropsychological Services; Non-Medical Transportation; Permanent Supportive Housing; Inpatient Psychiatrists; Rehabilitative Services for TBI; Residential Habilitation; Respite Care (Crisis, Evenings & Weekend, Out of Home); Supported Employment; Transition Age Services for Youth.

Indicated by Either County

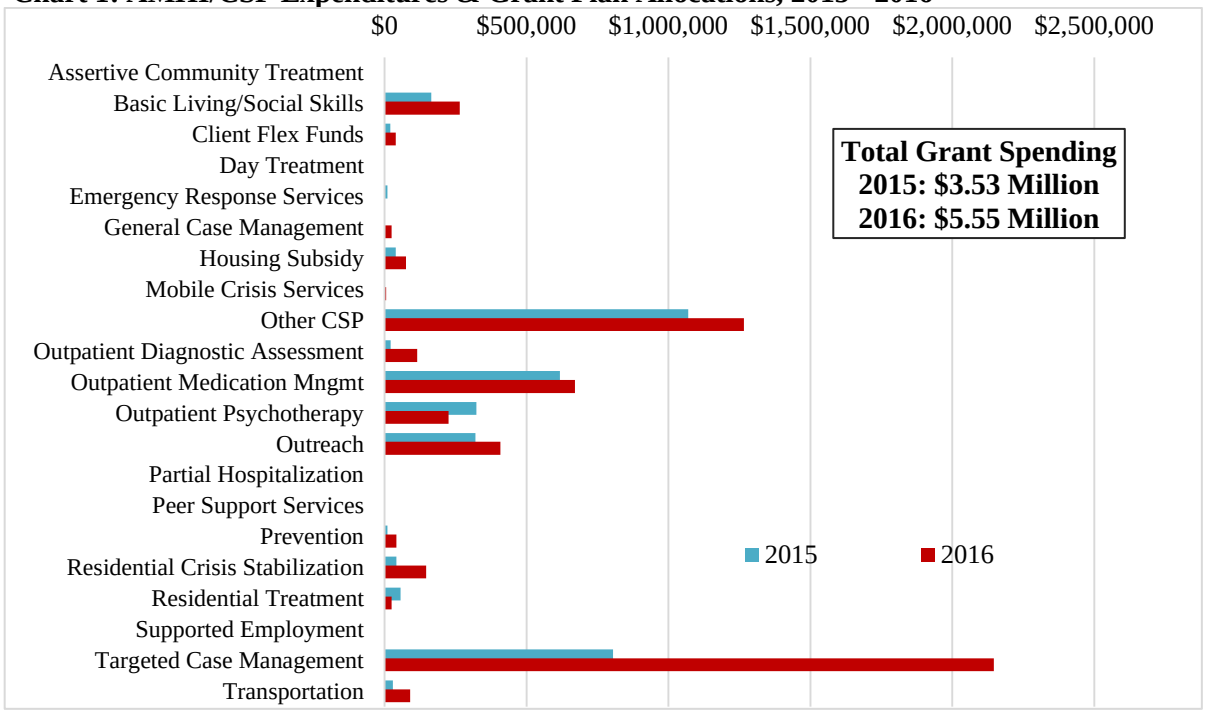
MH Targeted Case Management; Assistive Technology; Behavioral Programing; Bridges; Caregiver/Family Counseling; Caregiver/Family Training & Education; Clubhouses; Consumer-run Services; DBT; Drop-in Centers; Family Support & Edu; Integrated Primary Care w/BH; Medical Transportation; MH Diagnostic Assessment; ARMHS; MH Services for Veterans; Correctional Setting MH Services; Outreach; Prevention; Early Intervention for Behavioral & Cognitive Health; Problem Gambling Services; Projects for Assistance in Transition from Homelessness; Promotion; Psychological Testing; Psychotherapy (Group); Residential Treatment for Adults w/Eating Disorders; Respite Care (In Home); Transitional Supports; Treatment Services for Autism

Regional Profile: **SCCBI**



Mental Health Region 16 South Central Community Based Initiative (SCCBI) is comprised of Blue Earth, Brown, Faribault, Freeborn, LeSueur, Nicollet, Martin, Rice, Sibley, and Watonwan County (see map). In 2016, DHS awarded the region $5.5 million of CSP and AMHI dollars (see Chart 1), as well as $443,474 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 21,686 duplicated individuals across 13 service categories (Prevention and Outreach not included). In 2015, the region spent $3.5 million across 16 service categories. AMHI/CSP Grant dollars paid 27.6 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified 169 unique individuals being served across 4 service categories, and approximately 5,800 unidentified individuals in quarter 2 of 2016 across 14 service categories.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016

