REPORT TO THE LEGISLATURE

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MENTAL HEALTH PROGRAM DIVISION
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HISTORICAL OVERVIEW

The recent history of Minnesota's mental health system has been marked by critical evaluation from a number of independent bodies and major corrective action by the 1987 Legislature. This history dates back to June 14, 1985, when Governor Perpich announced the formation of a Governor's Mental Health Commission. The Governor's Commission was charged with examining Minnesota's mental health system and making recommendations regarding:

1. the needs of the people;
2. state planning functions;
3. appropriate ways to deliver mental health services;
4. the structure of the existing delivery system;
5. the level of funding and how funding is directed;
6. the provision of community support programs across the state;
7. a consolidated funding approach; and
8. minimum statewide service standards for all counties and all providers of service.

The Commission was broadly representative of consumers, advocates, mental health providers, professional groups, county government, county social services, businesses and the Legislature.

On February 3, 1986, the Governor's Mental Health Commission released its reports entitled "Mandate for Action". The Commission concluded that "the system of mental health services in Minnesota can only be described as a nonsystem". The Commission further found that "to the extent that a system exists, it is not well understood by those within it or those intended to be served by it." Other findings were:

"1. There are inconsistencies among the three sectors and levels of government in terms of regulations, uniformity and flexibility."
"2. Responsibility is not well identified or fixed within either the sector or levels of government."
"3. Leadership is often cited as a problem. As with responsibility, it must exist in all sectors and within all levels of government."
"4. There is no unified philosophy, set of goals, or policy driving the mental health system."
"5. An array of services does exist within the state, but not in all parts or in all types of service."
"6. There is no ongoing, integrated method of ensuring accountability in all sectors and levels of government."
"7. Funding remains a problem in terms of stability and level of funding, and incentives and disincentives for certain programs and services."

In conclusion, the Governor's Mental Health Commission found that "the system is, to a significant extent, divided, inconsistent,

uncoordinated, undirected, unaccountable and without a unified direction."

In addition to the Governor's Commission findings, four other significant events regarding Minnesota's mental health system occurred during the early part of 1986.

First, in February 1986 the Program Evaluation Division of the Legislative Auditor's Office released a report regarding the coordination of care for people discharged from the state regional treatment centers to the community. The Legislative Auditor's Office found that significant numbers of persons were released from regional treatment centers without adequate discharge plans and community follow-up. The report highlighted the problem of excessive client to case manager staffing ratios which result in inadequate follow-up for persons with serious mental illness within the community.

Second, in March 1986 a national consumer research group released a report which compared and ranked state programs for the care and treatment of persons with serious and persistent mental illness. This report ranked Minnesota's system as 37th in the nation. While one could argue the exact ratings, it was clear that Minnesota had lost considerable ground in its mental health system and was no longer considered a leader.

Third, in response to the findings of the Governor's Mental Health Commission, the Legislative Auditor's Office, and the national consumer research group, the 1986 Legislature took action. Legislation was introduced and enacted (M.S. 245.69) to establish a mission statement for Minnesota's mental health system. Specifically, the mental health mission statement is as follows:

> "The Commissioner of Human Services shall create and ensure a unified accountable, comprehensive system of mental health services that:
>
> a. recognizes the right of people with mental illness to control their own lives as fully as possible;
>
> b. promotes the independence and safety of people with mental illness;
>
> c. reduces chronicity of mental illness;
>
> d. reduces abuse of people with mental illness;
>
> e. provides services designed to:
>
> 1. increase the level of functioning of people with mental illness or restore them to a previously held higher level of functioning,

2. stabilize individuals with mental illness;

3. prevent the development and deepening of mental illness;

4. support and assist individuals in resolving emotional problems that impede their functioning;

5. promote higher and more satisfying levels of emotional functioning, and

6. promote sound mental health; and

f. provide a quality of services that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.

The Commissioner shall implement the goals and objectives of this subdivision by February 15, 1990. By February 15, 1987, and annually after that until February 15, 1990, the Commissioner shall report to the Legislature on all steps taken and recommendations for full implementation and additional resources to further implement this subdivision."

Finally, in the summer of 1986, ten statewide hearings were held with the Governor and the Commissioner of Human Services for the purpose of giving the public an opportunity to come forward with their concerns regarding Minnesota's mental health system. These public hearings produced an overwhelming outpouring of concern from clients and their families about the gaps in services and lack of coordination within the system. It was at this point that Allyson Ashley was named Assistant Commissioner of Mental Health and charged with reshaping Minnesota's mental health system and reestablishing Minnesota as a leader in the nation.

1987 LEGISLATIVE ACCOMPLISHMENTS

The 1987 legislative session produced remarkable results regarding statewide mental health policy. The following is a brief summary of 1987 legislation related to mental health.

Comprehensive Mental Health Act: Chapter 403 (Sections 16-40 of H.F. 243):

The comprehensive mental health act requires counties to develop a complete array of services to people with mental illness. The act defines services that must be provided and sets forth the purpose of and date for establishing each service. New funding in the amount of $13,569,000 is provided. Existing funding mechanisms such as Rules 12 and 14 are used. Medical Assistance will fund case management.

Insurance -- Expanded Mental Health Coverage (Chapter 337):

As a part of other major changes in insurance coverage, this law expands the minimum mental health benefits which must be made available for group policies offered by insurance companies, nonprofit health service corporations and HMO's. In addition to payment for 80% of the cost of the first ten hours of treatment, carriers must now cover 75% of the cost of additional treatment which has been prior authorized up to a maximum of 30 additional hours in a twelve month period. Dependent coverage is also expanded.

Release of Mental Health Data to the protection and advocacy system (Chapter 236):

This law permits dissemination of data on individuals who are in residential treatment facilities to protection and advocacy systems established under P.L. 99-319.

Mental Health Focal Point Bill (Chapter 342):

This law establishes the Office of Assistant Commissioner of Mental Health and a Division of Mental Health. A state advisory council on mental health is created which is composed of 25 members appointed by the Governor with representation by advocacy organizations, providers, consumers, counties and others.

Ombudsman for Mental Health and Mental Retardation (Chapter 352):

The law establishes an Office of Ombudsman for Mental Health and Mental Retardation and defines the powers and duties of the ombudsman. Reporting of abuse and neglect to the ombudsman is required. An appropriation of $39,000 was made for the creation of this office.

Housing for Persons with Mental Illness (Chapter 197):

The law prohibits the licensing of supportive living residences until a study of the housing needs of people with mental illness has been completed.

Licensing of Social Workers (Chapter 347):

The law establishes a board of social work and provides the authority to regulate and license social workers. A board of mental health service providers is also created, to regulate all unlicensed providers of mental health care.

IMPLEMENTATION OF THE COMPREHENSIVE MENTAL HEALTH SERVICES ACT

State Mental Health Advisory Council

During the 1987 legislative session legislation was passed (Chapter 342) which established a State Mental Health Advisory

Council to provide broad oversight of Minnesota's mental health system. The Council was given the authority to advise the Commissioner of Human Services, the Legislature, and the Governor regarding the unmet needs, issues and funding of the statewide mental health delivery system. On September 23, 1987 the Governor appointed twenty five (25) members, as required by law to serve on the new Council. The Council is chaired by Norma Schleppegrell, the former Chair of the Governor's Mental Health Commission which was dissolved when the State Mental Health Advisory Council was created.

Local Mental Health Advisory Councils

The 1987 Comprehensive Mental Health Services Act (Chapter 403) requires each county to establish and appoint a local mental health advisory council which is composed of at least a mental health professional, a community support program representative, a family member and a consumer of mental health services. The local mental health advisory council shall include other members as necessary to represent the broad community interest of the county. The local mental health advisory council is responsible to participate in the development of the county mental health plan, identify unmet mental health needs and be involved in the ongoing process of county planning as it is related to mental health services.

Upon receipt of the first 87 county mental health plans, all counties have appointed a local mental health advisory council. For the most part, these councils comply with the specific requirements of the statute and the broader intent of the statute. Problems discovered upon early plan review include a few local mental health advisory councils with inadequate membership and direct linkages with county boards. Corrective requests will be made of identified counties not complying with the intent of the statute prior to county plan approval.

Unmet needs identified in the first set of county plans include (in order of magnitude):

- Education and Prevention Services
- Community Support Services
- Housing and Housing Support Services
- Case Management
- Emergency Services
- Employability
- Child/Adolescent Services

Education and Prevention Services

Statutory Requirement:

By July 1, 1988, county boards must provide or contract for education and prevention services to persons residing in the county. (Section 245.468)

Objectives:

The objectives of education and prevention services are:

1. To provide information regarding mental illness and treatment to the general public or special high risk target groups.