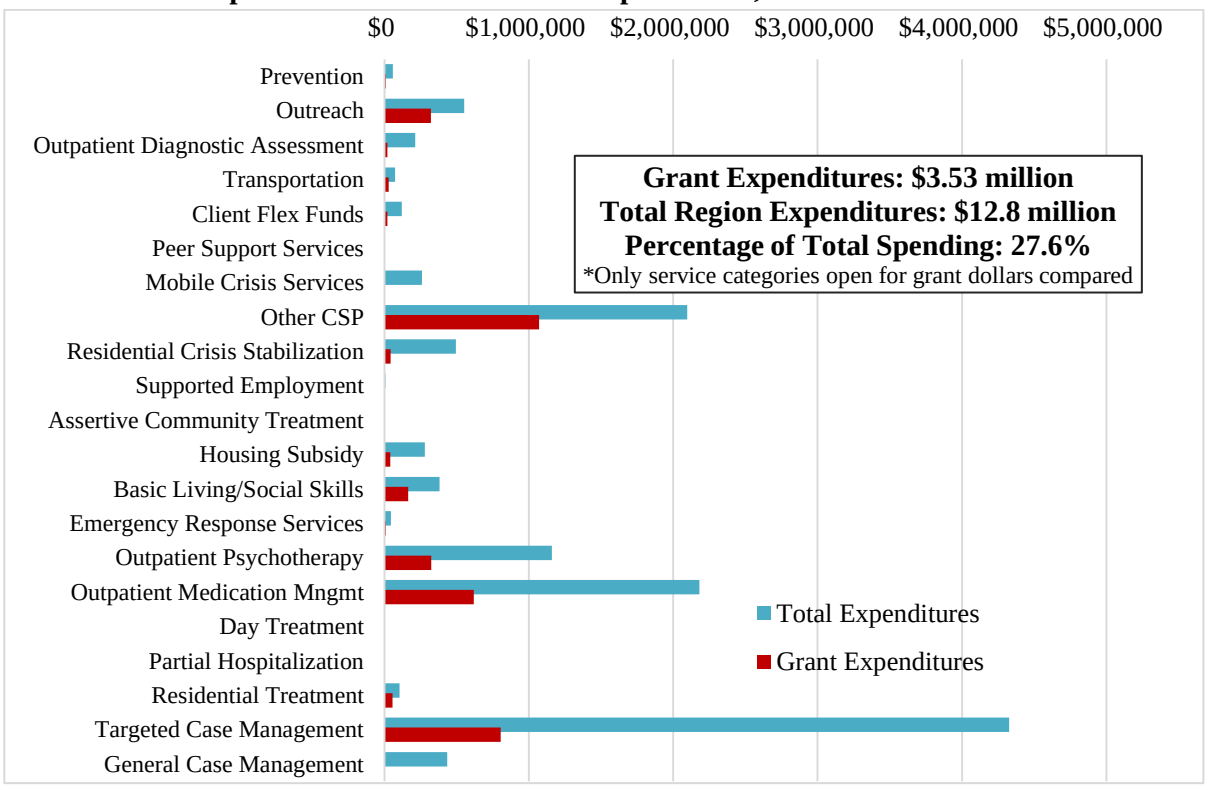


Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

Since the formulation of the AMHI, the 10 counties formulating the South Central Community Based Initiative have worked closely to regionally focus on gaps and barriers as they occur to come up with solutions. The scale of work on a regional level allows SCCBI to develop services that individual counties would not have the capacity to develop on their own. SCCBI is, 6,054 square miles, primarily rural. Here is the information related to ethnic diversity for the region's population of 308,176 as of 2013.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

The average county resident is 45.6 years old, with slightly more men than women (50.1 percent compared to 49.9). Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

In quarters 1 and 2 of 2016, the region provided services to 124 and 53 unique individuals respectively, or 169 people over six months. An additional 5,803 unidentified individuals also received services across 14 service categories. The majority of reported clients received Other CSP, Outreach, Client Flex Funds, Transportation, Medication Management, and Case Management Services.

Service Structure

The SCCBI region prides itself on years of strong public/private service partnerships. Within these 10 counties, there are nine county social/human services agencies that provide a variety of mental health related services and programming.

The SCCBI is governed by a Joint Powers Board, consisting of a Director from each county, a DHS liaison, and a Regional Mental Health Manager. The Regional Management Team, composed of a Mental Health Supervisor and a Consumer from each county as well as the Regional Mental Health Manager. Subcommittees, formulated as the need arises, are Consumer involved and at times Consumer led.

Table 2: Demographic Differences between SCCBI AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Rice/Nicollet Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**75636**	
18 - 19	0.6%	6.5%	*-5.9%*
20 - 34	33.1%	28.3%	*4.8%*
35 - 54	41.0%	33.1%	*7.9%*
55 - 64	19.9%	15.3%	*4.6%*
65+	5.4%	16.9%	*-11.5%*
Sex			
Male	48.2%	50.5%	*-2.3%*
Female	51.8%	49.5%	*2.3%*
Race			
Asian	3.2%	1.7%	*1.5%*
Black or African American	3.2%	3.2%	*0.0%*
Native American	0.0%	0.4%	*-0.4%*
Multiple Race	0.6%	1.6%	*-1.0%*
Other Race Alone	1.3%	1.8%	*-0.5%*
White	91.6%	91.4%	*0.2%*
Ethnicity			
Hispanic	2.4%	6.5%	*-4.1%*
Not Hispanic	97.6%	93.5%	*4.1%*

**Data excludes clients without demographic information available and the counties in SCCBI which did not provide client level data, in this case only Rice and Nicollet Counties reported identifiable individuals. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

There are three mental health centers directly connected to the Initiative infrastructure. Two of the Mental Health Centers are located within county Human Services buildings. The third is provided through a private agency.

There are numerous mental health center partners that maintain a strong connection to the Initiative via the Integrated Services Committee.

There is one Crisis Center located in the region. The Crisis Center provides a 12 bed Crisis Residential program, a Crisis Line, a Warm Line, and also is the facility out of which the 24 hour Mobile Crisis Program operates.

The region has 14 community hospitals, New Ulm Medical Center and Mayo Clinic Health System of Mankato, being the only with an adult behavioral health units. There are no inpatient behavioral health options for children. There are two Intensive Residential Treatment Services facilities located within the Region and one Community Behavioral Health Hospital (closing on November 7, 2015).

Barriers & Challenges to Providing Services

Transportation access continues to be a challenge as a majority of the region is rural. Most communities within the region have no access to public transportation. In addition, individuals often need to travel outside of their home community to access psychiatry, as the number of psychiatric providers within the region is limited. Case Managers often must utilize their time to drive Consumers to mental health related appointments. Counties report difficulty in maintaining MA-reimbursed volunteer drivers.

Inpatient Psychiatric Beds: There are 20 inpatient psychiatric beds (10 in New Ulm and 10 in Mankato) for the region's population, therefore, many hospitalizations take place in the metro, greater MN, even sometimes out of state.

Access to specialized programs, Dialectical Behavioral Therapy (DBT) for example, is also limited.

Housing: Housing is another challenge for the region. Not all counties in the region have GRH beds located within them, therefore individuals who need the support of a GRH are often forced to leave their community and natural supports in exchange for room and board. There is a need for increased permanent supportive housing options for individuals with mental illness within the region. Those that are offered are paired up with a requirement of long term homelessness, excluding others that would benefit from this level of support. In looking at longer term support options, waiver funding can be made available, however, the limited options available for housing supports and associated waiting lists, make obtaining placement difficult. The size of the region, and the miles that need to be covered by providers, make crisis intervention services difficult to provide. There is a need for support for people discharging from the AMRTC and CBHH facilities. The need for providers to participate in the care of these complex individuals, combined with the lack of a specialized workforce to meet this need, has extensively complicated and caused delay to the discharge planning process.

GAPS ANALYSIS FOR SCCBI

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 2 or More Counties

- Access to Transportation (89%)
- Geographic Location of Providers (44%)
- Lack of Housing (33%)
- Long Waiting Lists for Waiver (33%)
- Lack of Service Availability on Short Notice or During Crisis (33%)

Top Service Gaps

Indicated by 2 or More Counties:

- Inpatient Adult Psychiatry Beds (67%)
- Permanent Supportive Housing (56%)
- Psychiatric Prescribers (22%)
- Behavioral Programing (22%)
- Dialectical Behavioral Therapy (22%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

Assertive Community Treatment; MH Court; Non-Medical Transportation; Partial Hospitalization Program

Indicated by 8 Counties

Adult Day Treatment; Adult IRTS; Bridges; Foster Care; Correctional Settings MH Services; Inpatient Psychiatrists; Rehabilitative Services for TBI; Respite Care (In Home, Out of Home)

Indicated by 7 Counties

Medical Transportation; MH Services for Veterans; PATH; Consumer-run Services; Respite Care (Crisis; Evening & Weekend); Treatment Services for Autism

Indicated by 6 Counties

Residential Habilitation (In-Home Family Support; Supported Living); Complex Needs w/Multiple Diagnosis & Chronicity; Independent Living Skills Training; Integrated Primary Care w/BH; ARMHS; Psychiatric Consultations to PCP; Supported Employment

Strategies & Successes to Meeting Community Needs

The SCCBI region has had numerous successes over the years related to development of strategies to meet the specific needs of the region.

Horizon Homes South Central Crisis Center: A successful transition was able to take place allowing for privatization of the Crisis Center. This allowed the center to increase in bed size and decrease in cost. The facility is able to generate revenue to cover most of the cost by billing insurance for reimbursement. The Crisis Center is able to provide services, diverting close to 500 individuals on average per year from more restrictive alternatives (hospitalization, jail, detoxification services, etc.).

3 Community Mental Health Centers: The development and funding methodology support the psychiatric services for the three community-based sites.

Maintaining Community-Based Clubhouses: Communities have been able to maintain Clubhouse (also known as Consumer Resource Centers) sites locally, with over 670 participants per year across the region. Each site is able to utilize the participant's skills, abilities, and needs, combined with skilled staff supports, to develop a personalized site that best suits their population. Each clubhouse has tailored programming to provide training, support, and socialization. Consumers support each other, and in their promotion of socialization, decrease isolation and assist to keep one another out of the hospital and in the community.

ITV Telehealth Network: SCCBI pioneered in ITV services, and now has approximately 40 community-based sites for services. The ITV service has been able to lower the rate of 'no show' for appointments from the standard of 25% in publicly funded mental health centers, to 2-7%.

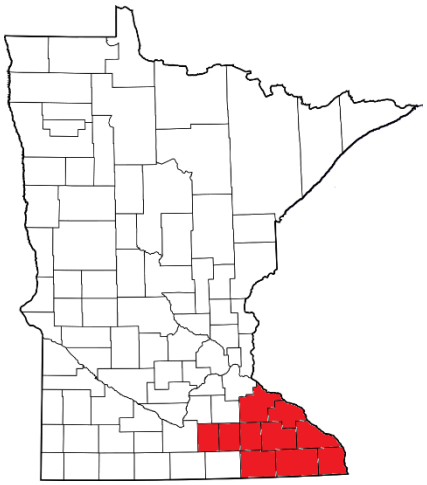
Consumer Stakeholder Meetings: Meetings that are self-directed by Consumers twice per year. The meetings, which have over 200 individuals in attendance per meeting, lessen stigma while increasing awareness and education around current mental health issues.

Flex Funding: Individualized funding to meet Consumer needs when there is an imminent risk of crisis. Funding is tied to services and supports that minimize the risk of a person entering a mental health crisis. Funding is customized to the individual's needs/goals.

Strong Consumer Leadership: Roles in Regional Management Team and various subcommittees support individuals in investing in their system of care as well as provide the AMHI with Consumer perspectives.

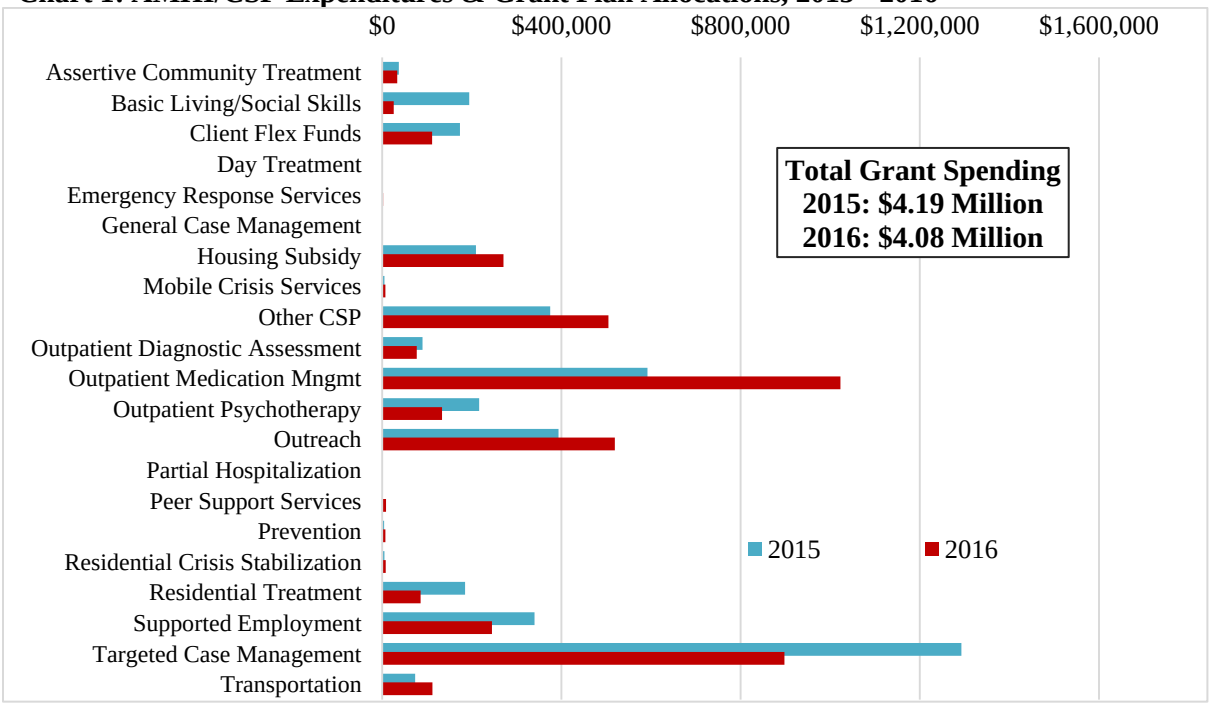
The SCCBI believes successes are due to the organizational structure based on regional needs, on a regional scale. The region continues to strategically support innovative, person-centered solutions with regional investments through collaborative planning utilizing evidence-based models. SCCBI succeeds because the 10 counties skilled leadership has strong partnerships with Consumers, treatment providers, hospitals, law enforcement, community collaborators, etc.