2. To increase understanding and acceptance of problems associated with mental illness.

3. To improve people's skills in dealing with high risk situations known to have an impact on people's mental health functioning.

4. To prevent the development or deepening of mental illness.

Early Plan Review Findings:

Upon early county plan review it was evident that many counties had inadequate education and prevention services available during 1986 and 1987. Most counties have made significant effort to plan for an array of education and prevention services to meet their local needs. The major problem identified is that some county targeted education and prevention activities have little relationship to mental health needs. Instead, they relate to general social service needs of the county. Corrective requests will be made of identified counties not complying with the intent of the statute prior to county plan approval.

Funding Mechanisms:

Funding for education and prevention services is available primarily from CSSA funds.

Emergency Services

Statutory Requirement:

By July 1, 1988, county boards must provide or contract for enough emergency services within the county to meet the needs of persons in the county who are experiencing an emotional crisis or mental illness. (Section 245.419)

Objectives:

The objectives of emergency services are:

1. To promote safety and emotional stability.

2. To minimize further deterioration.

3. To assist in obtaining ongoing care and treatment.

4. To prevent placement in settings that are more restrictive than necessary and appropriate to meet client needs.

Special emergency service requirements included in the statute include:

1. Toll free telephone access.

2. Clinical supervision by a mental health professional.

3. Availability of mental health professional for consultation within 30 minutes.

4. Sliding fee schedules permitted.

Early Plan Review Findings:

Upon early plan review it was evident that many counties did not have adequate emergency services available during 1986 and 1987. Most counties have made significant efforts to develop an emergency services system that utilizes hotlines provided by community mental health centers under contract with the county, acute care hospital settings, residential treatment settings, or county developed twenty four hour access in combination with the 911 system.

Funding Mechanisms:

Funding for emergency services uses a combination of Rule 14 (9535.0100 - 9535.1600) monies, CSSA monies, and third party or medical assistance (MA) reimbursement of face to face sessions. For the most part, counties put together these sources of funds to provide a grant to contract for this service or provide the service themselves. When county staff not affiliated with a Rule 29 (9520.0750 - 9520.0870) clinic or qualified at the mental health professional level provide face to face emergency services to individuals having third party or medical assistance coverage, funding must transfer to CSSA or Rule 14 dollars. Efforts will be made over the next 18 months to provide technical assistance to counties having this problem in order that all available funding from private third party carriers and the federal government in its share of medical assistance may be utilized. The impact of this activity is to preserve state and county mental health dollars for other mental health services

not covered by third party or medical assistance reimbursement.

Outpatient Services:

Statutory Requirement:

By July 1, 1988, county boards must provide or contract for enough outpatient services within the county to meet the needs of persons with mental illness residing in the county (Section 245.470).

Objectives:

The objectives of outpatient services are:

1. To provide diagnostic assessments.
2. To provide psychological testing.
3. To develop individual treatment plans.
4. To make referrals/recommendations regarding placements.
5. To provide ongoing treatment.
6. To provide medication management.
7. To prevent placements in settings that are more intensive, costly or restrictive than necessary and appropriate to meet client needs.

Special outpatient service requirements include:

1. Psychiatric consultation.
2. Licensed consulting psychologist (Ph.D) consultation.
3. Other multidisciplinary mental health professionals, as necessary.
4. Initial appointments within three weeks.
5. Sliding fee schedules.

Early Plan Review Findings:

Upon early plan review, it was evident that some counties did not have adequate outpatient services available during 1986 and 1987. In addition some counties report extremely low utilization often indicative of limited service accessibility or public knowledge regarding availability. Another finding was the low number of sessions per client projected in some

counties; i.e., as low as 2 sessions per client. National trends indicate an average of 6 to 10 sessions per client are more appropriate to proper treatment. Technical assistance will be provided to assess the reasons for the problems indicated in identified counties prior to plan approval.

Funding Mechanisms:

Funding for outpatient services is available from third party reimbursers, MA, GAMC, client fees and CSSA. It is critical that reimbursement be sought from all other sources prior to utilizing CSSA money in order to preserve state and county dollars for mental health activities not funded by other sources.

Community Support Services:

Statutory Requirement:

By July 1, 1988, county boards must provide or contract for sufficient community support services within the county to meet the needs of persons with serious and persistent mental illness residing in the county (Section 245.471).

Objectives:

The objectives of community supports services are to assist individuals with serious and persistent mental illness to:

1. Work in a regular or supported work environment.

2. Handle basic activities of daily living.

3. Participate in leisure time activities.

4. Set goals and establish plans.

5. Obtain and maintain appropriate living arrangements.

6. Reduce the use of more intensive, costly or restrictive placements in both the number of admissions and the length of stay as determined by client need.

A community support services program must include the following components:

1. Client outreach

2. Medication management

3. Assistance in independent living skills

4. Employability and supportive work opportunities.

5. Crisis assistance

6. Psychosocial rehabilitation

7. Assistance with government benefits

8. Help with living arrangements

9. Mental health professional clinical supervision

Prior to August 1987, only 47 counties received Rule 14 grants from the state to develop a community support services program. Much of the new 1987 mental health appropriation was allocated to fund the remaining 40 counties to develop community support services. By July 1, 1988, all counties will be provided Rule 14 funding to develop and maintain this service.

Early Plan Review Findings:

Upon early plan review, few problems were evident in the community support programs developed in most counties. In part this is due to the prior existence of this program in the 47 counties funded prior to August of 1987. The remaining 40 counties received considerable technical assistance from Mental Health Division staff between May and December 1987 in order to submit proposals to the state for Rule 14 funding in August and December. As the newly funded programs mature, problems in coordination among the full array of the subcomponents of this service will be resolved.

Funding Mechanisms:

Funding for community support programs is available from Rule 14, MA, GAMC, client fees, third party reimbursement, CSSA, and the Department of Jobs and Training. Each of these funding sources, other than Rule 14 and CSSA has strict requirements on which of the subcomponents of the community support service programs it will fund. Counties must put together all of these sources of revenue to develop an adequate community support service program. Ongoing technical assistance will be available to counties to assist them in gaining access to all potential sources of funds.

<u>Day Treatment</u>:

Statutory Requirement:

By July 1, 1989, day treatment must be developed as part of the community support program available to persons with serious and persistent mental illness residing in the county (Section 245.472). This requirement is waivable if counties can document that:

1. An alternative plan of care exists through the counties community support program for clients who would otherwise need day treatment services,

2. Day treatment, if included, would be duplicative of other components of the community support program, and

3. County demographics and geography make the provision of day treatment cost ineffective and unfeasible.

Early Plan Review Findings:

Upon early plan review, a number of small, sparsely populated rural counties requested a waiver from providing day treatment services. Waivers will be granted if adequate alternative community support program requirements are met.

Funding Mechanisms:

Funding for day treatment services is available through third party reimburers, MA, GAMC, client fees, Rule 14 and CSSA. Sources of funds from third parties, MA and GAMC, should be utilized prior to the use of CSSA and Rule 14 dollars. During the 1988 legislative session statutory language will be proposed to allow MA to fund day treatment in county contracted providers other than Rule 28 (9520.0010 - 9520.0230) approved community mental health centers. This expansion was intended during the 1987 legislative session and the money appropriated, however, the statutory provision to allow for this expansion was unintentionally lost during the session.

Residential Treatment:

Statutory Requirement:

By July 1, 1988, county boards must provide or contract for enough residential treatment services to meet the needs of all persons with mental illness residing in the county. Residential treatment services must be provided as close to the county as appropriate to client need. Residential treatment includes Rule 5 (9545.0900 - 9545.1090) facilities for children and adolescents and Rule 36 (9520.0500 - 9520.0690) facilities for adults.

Objectives:

The objectives of residential treatment are:

1. To prevent placements in settings that are more intensive, costly or restrictive than necessary and appropriate to meet client needs.

2. To help clients achieve the highest level of independent living.

3. To help clients gain the necessary skills to be referred to a community support program or outpatient service.

4. To stabilize crisis admissions.

In addition, residential treatment facilities must be licensed under Rule 36 (9520.0500 - 9520.0690) for adults or Rule 5 (9545.0900 - 9545.1090) for children and adolescents.

Early Plan Review Findings:

Upon early plan review it was evident that almost all counties utilize residential treatment services for both children/adolescents and adults. It was also evident that client lengths of stay in these facilities were excessive. It is hoped that adequate community support service programs, screening, case management and Mental Health Division technical assistance will lower client lengths of stay to more appropriate levels. It should be recognized, however, that in some areas this will occur only when affordable and suitable housing is available.

Funding Mechanisms:

The 1987 Legislature appropriated new Rule 12 (9535.2000 - 9535.3000) funds to develop three new Rule 36 facilities in rural areas of the state. The three new facilities have been approved and are under development in Bemidji, Moorhead and Marshall. In addition to Rule 12, funding is available from Title IV-E for children/adolescent residential treatment and from Minnesota Supplemental Assistance (MSA) and General Assistance (GA) for adult residential treatment. Funding is not available from MA or insurance for most residential treatment due to federal and private carrier restrictions.

Acute Care Hospital Inpatient Treatment

Statutory Requirement:

By July 1, 1988, county boards must make available through contract or direct provision enough acute care hospital inpatient treatment services as close to the county as possible to meet the needs of persons with mental illness residing in the county (Section 245.473).

Objectives:

The objectives of acute care hospital inpatient services are:

1. To stabilize the medical condition of people with acute or serious and persistent mental illness.

2. To improve functioning.

3. To facilitate appropriate referrals, follow up and placements.

All providers of acute care hospital inpatient treatment must be licensed as acute care hospitals and meet program licensure standards as developed by the Commissioner of Human Services.

Early Plan Review Findings:

Upon early review of county plans, all counties have been providing this service. In a number of counties, client utilization and client lengths of stay for this service are extremely high. Technical assistance will be provided during the upcoming year to assist identified counties in examining the reasons for the high client utilization and lengths of stay and to better develop alternative resources.

Funding Mechanisms:

Funding for acute care hospital inpatient services is available from third party reimburers, MA, GAMC, and client fees. At times counties must use CSSA dollars to fund the admission of individuals needing the service but not qualifying for other funding. This often occurs when clients are placed on 72 hour holds under the commitment act.

Regional Treatment Center Inpatient

Statutory Requirement:

By July 1, 1987, the Commissioner shall make sufficient regional treatment center inpatient services available to people with mental illness throughout the state (Section 245.474). Currently there are six regional treatment centers providing inpatient treatment for people with mental illness.

Objectives:

The objectives of regional treatment center inpatient treatment are:

1. To stabilize the medical condition of persons with mental illness.

2. To improve functioning.

3. To strengthen family and community support.

4. To facilitate appropriate discharge, aftercare, and follow up placements in the community.

In addition, regional treatment center inpatient treatment units must be licensed under Rule 36 (9520.0500 - 9520.0690) and the Commissioner must conduct biennial staffing studies to assess

the staffing needs of the mental illness units of the regional treatment centers.

Early Plan Review Findings:

Upon early plan review, all counties were utilizing regional treatment center inpatient treatment services for persons with mental illness. In some counties, both the number of admissions and the lengths of stay were excessive. Technical assistance will be provided throughout this year to both the counties and the regional treatment centers to examine the reasons for this finding and to develop alternative or more appropriate treatment.

Case Management

Statutory Requirement:

By January 1, 1989, the county board shall provide case management to all persons with serious and persistent mental illness.

Objectives:

The objectives of case management are:

1. To assist with access to needed medical, social, educational, vocational and other necessary services.

2. To obtain a diagnostic assessment.

3. To develop an individual community support plan.

4. To refer clients to services.

5. To coordinate services.

6. To monitor the delivery of services.

Early Plan Review Findings:

Upon early plan review, all counties are planning for the implementation of their case management system for 1989. Most counties are planning to directly provide this service. A few counties, however, are planning to contract with their community mental health center or community support services program for the provision of case management services. While some counties are currently providing some case management services, this is not a consistent finding throughout the state. A case management rule (Rule 74) is under development in order to comply with federal regulations on the use of medicaid monies. In addition, planning is underway for an invoicing system through the MMIS system and for amending Minnesota's state Medicaid plan to utilize federal funds for case management services.

Funding Mechanisms:

Funding for case management will be available through MA for MA eligible clients which will bring in approximately three million dollars of federal funding. Funding for non-MA eligible clients is available from Rule 14 (9535.0100 - 9535.1600) and CSSA. Efforts will be made to assist persons with serious and persistent mental illness eligible for SSI and SSDI to make proper applications and thereby maximize federal financial participation in Minnesota's mental health system.

Legislative Changes Needed:

During the 1988 legislative session, some clarifying language will be proposed to assure case management manpower availability, to better describe the relationship between case management and the community support services program and to assure federal approval of Minnesota's state Medicaid plan.

Screening

Statutory Requirement:

By January 1, 1989, the county board shall screen all persons before they may be admitted for treatment of mental illness to a residential treatment facility, an acute care hospital, or informally admitted to a regional treatment center if public funds are used to pay for the services (Section 245.476).

Objectives:

The objectives of screening are to:

1. Ensure admission is necessary.

2. Ensure that the length of stay is as short as possible consistent with client need.

3. Ensure assignment of a case manager to persons with serious and persistent mental illness.

Screening must be conducted by a mental health professional ten (10) days before admission or within 5 days of an emergency admission.

Early Plan Review Findings:

Upon early plan review, almost all counties are planning for the initiation of screening by January of 1989. Those counties which failed to develop a plan for this activity will be requested to do so prior to plan approval.

Funding Mechanisms:

Originally, funding for screening services was planned to be available from diversionary savings from unnecessary expensive treatment modalities. Upon closer examination, it is unlikely that diversionary savings will be made. Most psychiatric admissions to acute care hospital inpatient treatment and regional treatment center inpatient treatment are emergency admissions. Consequently, mental health professional screeners will need to be sent great distances to screen persons already admitted to facilities. This will be an enormously costly and cumbersome system. Therefore, during the 1988 legislative session, changes will be sought in this process. The proposed change will involve "screening" persons whose length of stay exceeds a specific number of days established for each treatment setting. This type of process will greatly reduce the overall number of screenings necessary and will focus screening on those situations where client lengths of stay exceed statewide and national norms. Efforts can then be directed at eliminating the causes of unnecessarily "long" admissions.

OTHER ACTIONS OF THE MENTAL HEALTH DIVISION TO IMPLEMENT THE COMPREHENSIVE MENTAL HEALTH SERVICES ACT:

1. Job descriptions were developed for ten new Mental Health Division positions, seven state funded and three federally funded. Of those, nine positions have been filled. The remaining position will be filled by the end of February 1988.

2. A uniform format was developed for the county mental health plan and the review of those plans has been coordinated with the Divisions of Social Services, Chemical Dependency, Deaf Services, the State Mental Health Advisory Council, regional treatment centers, the Mental Health Association, the Alliance for the Mentally Ill, the League of Women Voters and other advocates. The formal review of county mental health plans will take place during February 1988.

3. Ten workshops were held throughout the state to explain the Comprehensive Mental Health Services Act and the planning process. Nearly 800 people attended these training sessions including county staff, providers and advocates.

4. Individual technical assistance has been provided by the Mental Health Division upon request both by telephone and in person. Almost all counties have either called or met personally with Mental Health Division staff to discuss issues related to the development of mental health services required by the Comprehensive Mental Health Services Act.

5. Detailed county specific data was obtained for each county regarding the use of MA for mental health services and the use of state regional treatment centers and residential treatment. County specific mental illness incidence data utilizing the NIMH incidence studies was developed through a contract with the University of Minnesota. All available data was provided to each county to assist in their mental health planning.

6. Applications for federal block grants and Rule 12 and Rule 14 grants have been reviewed in light of the new mental health act.

   - Continuation and expansion grants were approved for 80 Rule 36 facilities.

   - New Rule 12 grants were approved for three new Rule 36 facilities.

   - Continuation and expansion grants were approved for 47 counties for Rule 14 community support programs.

   - New Rule 14 grants were approved for 18 counties, with grants for 18 more to be approved in January 1988.

7. A plan was developed for use of the new state appropriation for mental health special projects. (See later section of report.)

8. A contract was developed for a study of the housing needs of persons with mental illness. A report, with the Department's recommendations, will be available to the Legislature in February 1988. (See later section of report.)

9. Major steps have been taken in an intensive planning effort for a mental health information system in cooperation with the Information Management Resource Division.

10. A package of "clean up" legislative revisions have been prepared/drafted to the Comprehensive Mental Health Services Act for submission to the 1988 Legislature.

11. Grant applications have been prepared by the Mental Health Division and submitted to the National Institute of Mental Health and a private foundation for:

    A. A $396,000 federal National Institute of Mental Health block grant for mental health services to the homeless.

    B. A $600,000 grant from the Robert Wood Johnson Foundation for employability services, to be provided in cooperation with the Division of Rehabilitative Services. (Response expected in June 1988)

C. A $300,000 federal National Institute for Mental Health rural mental health services grant (approved).

12. Progress has been made on a study being done with the Residential Services Division regarding involuntary outpatient commitment, as requested by the Legislature. The study will be completed for presentation to the 1988 Legislature. (See later section of report)

STUDIES REQUIRED BY THE 1987 LEGISLATURE

The 1987 Legislature required three studies related to mental illness to be completed for the 1988 Legislature.