Regional Profile: **CREST**



Mental Health Region 17 CREST is comprised of Dodge, Fillmore, Goodhue, Houston, Mower, Olmsted, Steele, Wabasha, Waseca, and Winona County (see map), as well as Prairie Island Tribal Jurisdiction. In 2016, DHS awarded the region $4.08 million of CSP and AMHI dollars (see Chart 1), as well as $735,825 in adult crisis funding. In 2016 with AMHI/CSP grant dollars, the county projected serving more than 9,370 duplicated individuals across 17 service categories (Prevention and Outreach not included). In 2015, the region spent $4.19 million across 18 service categories. AMHI/CSP Grant dollars paid 37.7 percent of county expenses in eligible service categories (see Chart 2). In the first and second quarter of 2016, the county identified 1,610 unique individuals being served across 11 service categories, and approximately 250 unidentified individuals in quarter 2 of 2016 across 6 service categories.

Chart 1: AMHI/CSP Expenditures & Grant Plan Allocations, 2015 - 2016



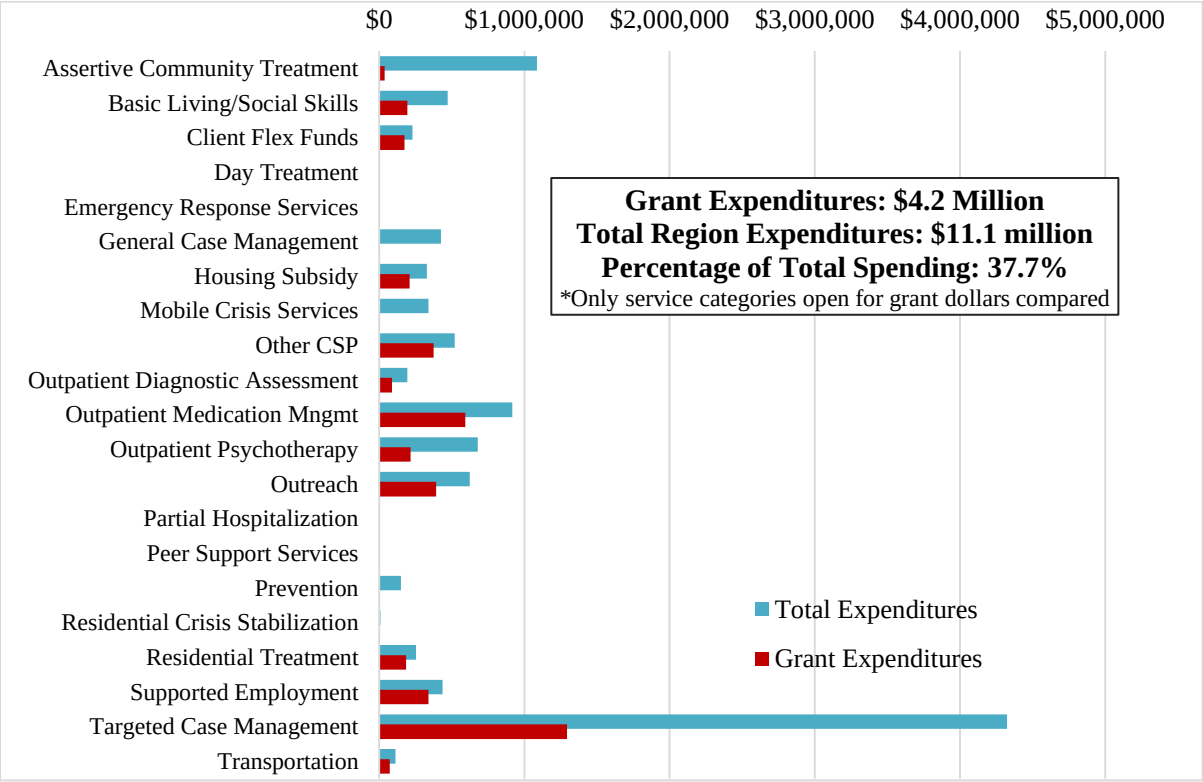
Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

CREST has ten counties in the SE corner of the state. Some of counties are quite rural (Houston, Fillmore, Dodge, Waseca, and Wabasha). Olmsted has the third largest city in the state, Rochester which is growing rapidly and the rest (Winona, Mower, Goodhue, and Steele) are a combination of rural areas with at least one large town.

The region has a significant Hispanic population in most counties. It also has Eastern Europeans populations in several of the counties and a quite large Somali population in both Olmsted and Steele counties. Special services have been developed for these populations and eight counties have some bi-lingual staff.

Chart 2: Grant Expenditures Relative to Total Expenditures, 2015



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

In recent years, there has been a larger proportion of mental health consumers who are sicker, have more complicated diagnoses, and also have co-occurring physical health issues. These complicated clients require more services, take more time, and are frequently difficult to house.

The average county resident is 39.96 years old, with more women than men (51.3 percent compared to 48.7). Women are also served at a higher rate by grant funds, making up 57.4 percent of AMH grant service recipients. Table 1 shows the regions demographics compared to the identified clients and shows how the region is reaching various populations (see Table 1).

In quarters 1 and 2 of 2016, the region provided services to 1,379 and 1,160 unique individuals respectively, or 1,610 people over six months. An additional 250 and 266 unidentified individuals received services across 8 service categories in quarters 1 and 2. The majority of reported clients received Adult Outpatient Psychiatry, Targeted Case Management, Other CSP, Client Flex Funds, and Transportation services.