Housing

A study of the housing and housing support needs of persons with mental illness was completed for the Department by Ernst and Whinney. Study questionnaires were sent to consumers, family members, housing agencies, county social services, and mental health providers.

The Department's objective in this project was to have an independent expert study, evaluate and make recommendations on Minnesota's housing and residential treatment services to persons with serious and persistent mental illness.

A detailed study summary and recommendations have been completed and forwarded to the Legislature.

Diagnostic Related Groups: Inpatient Hospital Payment System for Mental Health

As required by 1987 session laws, Chapter 403, article 2, section 161, the Department is in the process of conducting a study and developing recommendations regarding alternative payment mechanisms for reimbursing hospitals for inpatient psychiatric care. Currently, rates are established by a system that is based on diagnosis related groups. Department staff have meet with program representatives of individual hospitals, staff of the Council of Community Hospitals, and a government liaison specialist for the Minnesota Psychiatric Society to gather input regarding the effects of the current rules on management and program/care.

The report will cover the history, rates methodology, incentives and effects of the current system. It will also discuss alternative payment systems and the effects of change.

A final report is expected in early to mid February 1988.

Outpatient Commitment

In July, 1987, the Commissioner of Human Services appointed a task force to examine issues related to Minnesota Statutes, Chapter 253B, the Minnesota Commitment Act. Under the direction of Allyson Ashley, the task force was directed by the Commissioner to review, at a minimum, the following issues: informed consent issues relating to involuntary treatment; the standards for commitment for both inpatient and outpatient; admission and discharge procedures for persons with mental retardation; a comparison of the psychopathic personality statute to similar provisions in other states of the right to treatment granted through statutory language or case law and discharge criteria; and review the treatment of adolescents under the commitment act.

The task force report to the Commissioner included in recommendations for amendments to the commitment act in several areas. There should be a limited court determination of competency at the time of commitment which would allow the receiving facility to involuntarily treat for an initial 30 day period. The current statute should be recodified to bring together in one subheading or otherwise highlight the various provisions for outpatient commitment that already exist but frequently go unrecognized. In addition, mechanisms are needed to ensure appropriate follow up and court review. It was not recommended that the standards or requirements for commitment be changed. Language should be added which identifies the treatment alternatives available to the courts. The use of stays and continuances should be more formalized and should be surrounded by greater protections and provision for accountability Persons with mental retardation should be committed for determinate periods of time similar to those for persons with mental illness or chemical dependency. By a narrow margin, the committee recommended repeal of the psychopathic personality statute, recognizing that members are widely divided on the issues attached to this statute of public protection, treatment rights and civil liberty issues. In addition, the committee recommended that a specific agency be identified, and properly funded and staffed to be the leader in addressing the issues of adolescent mental health and to create a uniform and comprehensive system of services.

The committee also saw the need for ongoing work and study of the commitment act to identify and evaluate those issues which could not be addressed due to time limitations and to ensure that the commitment process balances patients' rights and the provision of services.

The task force report will be available in February for legislative review.

MENTAL HEALTH DIVISION GRANTS FROM OUTSIDE SOURCES

Employability

The Mental Health Division, in collaboration with the Division of Rehabilitative Services, requested an award of $600,000 from the Robert Wood Johnson Foundation to develop coordinated vocational rehabilitation and employment services for persons with serious and persistent mental illness. Over a three year period, the division would seek to implement models of coordinated rehabilitation systems in at least two diverse parts of the state. Initial vocational planning for all persons in those counties with serious and persistent mental illness would be provided. This proposal would adopt a multilevel approach intended to address the lack of coordinated employability services at both the state and local levels and to involve mental health, vocational rehabilitation personnel and employers in collaborative solutions to client needs for real work. Components of the proposal include a coordinator and task force at the state level to address interagency policy and legislative matters and two demonstration projects based on coordinated interdisciplinary service teams.

By the end of the grant period, if funded, the division would also seek to have developed the resources to continue statewide implementation of those services found most effective in achieving the goal of appropriate employment of persons with mental illness.

Rural Mental Health Crisis Project Grant

The decade of the 1980's brought severe economic hardships to many persons living in rural areas of Minnesota. Problems began first with major cutbacks in the iron mining industry, and more recently, severe economic problems have developed across most of the counties depending on agriculture/farm based economy. As a result, many farm families have found themselves facing major financial losses, and in many cases, the loss of their way of life and their means of self support. The problems of farmers impact the entire local rural community, as other agriculture dependent industries and rural main street businesses have felt a ripple effect.

Studies of the emotional and psychological impact of economic crisis on individuals and families document an increased need for existing and new, innovative, types of mental health services. Studies have reported that many rural people, particularly farmers, do not, or will not, use traditional mental health services that typically have been provided at the local community level.

In an effort to help Minnesota's rural mental health system develop appropriate service responses, the Mental Health Division submitted a project demonstration proposal to the

National Institute of Mental Health (NIMH) in April of 1987. This proposal was approved and a $300,000, eighteen month grant was awarded to the Division.

At the state level, the project includes development of interagency cooperative agreements between the Department of Human Services, the Minnesota Extension Service and the Minnesota Department of Agriculture. At the community level, service demonstration grants will be made to three community mental health centers serving 15 counties. These are: The Southwestern Mental Health Center, Luverne, Minnesota; the West Central Community Services Center, Willmar, Minnesota; and the Western Human Development Center, Marshall, Minnesota.

This project is scheduled to be fully implemented by February 1, 1988.

Elderly Grant

National Institute of Mental Health Grant Number H84 MH42397-01, "Services to Elderly Persons with Long Term, Severe, Disabling Mental Illness" began September 30, 1986 and will end December 31, 1989. First year funding was $138,898 (total direct costs). Second year funding of $139,000 was approved, but since NIMH is operating under a continuing resolution pending enactment of an annual appropriation, the award was reduced by 8 1/2% to $127,185, as of December 18, 1987. It may be possible to restore or partially restore lost funds after the resolution of NIMH's annual 1988 appropriation level. Also, we expect to have about $13,000 to carry over from 1987 to 1988.

The project demonstration site is the Range Mental Health Center in Virginia, Minnesota. Recognizing that the mental health problems of older adults are not the sole responsibility of the mental health system nor of the aging network, the project goals are to:

1. Enhance collaboration and linkages between the Mental Health Division of the Department of Human Services and the aging, long term care, health and social service networks in the state.

2. Clarify roles among these networks to assist in identifying service gaps and avoid competition for valuable, scarce resources.

3. Strengthen the use of community based services and facilities and decrease the use of more restrictive alternatives.

4. Stimulate creative approaches to providing an accessible, high quality and cost effective continuum of mental health services.

5. Enhance provider knowledge and skills with increased emphasis on geriatric training for mental health providers and on sensitivity to mental health needs for geriatric care providers.

6. Collect data for further planning and evaluation in order to build on this model to adapt it to other settings.

7. Promote public education about mental health and aging.

The State Project Director in the Mental Health Division of the Department of Human Services is responsible for overall monitoring and evaluation as well as for developing linkages with the Mental Health, Aging, Long Term Care, Social Services, and Gerontology Divisions within the Department and also with the State Departments of Health and Veterans Affairs and the federal Veterans Administration. The State Project Director is involved in implementing the Minnesota Comprehensive Mental Health Services Act of 1987, analyzing statewide data on mental health needs and services to older adults, assuring that the mental health needs of older adults are addressed in local mental health proposals and therefore in the redesign of the mental health system in Minnesota and providing technical assistance to local mental health authorities and providers.

The county's role is that of local planning and coordination, pre-admission screening and alternative care grants, case management and other generalist services. St. Louis County has a relatively long history of well organized social services including mental health and aging, but the linkage between the mental health system and the aging and other health and human services networks was not formalized.

The Range Mental Health Center in Virginia provides the contractual, specialized treatment services such as adult day care and treatment, home care, supervised apartment services, respite services, family support, inpatient and outpatient geriatric psychiatry service, medication management, emergency service, and consultation and outreach to nursing homes, board and lodging facilities, senior centers and senior high rises.

Both St. Louis County Social Services and the Range Mental Health Center are involved in voluntary networks of service providers and consumers. The grant capitalizes on these networks and serves to stimulate them to be sensitive to the mental health needs of older adults, and to promote their involvement in the planning and delivery of services.