Table 2: Demographic Differences between CREST AMHI/CSP clients and total population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**320776**	
18 - 19	3.0%	3.6%	*-0.6%*
20 - 34	26.0%	25.3%	*0.7%*
35 - 54	39.6%	34.3%	*5.3%*
55 - 64	22.9%	16.8%	*6.1%*
65+	8.5%	20.0%	*-11.5%*
Sex			
Male	42.6%	48.7%	*-6.1%*
Female	57.4%	51.3%	*6.1%*
Race			
Asian	3.8%	2.7%	*1.1%*
Black or African American	5.7%	2.7%	*3.0%*
Native American	0.0%	0.3%	*-0.3%*
Multiple Race	0.8%	1.8%	*-1.0%*
Other Race Alone	0.8%	0.9%	*-0.1%*
White	88.9%	91.7%	*-2.8%*
Ethnicity			
Hispanic	4.1%	4.5%	*-0.4%*
Not Hispanic	95.9%	95.5%	*0.4%*

**Data excludes clients without demographic information available and counties that did not provide client level data. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Service Structure

All of the counties provide Targeted case management, some provided by the county and some contracted for with private providers in the community. The initiative also provides ARMHS services in all counties either thru the mental health centers or private providers. The region has two ACT teams in the region and four IRTS facilities, but only one CBHH centrally located in Rochester. It is very difficult to access due to the state shortage of inpatient beds and the CPA program controlled by the state. The region works closely with the three mental health centers, located in Winona, Rochester, and Owatonna. It works via a hub and spoke system that has developed over many years, with the eastern hub centered in Winona, the central hub centered in Rochester, and the western hub centered in Owatonna. Each hub has a mental health center.

The region is presently working on goals that include coordinating all counties in the mental health administration, budgeting, planning, and equal service opportunities for all clients. Regional supported housing facilities/programs have been developed that have been very successful. In addition regional training and regional strategic planning are held. Consumers are included in all the planning and in regular meetings. The initiative would like to recruit even more, at least a few from every county.

The region shares psychiatric providers to the extent possible and have a regional Mobile Crisis Team. This is a new program which continues to develop.

Barriers & Challenges to Providing Services

Transportation: One challenge faced is the ability to serve clients in very rural areas with no public transportation. Transportation is also an issue in towns as it is not readily available evenings, weekends, or holidays. The amount of transportation counties/regions can provide is very limited due to costs,

regulations, and liabilities. People we serve frequently have very low income and may not have a car or gas money.

Inpatient Beds: Another serious problem finding inpatient beds in a timely fashion when needed. This leads to problems of patients being stuck in emergency departments or jails for days, weeks, and occasionally months waiting for the hospital services they need.

Housing and Holding Very Ill and/or Aggressive Patients: Another difficulty is with very ill and/or aggressive patients that are not at hospital level of care but are too unstable to be safe for themselves or others to be in the community. They become very expensive clients for the counties to maintain if they cannot be moved out of the CBHH or Anoka or the Competency Restoration program. There is frequently no place for them to go.

Shortage of Housing: Housing that is safe and affordable also continues to be a challenge. There is very little available housing of any kind in rural communities. In the more populated areas cost and safety are factors of concern. Success has been experienced with supported housing with services but there is not enough.

Prescriber & Staff Shortage: We continue to have a shortage of prescribers and a shortage of staff to deliver needed services. This would include psychiatrists, mental health nurse practitioners, nurses, ARMHS, DBT, PCA, and home health aide staff.

Strategies & Successes to Meeting Community Needs

In the CREST region, all ten counties have used strategic planning for the previous three years, and a regional plan for the next three years is complete.

GAPS ANALYSIS FOR CREST

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

Indicated by 2 or More Counties

- Access to Transportation (75%)
- Geographic Location of Providers (50%)
- Lack of Housing (50%)
- Lack of Service Availability on Short Notice (50%)
- Long Waiting Times for Services (25%)

Top Service Gaps

Indicated by 2 or More Counties:

- Psychiatric Prescribers (63%)
- Inpatient Adult Psychiatry Beds (25%)
- Non-Medical Transportation (25%)
- Psychotherapy (Individual) (25%)
- Foster Care (25%)

Other Services Identified as Unavailable or Short of Demand

Indicated by All Counties

Adult IRTS; Partial Hospitalization Program

Indicated by 7 Counties

Assertive Community Treatment; Behavioral Programing; Integrated Dual Diagnosis Treatment; Medical Transportation; Mobile MH Crisis Response; Non-Medical Transportation; Permanent Supportive Housing; Residential Habilitation; Respite Care (Crisis)

Indicated by 6 Counties

Adult Day Treatment; MH Targeted Case Management; Bridges; Peer Specialists; Clubhouses; Consumer-run Services; Crisis Stabilization (Residential); Dialectical Behavioral Therapy; Drop-in Centers; Health & Behavior Assessment; Integrated Primary Care w/BH; Medication Management; MH Court; MH Diagnostic Assessment; Neuropsychological Services; Physician Consultation, Evaluation, & Management; Prevention; Early Intervention for Behavioral & Cognitive Health; PATH; Psychiatric Consultations to PCP; Psychological Testing; Psychotherapy (Group); Residential Treatment for Adults with Eating Disorders; Respite Care (Evening & Weekend; In Home; Out of Home); Transition Age Services for Youth

Housing: CREST addressed housing needs by forming a collaboration with the counties, MH providers, and building management agencies to build facilities with small individual apartments, and 24/7 supervision/services within. Homeless, at risk of homelessness, and those with eviction history benefit from this environment. Clients who live in these buildings have done well and work continues with landlords and other corporate providers to increase apartment availability for clients.

Bilingual Staff: Another initiative has been increasing bilingual staff available to serve our minority populations. The region has also conducted cultural sensitivity training and outreach to specialty communities, making services helpful and relevant.