The demonstration project model, which is being implemented during the first year of the grant, will be evaluated in years two and three in anticipation of possible adaptation to other areas of the state. The concept of the grant fits well with the Minnesota Comprehensive Mental Health Services Act, which was

enacted during the 1987 legislative session, about six months after the grant was awarded. Services such as assessment and case management, which were goals of the project for older adults are now mandated for all persons with serious and persistent mental illness in Minnesota. It is encouraging to realize that the mental health needs of older adults will be addressed in the redesign of the mental health system in Minnesota.

Homelessness -- Mental Illness Block Grant

The primary focus of the Mental Health Division's work activity relating to homelessness of persons with mental illness has been the McKinney Homeless Assistance Act, specifically the Mental Health Services to the Homeless Block Grant Program, Title VI, Subd. B, Section 611. The mental health component of the legislation emphasizes outreach services, outpatient mental health services, training, case management and supportive/supervisory services to homeless persons experiencing mental illness. All required services are consistent with the mental health initiatives and development of each county mental health plan. Other major titles address issues such as physical health care, literacy, prevocational and vocational needs and housing, both shelter and transitional.

The division participated in the development of Minnesota's Comprehensive Homeless Assistance Plan and continues to work with the State Planning Agency as part of a statewide coordination and information clearinghouse effort. Data was generated by surveys conducted by the Department of Jobs and Training. It reflects that between 2,500 and 4,000 persons use shelters, with anywhere from 30-70% experiencing some degree of mental illness.

Specific to the mental health services component, the division submitted and has received formal approval for a block grant that will combine federal FY 87-88 funds of $396,190 with $350,000 in state FY 88-89 Rule 14 funds that were designated for special projects to the homeless during the 1987 Minnesota legislative session. Notification of allocations and requests for proposals have been made to six areas of the state having the highest concentration of homeless persons (St. Louis, Ramsey, Hennepin, Blue Earth, Polk and a combined area of Clay and Wilkin Counties). A seventeen month grant period has been established, February 1, 1988 through June 30, 1989.

Additional federal FY 90 funding is possible at the 50% level and the division will consider a request to the 1989 session of the Legislature for continuation of the homeless special project Rule 14 funds. Specific policy issues and legislative proposals will be developed in coordination with results of the housing study addressed earlier in this report.

Refugee Mental Health Grant

In October 1985, The National Institute of Mental Health awarded the Mental Health Division a grant of $139,255 annually to study the mental health needs of Minnesota's refugee population. This grant was for a three year period. We are currently in the third grant year.

This past year, the Office of Refugee Mental Health has provided education, training, and technical assistance to 278 people throughout the state. Two hundred and thirty-eight of those attended training sessions or workshops held in St. Cloud, Rochester, Minneapolis, and St. Paul.

The Mental Health Division has funded one mainstream mental health program for refugees through the federal block grant and plans to allocate another $160,000 to provide emergency consultation and technical assistance to mental health professionals and practitioners throughout the state.

The Office of Refugee Mental Health has also continued to provide consultation to agencies interested in developing or expanding services to refugees. A statewide agency survey was completed and a report written.

The Refugee Mental Health Advisory Council has continued to meet on a monthly basis. They have worked with the office to submit recommendations to the Department in the summer of 1987, and to the Mental Health Division in December of 1988. The council is currently working on standards of care, evaluative measures, model programs, and training and technical assistance priorities.

County mental health plans will be reviewed for their efforts with their refugee residents. Currently 85% of the Minnesota refugee population resides in three counties; Hennepin, Ramsey and Olmsted. Technical assistance has been offered to high concentration areas in order to assure ongoing mental health services to the refugee population beyond the grant period.

MENTAL HEALTH DIVISION GRANT PROGRAMS

The Mental Health Division operates five grant-in-aid programs to fund a statewide mental health system. The status of these grant programs is as follows:

Rule 12 Grant Status Report

Rule 12 grants were established by the Legislature in 1981 to ensure that all community residential facilities for adults with mental illness can meet and maintain compliance with program licensing standards. The program licensing standards are contained in Rule 36; the funding criteria and procedures are contained in Rule 12.

The Rule 36 standards address individual program plans, resident rights and staffing requirements. Rule 36 also mandates compliance with health and fire safety standards and the Vulnerable Adults Act. Major objectives of Rule 36 are to reduce hospitalization and assist persons with mental illness in achieving a higher level of independent living. Through Rule 12, the state pays for up to 75% of program costs. Rule 12 requires these funds to be used for direct service costs only, not for room and board or capital expenditures. On the average, 94% of state Rule 12 funds are used for salary costs of direct service staff. County boards apply for Rule 12 funds on behalf of Rule 36 facilities by providing the Commissioner of Human Services with a budget and program plan. Awards are based on compliance with the statute and Rule 12, reasonableness of costs and availability of funds. For FY '88, the appropriation for Rule 12 grants is $10.4 million.

The Governor's budget, as approved by the Legislature, included three major objectives for Rule 12 for the 1988-89 biennium:

1. Continue funding for 77 previously funded facilities;

2. Add staff and services at existing facilities to better meet the needs of dual-disorder adults; and

3. Develop three new facilities in unserved areas of the state.

The Mental Health Division is pleased to report that accomplishment of these objectives is proceeding on schedule.

The Mental Health Division has awarded continuation grants to 29 counties to pay for ongoing direct service costs at 77 facilities. These grants included cost of living increases averaging 4%. These increases were particularly important since facilities had received only 1% cost of living increases during the previous two years.

In addition, the division awarded service expansion grants totaling $466,542. These grants enabled the addition of staff and services at 26 facilities to better meet the needs of residents who suffer from both mental illness and other disorders, including chemical dependency, behavioral aggressiveness, low intellectual functioning and physical disabilities.

The division has approved awards for three new facilities in Bemidji, Marshall and Moorhead. Applications were received for seven new facilities. The division analyzed quality of applications, potential utilization rates and distance from existing facilities in deciding which areas to fund.

Opening a new residential treatment facility requires a large amount of planning and preparation, including the state level

request for proposal process, the local level planning by the counties and vendors, zoning approvals, facility construction, staff hiring, and separate licensure approvals from the Health and Human Services Departments. The three new facilities approved this year are opening, on average, about nine months after the legislative appropriation; this compares to twelve to twenty four months required for most new facilities in previous years. Intensive work and cooperation by and among the state, the counties, private vendors, advocacy groups and others is thus enabling residential services in these areas of the state to become available sooner than expected.

The attached map shows the current location of Rule 12 funded facilities. Facilities in rural areas typically serve more than one county. For example, the applications for the three new facilities described above were each supported by four to seven neighboring counties.