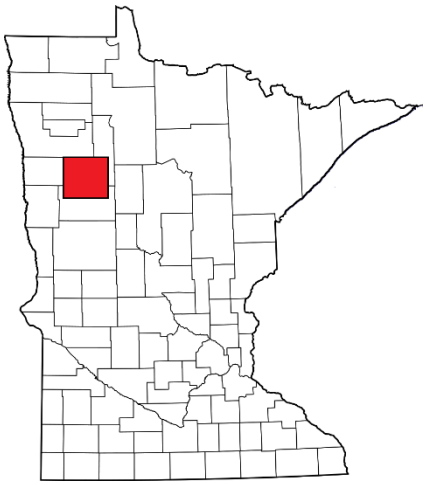
In-Reach Workers & Reduced ER Admissions: The initiative is working with local hospital emergency departments sharing an in-reach social worker to help address mental health issues for clients and/or family members. The social worker connects clients to services they may need in the community. In the Owatonna Community Hospital, this programs operation over 5 years has reduced ER admissions from approximately 949 a year to 207 a year.

Mobile Crisis Team & Regional Crisis Center: The Mobile Crisis Team, in its first year of delivering home services, already successfully providing services and increasing numbers of clients seen. In the future, the region is considering a regional crisis center that would include some crisis beds and 24/7 staffing, targeted case management designed for very high risk clients, and support services for family members with a loved one with mental health concerns. Funding is the challenge.

Prescriber Teams: Developing prescribing teams that include an MD, an NP, nurses and ancillary staff has extended the number of clients seen and the number of prescriptions provided.

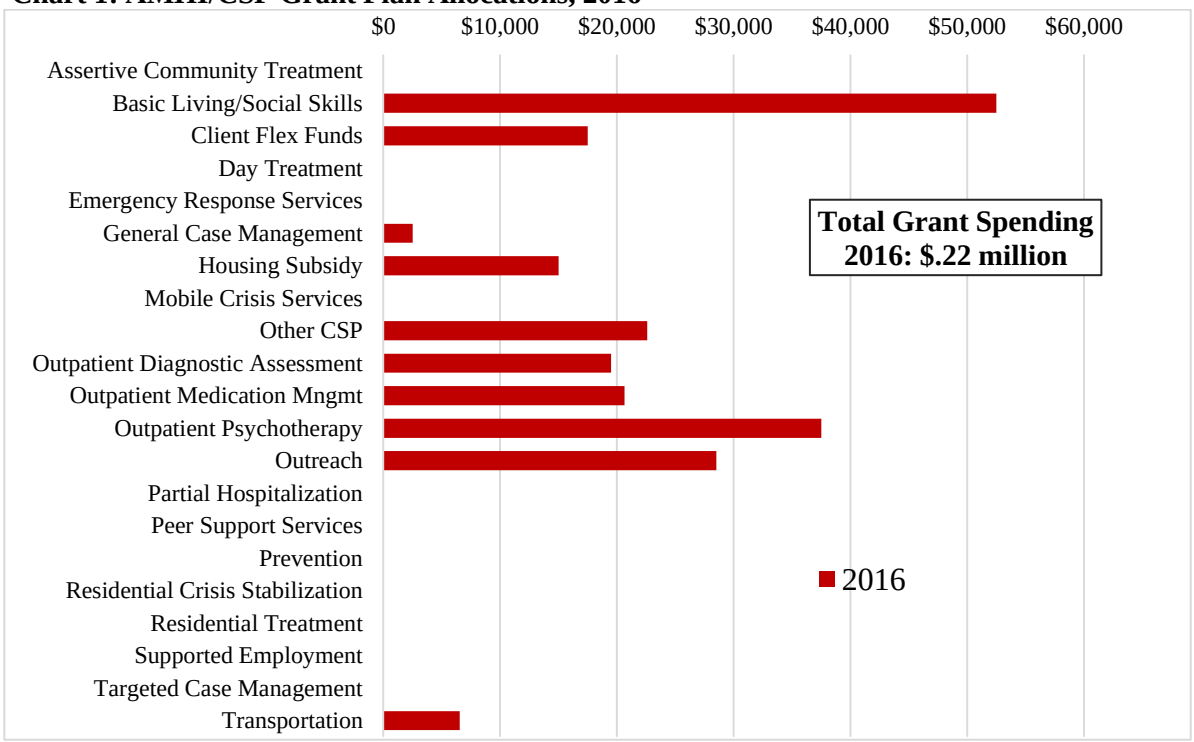
The initiative would like to expand all of these services, as the more the region operate from a regional perspective, the more services are provided at affordable costs. CREST provides many services, but still has many gaps that require additional state support and cooperation. Optimism describes what can be accomplished in the future with cooperative working relationships.

Regional Profile: **White Earth Nation**



Mental Health Initiative Region 18 is comprised of White Earth Nation (see map). In 2016, DHS awarded the region $1.1 million of CSP and AMHI dollars (see Chart 1). In 2016 with AMHI/CSP grant dollars, the county projected serving more than 810 duplicated individuals across 9 service categories. Grant dollars were used to fund more than 11 outside providers. In the first and second quarter of 2016, the county identified 212 unique individuals being served across 10 service categories.

Chart 1: AMHI/CSP Grant Plan Allocations, 2016



Source: Department of Human Services (DHS), Adult Mental Health Grant Application, 2016; DHS, SEAGR Expenditure data.
Note: 2016 amount awarded may differ from grant application totals if funds were awarded after application complete.

Regional Mental Health Community Needs and Service Structure

White Earth nation has a population of approximately 9,919 individuals living on reservation, with additional band members living across Minnesota. The reservation is 1,093 square miles with a population density of approximately 9.1 people per square miles. Located in northwestern Minnesota, the reservation includes all of Mahnomen County, as well as parts of Becker and Clearwater County. The average county resident is 37.4 years old, with slightly more men than women who are over 18 (40.7 percent compared with 49.3 percent). Despite more men than women, AMHI/CSP clients are 71.2 percent female and 28.8 percent male. Table 1 shows County demographics (see Table 1).

Individuals age 20 to 34 make up 43.2 percent of service recipients, despite being only 22.4 percent of the population in White Earth Nation. At the same time, individuals ages 55 to 65 make up 20.7 percent of the population, but are only 3.4 percent of recipients. Despite this, individuals over 65 make up approximately the same percentage of service recipients as population (22.7 percent and 21.7 percent). While race demographics look very different than race reported in client level data, this is likely attributable to differences in how Native American's are categorized in the AMHI/CSP data; as 83.3 percent are listed as "some other race alone."

In quarters 1 and 2 of 2016, the region provided services to 32 and 202 unique individuals respectively, or 212 people over six months. The majority of reported clients received adult outpatient psychotherapy, adult outpatient medication management, outreach, outpatient diagnostic assessment/psychological testing, or transportation services.