Rule 14 Status Report

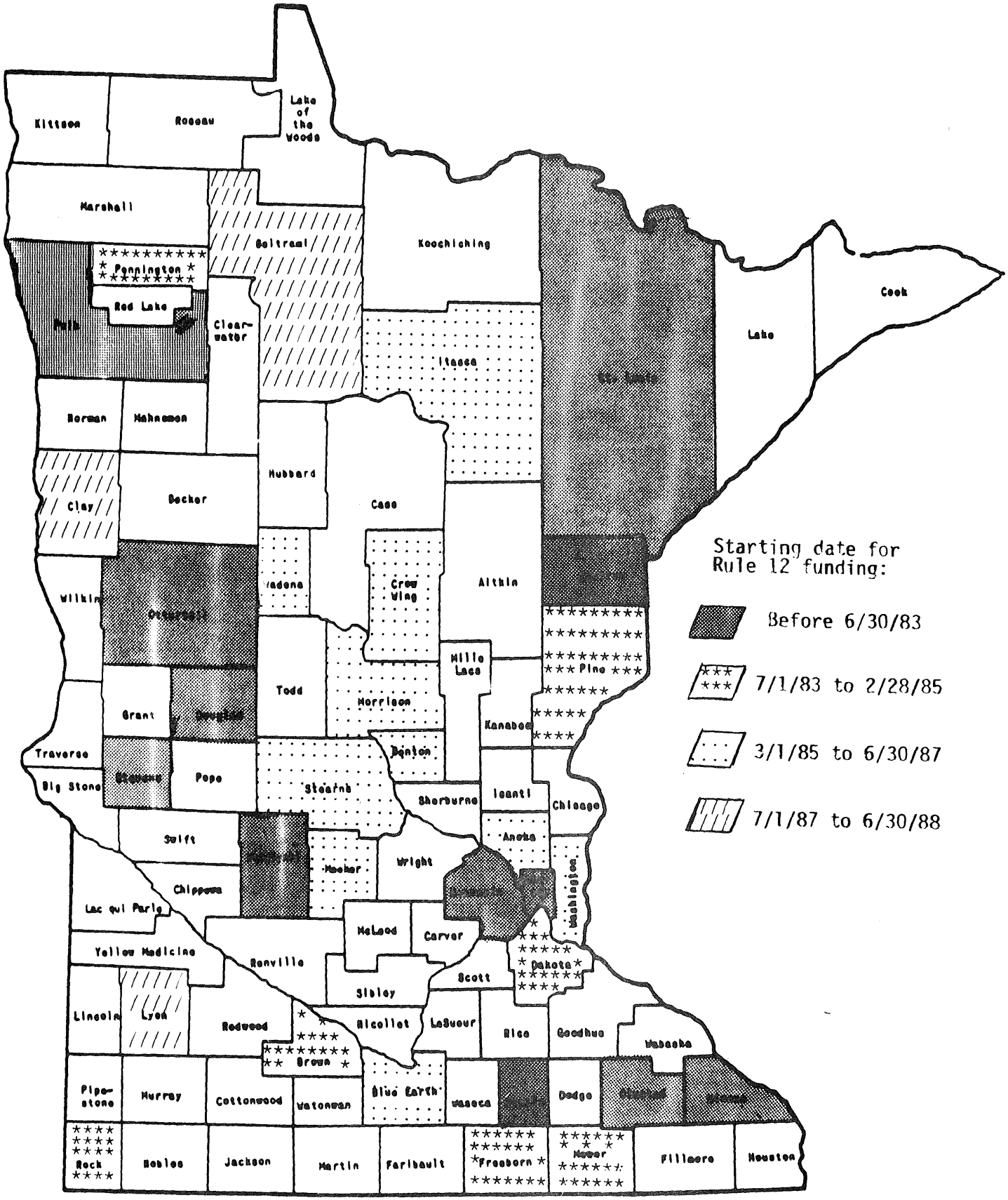
The Mental Health Division made excellent progress during the past year toward meeting its goal of making community support program services (CSP) available statewide to all persons with serious and persistent mental illness. In an effort to help all counties develop their CSP services, the division provided counties with three separate grant application cycles during the FY 1988 period. This approach allowed the usual pre-July 1st processing of continuation grants to all the previously funded counties and two later opportunities for the remaining new counties to plan and develop program applications. Second and third grant application cycles were announced for October 1987 and January 1988. Following this plan, the division awarded continuation grants in June of 1987 for CSP programs serving a total of 48 counties; second cycle grants were awarded in September, 1987 for services to 15 counties, and third cycle grants for programs serving 18 counties were awarded during January and February of 1988.

Please note the attached table that shows the current program status of all counties.

The first cycle grants also provided replacement funding for the eight programs that had been receiving mental health initiative grants from the McKnight Foundation.

The division has hired four of the five approved complement of community based service staff consultants, allowing us to offer technical assistance by mental health professional staff to all 87 counties. We are confident the availability of this resource will enhance the quality of programming across the state and will enable those remaining counties not having grants to develop appropriate programs and services by July 1, 1988.

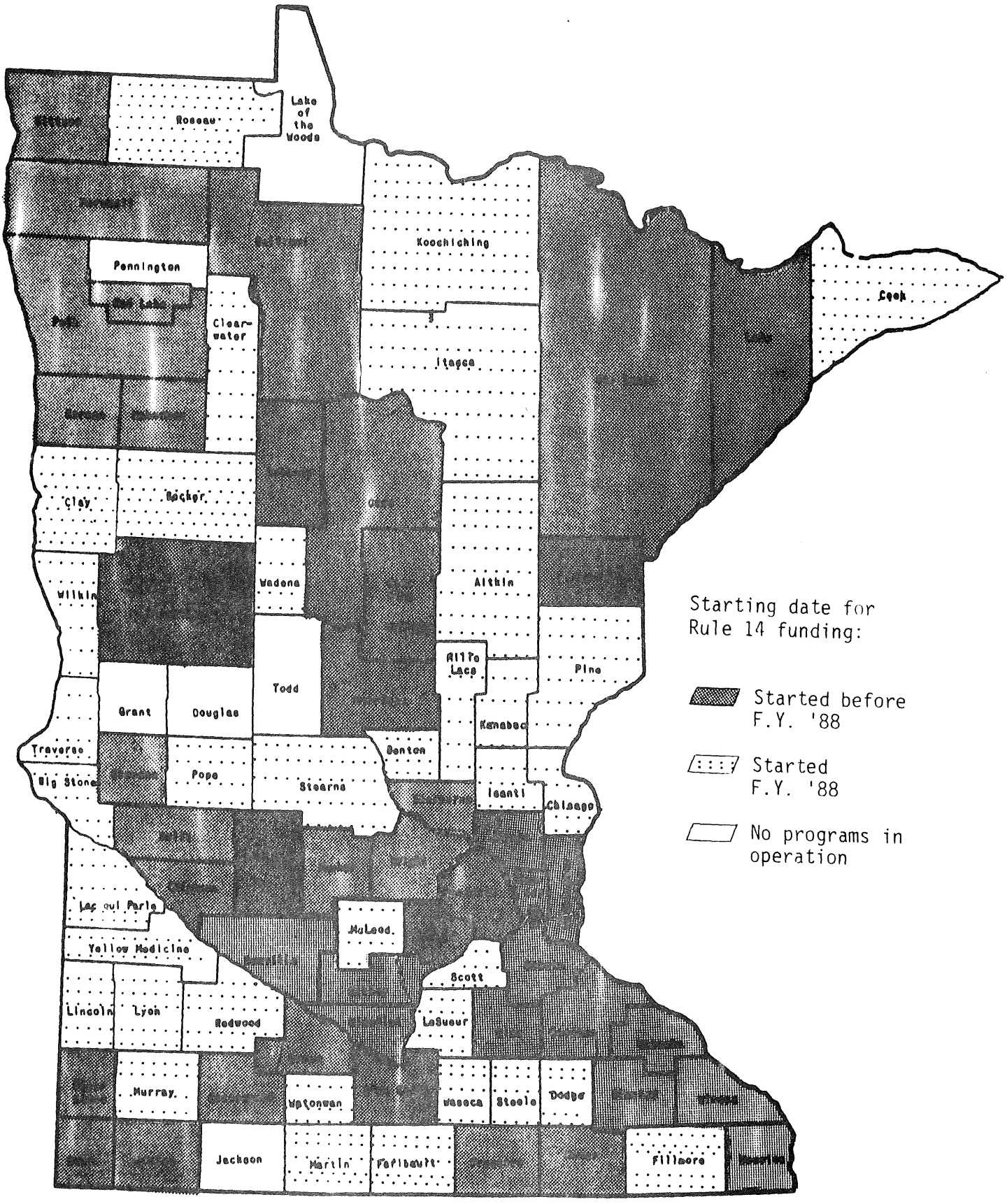
RULE 12 FUNDED COUNTIES -- F.Y. 1981 - F.Y. 1988



Total: 32 counties

Mental Health Division
January 1988

RULE 14 FUNDED COUNTIES -- F.Y. 1980-F.Y. 1988



The division also continues its initiative within community support programs in all counties to expand availability of vocational and employment opportunities for seriously and persistently mentally ill persons. This effort has resulted in a new and revised cooperative interagency agreement with the Department of Jobs and Training, Division of Rehabilitative Services. The two departments also recently submitted a joint grant application to The Robert Wood Johnson Foundation for funds to demonstrate innovative program approaches as discussed previously.

Alcohol, Drug Abuse and Mental Health Block Grants (ADM)

A joint meeting of Minnesota House and Senate legislative committees held a public hearing on the intended uses of the federal Alcohol, Drug Abuse and Mental Health (ADM) block grant funds on December 1, 1987. This plan was prepared based on existing federal law and reflects changes in the use of federal ADM block grant funds which were adopted as a part of the new mental health legislation adopted in 1987. The spending plan outlined in that report includes the following spending categories:

Awarded to:	Amount:
1. Indian Mental Health Projects	$387,271
2. Special Populations	$851,998
3. Administration	$154,998
4. Planning	$154,998
TOTAL:	$1,549,085

The activities include:

1. Indian Mental Health Projects:

   A total of $387,271 is set aside for Indian mental health services, which includes grants to Indian tribal organizations for special mental health service projects. In addition, funding is made available for the expenses of a state Indian Mental Health Advisory Committee.

2. Special Populations:

   The state has used a portion of the block grant award for support of projects for special populations as is required by Section 1916(B)(15). State service priority for special target groups include: (a) severely emotionally disturbed children and adolescents; (b) deaf and hearing impaired mentally ill people; (c) severely emotionally disturbed refugees; (d) residents of severely economically distressed rural areas evidencing mental illness problems.

3. The $154,998 set aside for administration of state and federal grants.

4. The Department plans to use $154,998 of the block grant funds to implement Section 1915(2)(E) for planning, and educational activities related to the provision and coordination of services.