White Earth Nation contracts with individuals who provide care. The individual service providers offer individual services, as well as group activities. Some of the provided services include basic living and social skills training, mental health interventions, etc.

Table 1: Demographic Differences between White Earth Nation AMHI/CSP clients and WEN population, 2016

	AMHI/CSP Population (%)	Total Pop. Over 18 (%)	Difference (%)
Age (Over 18 Population)		**6888**	
18 - 19	2.8%	2.5%	*0.3%*
20 - 34	43.2%	22.4%	*20.8%*
35 - 54	27.8%	32.7%	*-4.9%*
55 - 64	3.4%	20.7%	*-17.3%*
65+	22.7%	21.7%	*1.0%*
Sex			
Male	28.8%	50.7%	*-21.9%*
Female	71.2%	49.3%	*21.9%*
Race			
Asian	0.0%	0.5%	*-0.5%*
Black or African American	0.0%	0.5%	*-0.5%*
Native American	1.4%	42.7%	*-41.3%*
Multiple Race	7.2%	8.7%	*-1.5%*
Other Race Alone	83.3%	0.6%	*82.7%*
White	8.0%	46.9%	*-38.9%*
Ethnicity			
Hispanic	1.4%	2.2%	*-0.8%*
Not Hispanic	98.6%	97.8%	*0.8%*

**Data excludes clients without demographic information available. American Communities Survey, 2014; Adult Mental Health Grant Data, Mental Health Division, Community Supports Administration, Department of Human Services, 2015-2016.*

Barriers, Challenges, and Solutions to Providing Services

Housing: One of the largest barriers is housing availability. Also, consumers' background checks frequently do not go through and limit options for how supportive funding can be used. Housing subsidy

funds have been used to increase access to rent/mortgage assistance, and provide deposits and utility assistance to consumers. These funds may be accessed faster than many other programs, providing quicker access to quality housing.

Rural Community: White Earth Nation is a rural location with the population spread over a large area. This makes providing many services, such as adult day treatment challenging, and also creates challenges to keep in touch with clients who are receiving care. For instance, case managers face difficulties keeping in contact with clients. Further compounding this issue is a lack of transportation across the region. The region has very little public transportation, although gas vouchers and transit cards are offered to many consumers.

Emergency Crisis Services: Through use of prevention and emergency response service funding, WEN is aiming to inform more residents of available services through advertising in the local paper, as well as increase the availability of crisis phone services on or near the White Earth nation.

Internet: Going forward WEN would like additional assistance establishing better access to internet in rural service areas. Expanded internet both benefits service providers when working with clients online, who cannot currently access real time data online, including when helping with housing, employment, or other services online with rural clients, as well as clients in rural areas, who would benefits from having internet in home to better receive care without traveling great distances.

GAPS ANALYSIS FOR WHITE EARTH

Lead agencies for counties are asked every two years to provide information on perceived capacity and gaps in the county.

Top Barriers to Service

- Geographic Location of Providers
- Long Waiting Times for Providers
- Stigma

Top Service Gaps

Indicated by 2 or More Counties:

- Inpatient Adult Psychiatry Beds
- Outreach
- Crisis Stabilization - Residential

Other Services Identified as Unavailable or Short of Demand

Adult Day Treatment; Adult IRTS; Adult Protection; Assertive Community Treatment; Behavioral Programming; Bridges; Caregiver/Family Training & Education; Case Management; Clubhouses; Complex Needs w/Multiple Diagnosis & Chronicity; Consumer Directed Community Supports; Consumer-run Services; Dialectical Behavioral Therapy; Drop-in Centers; Explanations of Findings; Family Support and Education; Foster Care; Health & Behavior Assessment; Illness Management & Recovery; Independent Living Skills Therapies & Training; Integrated Dual Diagnosis Treatment; Integrated Primary Care w/BH; Medical Transportation; Medication Management; MH Courts; MH Diagnostic Assessment; MH Services for Veterans; MH Services in Adult Corrections Setting; Neuropsychological Services; Non-Medical Transport; Partial Hospitalization Program; Permanent Supportive Housing; Physician Consultation, Evaluation, and Management; Prevention; Early Intervention for Behavioral & Cognitive Health; Problem Gambling Services; Promotion; Psychiatric Consultations to PCP; Psychiatric Prescribers; Inpatient Psychiatrists; Psychotherapy (Family, Group, Individual, Multi-family); Residential Habilitation (In-Home & Supported Living); Residential Treatment for Eating Disorders; Respite Care (Crisis, Evening & Weekend, In Home, Out of Home); Specialized Supplies & Equipment; Supported Employment; Transition Age Services for Youth; Transitional

C. Minnesota BRASS Codes

Counties budget and report spending for these grants, based on commonly defined services in Minnesota's Budgeting, Reporting and Accounting for Social Services (BRASS) codes.

Community Education and Prevention

Community Education and Prevention (referred to as Prevention) services are defined as "Activities designed to educate the general public or special high-risk target individuals and their families about problems associated with mental illness, chemical dependency, developmental disabilities, child welfare, or other social problems. The goals are to increase the understanding and acceptance of these problems, increase awareness of the availability of resources and services, and improve skills in dealing with the high-risk situations."

Specific services provided included:

- 1:1 Staff Time for Questions
- Advertisements & Public Relation Campaigns
- Community Events, Classes, Workshops
- Community literature & Printed Materials
- Community Support Groups
- Local Advisory Council Activities
- Staff Training
- Stakeholder Networking Activities
- Website

Client Outreach

Client Outreach (referred to as Outreach) services are defined as "Services designed to locate adults within the community who have or may have serious and persistent mental illness, inform them of available community support services, and assure that they have access to those services. These services must be provided as part of the county's community support program as described in the county mental health plan and approved by DHS."

Specific services provided included:

- ACCESS and other homeless outreach programs
- Adult In-reach worker
- Adult Outreach Worker/Staff Member
- Health fairs/local health center activities
- Incarcerated Individual Outreach
- MH Intake and Triage
- Needs & Eligibility Assessments

- Outreach Events & Activities
- Partnership Referrals for CSP services
- Targeted Advertising to SMI Individuals

Adult Outpatient Diagnostic Assessment/Psychological Testing

Adult Outpatient Diagnostic Assessment/Psychological Testing (referred to as Adult Outpatient Diagnostic Assessment) services are defined as "Diagnostic assessment of an adult including history, mental status, disposition, psychological testing and explanation of findings by physician/psychologist. This excludes diagnostic assessments provided as part of a day treatment or community support program, and those provided by staff of a residential or inpatient program."