Accomplishments:

In general, we have refocused use of these funds to be sure that projects are demonstrating new service delivery models which can be replicated in other parts of the state.

Specific project accomplishments include the establishment of an apartment living program for hearing impaired mentally ill persons, delivery of special refugee mental health services in a community mental health center setting, and assistance in addressing rural crisis issues.

Indian Mental Health Program Grants

The Mental Health Division continues to place a high priority on providing funding support and leadership in development of culturally appropriate mental health services for Minnesota's Indian population. The goal is to fund mental health service projects on all 11 of the state's reservations and the major urban populations. To help meet this goal, the division requested and received legislative approval to increase the set-aside of federal Mental Health Block Grant funds from 12% to 25%. Depending on the amount of the state's annual federal ADM block grant award, this increase should make available approximately $360,000 annually for grants for Indian service projects.

Another goal has been to recruit an Indian mental health professional to the division staff. This individual would be responsible for providing technical assistance and program consultation to the Indian service providers. A request for this position was approved by the 1987 Legislature and the position has now been filled.

Prevention services are important for all target populations including Minnesota's Indian communities. The development of a better understanding and acceptance of mental illness is a vital part of any program initiative. In recognition of this need, special, culturally appropriate community education, the division funded development of two one hour video educational training films. These are intended to demonstrate the collaboration necessary from both the Indian community and non-Indian service provider groups. All field reports on the use of these films have been very positive.

The following reservation projects were approved for funding during Calendar Year 1987:

Reservations	CY 1987 Award
Bois Forte	$ 26,651
Fond Du Lac	35,372
Grand Portage	13,336
Leech Lake	34,171
Shakopee Sioux	10,184
Mille Lacs/Minnesota Chippewa Tribe	23,576
Upper Sioux	6,500
White Earth	29,856
Education/Information Video	13,576
TOTAL:	$ 193,222

STATE SPECIAL PROJECTS -- STATE GRANT MONEY

The 1987 Legislature in finalizing its appropriation for the Comprehensive Mental Health Services Act, made $1,000,000 available for special projects. The specific nature of those projects was not defined or suggested by the Legislature. The Mental Health Division asked the Governor's Mental Health Advisory Council for input and recommendations regarding the use of this money during the biennium. The Governor's Mental Health Advisory Council submitted the following recommendations:

1. Development of a Mental Health Leadership Institute, focused on increasing leadership skills among community members, consumers, etc., and enhancing opportunities for cross-disciplinary perspectives and learning.

2. Housing needs of persons with mental illness.

3. Enhancing supports for, and easing the transition into, independent living.

4. Vocational/employment needs of persons with mental illness.

5. Mental health needs of older, mentally ill persons and younger mentally ill persons in need of skilled nursing care.

6. Child and adolescent mental health issues.

7. AIDS and mental illness.

Upon receipt of the above recommendations, the Mental Health Division examined the current activity, special federal

projects, activity planned in the implementation of the Comprehensive Mental Health Services Act, citizen comments from the statewide public hearings conducted in 1986, and potential new grant funding to determine the most critical needs which could best be met through the use of the state special project money. In making its determinations, the Mental Health Division was cognizant of the possibility that this appropriation might be a one time action and not repeated in the 1989 legislative session. This factor entered into decision making regarding the use of the state special project money by highlighting the need to consider projects which could be completed with substantial benefit during the biennium. The Mental Health Division decided upon the following activities to be funded by the state special project money.

1. The development of a leadership institute to provide extensive training of local mental health advisory council members on the requirements of the Comprehensive Mental Health Services Act and impacting local public policy making. In addition, the leadership institute will begin the process of interdisciplinary coordination and knowledge building among the four core mental health professional disciplines (i.e., psychiatry, psychology, social work and nursing) and other professional groups who will be involved in the implementation of a comprehensive mental health service delivery system within the State of Minnesota. An RFP planned for January of 1988 will begin the development of such an institute.

2. The development of a statewide media campaign designed to educate the public about mental health and mental illness and reduce the stigma associated with mental illness. While the Mental Health Division recognizes that each county has responsibilities to conduct public education and prevention activities, it is also recognized that the state can access video and television media more efficiently and should assume a leadership role in reducing the stigma associated with mental illness.

3. The development of specific child/adolescent mental health service demonstration projects. Currently, specialized funding for intensive mental health services for children and adolescents is limited to fee for service medicaid funded activities and some therapeutic home based family treatment projects. Some state special project money will be used to develop specialized mental health services for this population. A bulletin to announce the availability of funds for this purpose is planned for publication in April of 1988.

4. The development of specific elderly mental health service demonstration efforts. Currently the elderly are severely underserved by the mental health delivery system despite the

fact that the risk of mental illness increases in the elderly. Some state special project money will be used to develop specialized approaches to deal with the mental health needs of the elderly. A bulletin to announce the availability of funds for this purpose is planned for April of 1988.

5. The development of specialized training regarding the provision of case management services to persons with serious and persistent mental illness. As the new case management system is developed, case managers need substantial indepth training regarding mental illness, mental health services and appropriate coordination and linkage. This training package will allow counties to train new case managers as they are employed between now and 1990 or beyond. Development of print and video materials is a one time activity which lends itself well to funding from the state special project money. This type of material will greatly assist in the ongoing manpower training needs of counties and in reducing individual county cost for this activity.

MENTAL HEALTH DIVISION RULE DEVELOPMENT

The Mental Health Division and Rulemaking Division have prioritized four rules for work between July 1, 1987 and January 1989. A report on the status of these rules is as follows:

Revision of Rule 36 -- Adult Mental Illness Residential Treatment

Work on revision of existing Rule 36, standards for the care and treatment of adult persons experiencing mental illness residing in community residential facilities, remains a priority. The projected effective date for a revised rule is early 1989. A draft revision will be completed during January 1988 based on suggestions made by staff, representatives of the Minnesota Association of Mental Health Residential Facilities, Mental Health Law Project, the Alliance for the Mentally Ill, the Mental Health Association, the State Mental Health Advisory Council, counties, legislators and, extensive research done by staff of the Department's Rulemaking Division. An advisory committee will be created to assist in review of the draft and development of a proposed rule before a public hearing date is established.

Major focus will be changes that reflect:

1. Assessment and evaluation mechanisms that ensure client need based placements;

2. Clearer and more functional levels of treatment, programming, and supervision;

3. State of the art programming that increases effectiveness and efficiency of residential programs;

4. A strong relationship between residential settings, case management, community support programs and counties' mental health plans;

5. Consistency with other laws, rules and regulations;

6. Increased capacity for effective data collection, monitoring, and outcome measurement; and

7. Identification of policy, statutory and/or funding issues that need to be addressed.

Rule 14 -- Community Support Services

Minnesota Rules parts 9535.0100-9535.1600 (commonly known as Rule 14) which funds adult community support service programs has been extensively reviewed by the Department with a first draft written and ready for review with the rule's advisory committee in February, 1988. The purpose of this rule revision is to assure that the rule meets the new statutory requirements of the Comprehensive Mental Health Services Act. Publication of the rule in the State Register is planned for March 28, 1988, to ensure a July 1, 1988 effective date.

Rule 47 -- Medical Assistance

Rule 47 (9500.0750 - 9500.1080) is a medical assistance rule which governs the reimbursement of health care services. Most of this rule was revised and adopted during 1987, however, the sections pertaining to psychological and community mental health services was delayed until the completion of the 1987 Legislature and its work on the Comprehensive Mental Health Services Act. Work is now proceeding on the revision of the mental health sections. Work is scheduled to be completed by January of 1989.

Rule 74 -- Case Management

Rule 74 (not codified) will be the rule governing the provision of case management services to persons with serious and persistent mental illness. By February 16, 1988, the case management rule will have been reviewed by the Rule 74 Advisory Committee three times. The Department is working closely with the federal agency to ensure that our state plan is approved to add case management as a reimbursable MA service for persons who have serious and persistent mental illness. The case management rule timelines have been developed to ensure the implementation of case management services by January of 1989.

MENTAL HEALTH INFORMATION SYSTEM STATUS REPORT

The Mental Health Division has been working with the Information Management Resources Division in conducting an information requirements analysis of mental health data. This process is part of an overall information systems analysis of all social services reporting being conducted by the Department. This process involved examining all data requirements from mental health legislation and what data are being collected currently. In conducting this analysis, it was determined that some type of client/database reporting would best meet the reporting needs. The Department submitted a report to the Legislature in January 1988 which describes all social services, including mental health, reporting and makes recommendations regarding changes in that system.