Transportation

Transportation services are defined as "Provision of travel and escort to and from community resources and facilities."

Specific services provided included:

- Bus Passes
- Car Insurance Payments
- Car Repairs
- Contract Ride Business/Service
- Crisis Transportation
- Gas Vouchers
- Protected Transport
- Staff Drivers
- Taxi Vouchers
- Volunteer Drivers

Client Flex Funds

Client Flex Fund services are defined as "Non-housing related goods or services purchased on behalf of a client to meet basic physical, mental health or medical needs. Examples include medications, clothing and food."

Specific services provided included:

- Medications
- Transportation
- Clothing
- Food & Household Supplies

- LAC Stipends
- Utilities
- Life Skill Classes (parenting, fitness, food, CNA)
- Misc. Medical/Dental Expenses
- Other Misc. Living Expenses

Peer Support Services

Peer Support Services are defined as "Non-clinical, recovery-focused activities encouraging empowerment, self-determination, and decision-making provided by a Certified Peer Specialist."

Adult Mobile Crisis Services

Adult Mobile Crisis services are defined as "Face-to-face assessment of an adult who may be experiencing a mental health crisis or a mental health emergency and/or provision of crisis intervention services to a person with mental illness experiencing a mental health crisis or a mental health emergency."

Other Community Support Program Services

Other Community Support Program (referred to as Other CSP) services are defined as "Community-based services not otherwise classified which are provided or coordinated under the clinical supervision of a mental health professional and designed to help adults with serious mental illness to function in the community and remain in the community."

Specific services provided included:

- Chemical Wellness Programs
- Clubhouse/Drop-in Centers
- Community Education Programs & Scholarships
- Employment Support Services
- Group & Community Social Activities
- Housing Support Services
- Independent living skills training
- Jail Transitional Services
- Medication Monitoring
- Pre-Hospitalization Screening
- Public Benefit Application Support
- Rule 20 Discharge Planning
- Socialization Skill Building
- Wellness & In-home Visits, Daily Living Assist.

Adult Residential Crisis Stabilization

Adult Residential Crisis Stabilization services are defined as "Individualized services to restore the recipient to their prior functioning level provided immediately following a mental health crisis and as part of the treatment plan for this crisis."

Supported Employment

Supported Employment services are defined as "Systematic yet flexible support provided to persons with a serious mental illness to locate and maintain competitive employment in the community."

Assertive Community Treatment

Assertive Community Treatment (ACT) services are defined as "Intensive, non-residential mental health services provided by a multidisciplinary staff that uses a total team treatment model. This service is available for youth 16 - 21 and adults. The team for youth includes, at a minimum, a medication prescriber, a mental health professional with supervisory experience, a peer specialist and a Licensed Alcohol and Drug Counselor. The adult team includes, at a minimum, a psychiatrist, a mental health professional with supervisory experience, a registered nurse, and vocational and substance abuse specialists. ACT services are available 24 hours a day on a time-unlimited basis. ACT teams assume full responsibility for the clients mental health treatment, including crisis services, medication management, hospital admissions, and case management, in addition to providing psychosocial rehabilitative services."

Housing Subsidy

Housing Subsidy services are defined as "Direct payments for rent, utility costs, deposits on housing and utilities; household furnishings and supplies; or storage and moving costs."

Specific services provided included:

- Rent/mortgage assistance
- Damage Deposits
- Utility Assistance and Deposits
- Rental application fees
- Transitional/Emergency Housing Assistance

Basic Living/Social Skills and Community Intervention

Basic Living/Social Skills and Community Intervention services are defined as "Basic living/social skills and community intervention services provided to rehabilitate and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, including Adult Rehabilitative Mental Health Services (ARMHS) and other rehabilitative treatments, unless medication management."

Emergency Response Services

Emergency Response services are defined as "Response services available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, a mental health crisis, or emergency. Emergency response services include telephone hot lines and similar services."

Adult Outpatient Psychotherapy

Adult Outpatient Psychotherapy services are defined as "Psychotherapy provided by or under the clinical supervision of a mental health professional to an adult with mental illness. This service is provided outside of an inpatient or residential setting and excludes psychotherapeutic services provided as part of a day treatment or community support program."

Adult Outpatient Medication Management

Adult Outpatient Medication Management services are defined as "Prescription, medication education and review for an adult as a means of controlling or eliminating severe behavior problems, or the effects of mental illness. This excludes medication management services provided as part of a day treatment, community support program, and services provided by staff of a residential or inpatient program."

Adult Day Treatment

Adult Day Treatment services are defined as "A short-term structured program of group psychotherapy, rehabilitative mental health, and other intensive therapeutic services provided by a multidisciplinary team to reduce the effects of mental illness, promote recovery, and enable transition to a lower level of care in the community."

Partial Hospitalizations

Partial Hospitalizations services are defined as "A time-limited structured program consisting of multiple and intensive therapeutic services provided as an alternative or adjunct to inpatient hospitalization. It is provided in an outpatient hospital or facility or community mental health center by a multi-disciplinary staff to a client experiencing an acute episode of mental illness that meets the criteria for an inpatient hospital admission, but has the necessary and appropriate family and community resources to support the client's residence in the community during the treatment. Providers must be Medicare certified."

Adult Residential Treatment

Adult Residential Treatment services are defined as "A 24-hour residential treatment program under the clinical supervision of a mental health professional in a community residential setting, licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 (Rule 36) other than an acute care hospital or State-Operated Inpatient Treatment Center."

Adult Rule 79 Case Management

Adult Rule 79 Case Management services, also known and referred to as Targeted Case Management, are defined as "Activities that are coordinated with the community support services program to help adults with serious and persistent mental illness gain access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. These activities include developing a functional assessment, an individual community support plan, referring and assisting the client to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services."

Adult General Case Management

Adult General Case Management services are defined as "A systematic process of ongoing assessment, planning, referral, service coordination, and monitoring, consultation and advocacy through which multiple service needs of clients are addressed."