In order to implement changes in the mental health reporting of counties, the issue of data privacy for mental health data must be addressed. The decision on sharing client identifying information between mental health providers and county agencies will determine what type of information system is feasible. A client database system would necessitate some type of unique client identifier to track client services.

The Mental Health Division has started meetings with the Health Care Management Division to examine changes in the Medicaid Management Information System (MMIS) to allow the addition of case management services. The addition of this service to the MMIS would allow the Department to partially meet the legislative mandate of developing a mental illness information management system by January 1, 1990. If possible this would allow tracking of service use of Medicaid and GAMC services for clients who are suffering from serious and persistent mental illness. The feasibility of allowing this system to handle case management information on non-Medicaid eligible clients is being explored.

Also important to information systems for persons suffering from serious and persistent mental illness is the development of an information system which collects the same data from regional treatment centers. Currently the department is in the process of issuing a Request for Proposals (RFP) to set up demonstration management information systems at Anoka Metro Regional Treatment Center and St. Peter Regional Treatment Center. If information on clients in regional treatment centers could be linked with the MMIS, a database could be created on all mental health clients either directly served or directly paid for through the state system.

INTER/INTRADEPARTMENTAL COORDINATION

There is an ongoing need to improve inter and intradepartmental coordination on behalf of persons with, or at risk of, mental illness. The provision and funding of effective, comprehensive mental health services requires coordination and cooperation with other agencies involved in the lives of affected individuals. When the coordination effort involves agencies other than the Department of Human Services, efforts will be made to develop written interagency agreements. When the coordination effort involves other divisions of the Department of Human Services, staff of the involved divisions will need to make ongoing efforts to jointly address issues. The following is a list of key agencies and other divisions within the Department of Human Services and the activities which have occurred or are planned.

Department of Education

Only a preliminary discussion has occurred with the Department of Education regarding the need to coordinate our mutual efforts on behalf of seriously emotionally disturbed children. Work toward the development of an interagency agreement is planned for the spring of 1988 and beyond, facilitated primarily by the child/adolescent mental health specialist employed by the Division of Mental Health.

Department of Corrections

No efforts have occurred between the Mental Health Division and the Department of Corrections outside those required when caring for those persons committed to both the Department of Human Services and the Department of Corrections and residing at Minnesota Security Hospital or a penal institution. Effort is necessary to address the mental health needs of those incarcerated in jails and prisons and with those on probationary status. Effort will be made during 1988 to develop an interagency agreement and explore methods of service delivery to shared clients or potential clients.

Department of Jobs and Training

The Department of Human Services, Mental Health Division and the Department of Jobs and Training, Division of Rehabilitative Services, are attempting to coordinate all activities as they relate to employability for persons with mental illness. Examples include the adoption of a new interagency agreement which includes ongoing administrative coordinating mechanisms, joint review of programs, grants and proposals, and other cooperative efforts. Current cooperative efforts include: collaboration in requesting $600,000 from The Robert Wood Johnson Foundation establishing persons with serious and persistent mental illness as a priority for Title VI-C funds.

Department of Health

The Division continues to work with the Department of Health on two issues directly related to community residential (Rule 36) facilities.

The Department of Health was mandated by Chapter 197, Subd. 1b, 1987 Session of the Legislature, to develop a plan by January 1, 1989 that will ensure appropriate placements of adult persons with mental illness in residential facilities. Discussions have begun and it is expected that a monitoring mechanism will be in place as required.

The second issue relates to the delivery of medications in board and lodging facilities. Under existing state law and rule, medications cannot be delivered by staff of a facility unless the facility has a health care license. Someone else must assist a resident with medications, e.g., a family member or public health nurse. This is often cumbersome, expensive and, forces placement of some individuals in facilities that are primarily designed for health care or have a mental health treatment program that is not appropriate to the level of care needed.

The solution appears to be in the development of a new rule which would allow staff of board and lodging facilities to deliver and supervise medications based on an appropriate level of training. A rule was proposed in 1985 and then withdrawn in the spring of 1986 pending action by the State Planning Agency which was studying the issue of licensing by the Department of Human Services and, because of difficulty in reaching agreement as to how many hours of training should be required.

Staff of the Department of Health have assured the Department of Human Services that the possibility of reopening the rule making process is being considered. Additional discussions will be held to encourage an affirmative decision and arrive at agreement concerning the training component to be proposed for public hearing.

Housing Authority

During the past year, the Mental Health Division has coordinated regularly with the Minnesota Housing Finance Agency and the Housing and Urban Development Office (HUD) regarding housing for persons with mental illness. Additionally, both agencies have representation on the division's Housing Task Force which meets monthly.

Health Care Programs Division of the Department of Human Services

Massive efforts have occurred during 1987 and are planned for 1988 between the Health Care Programs Division and the Mental

Health Division to jointly work on improving medicaid functioning for persons requiring mental health services. This effort has occurred around rule development (i.e., Rule 47 -- Medicaid Services and Rule 74, the new case management rule). In addition, legislation affecting General Assistance Medical Care (GAMC) and Medicaid (MA) rates and coverage for mental health services has been worked on jointly. Cooperation with this division has involved sharing staffing and excellent communication. Minnesota was rated in early 1988 as having the nation's best medicaid program by a national consumer research group. This type of excellence also relates to Medicaid funded mental health care.

Long Term Care Division of the Department of Human Services

The State Project Director of the National Institute of Mental Health (NIMH) grant on older adults has been the Mental Health Division's link and coordinator with the divisions of Long Term Care Management, Gerontology and Aging. She has reviewed the PAS/ACG rule, provided input regarding mental health issues so screeners will be required to make referrals on persons with mental health problems. (The rule now will reference the Comprehensive Mental Health Services Act.) She also provided consultation to the department management team at the Minnesota Veterans Home. The State Project Director and the Gerontology Division Director have met with representatives from the geriatric programs at the regional treatment centers and state nursing homes to address general geropsychiatric issues and also the Comprehensive Mental Health Services Act. They also made site visits to Willmar, Moose Lake, and Brainerd Regional Treatment Centers as well as Ah-Gwah-Ching Nursing Home. They are collaborating on the geriatric mission statement for the state facilities. The State Project Director has met with a subcommittee of the Minnesota Board on Aging. She has ongoing contact with the Executive Secretary and Deputy Secretary, as well as the Program and Policy Director. In addition, she has met with the Directors of the Area Agencies on Aging, as a group and individually with the directors in the Duluth and Willmar area regarding both Alzheimer's Disease and mental health issues.

Residential Services (Regional Treatment Centers)

The Mental Health Division is actively involved in coordinating mental health services with the regional treatment centers. We are currently in the process of hiring a hospital liaison, involved in interagency administrative coordination meetings and providing technical assistance and data to the regional treatment centers. We are jointly attempting to address issues of discharge planning, development of specialized needed services, and coordination of client enrollment in eligible government benefits prior to discharge. We have begun to identify a common mental health mission as it relates to the regional treatment centers.

Children's Services

The Mental Health Division has hired a child/adolescent consultant to coordinate child/adolescent services in the following areas: legislative, interagency coordination of services and policies, interagency coordination of program development, federal grant development (CASSP) and technical assistance.

Deaf Services Division

The Mental Health Division is working cooperatively with Deaf Services Division to develop unmet needs for persons who are deaf or hearing impaired and mentally ill by: (1) joint grant reviews for Rule 12/14 programs; (2) joint county plan reviews; (3) joint participation in the provision of technical assistance; and (4) identification of service gaps.

MENTAL HEALTH RESEARCH ACTIVITIES

During the year the Mental Health Division has contracted with Dr. Rama Pandey from the University School of Social Work to develop prevalence estimates for different mental disorders in the state. Based on national epidemiological studies conducted by the National Institute of Mental Health, Dr. Pandey developed estimates for the different disorders for each county in the state. These estimates were distributed to the counties and at the statewide workshops held on the mental health initiative.

Dr. Pandey also developed some indicators of risk of mental illness based on a data tape of 1980 Minnesota census information provided by the National Institute of Mental Health. These mental health indicators which are preliminary in nature were developed for each county. The division is currently working to develop a contract to further develop these indicators and test them out on service use information from existing data sources such as the Medicaid Information System.

The Mental Health Division is also contracting with the Wilder Research Center to do data entry and some data analyses of the reports submitted by residential facilities treating emotionally disturbed/mentally ill children and adolescents. These annual reports are mandated under M.S. 253C. The reports submitted contain descriptive information on the number of admissions and discharges, the average lengths of stay, court ordered stays, diagnoses as well as age, race and sex. An analysis will be conducted by type of Department of Human Service license (Rule 5, Rule 8 and/or Rule 35).

SUMMARY OF MENTAL HEALTH FUNDING

Funding for mental health services, as has been discussed previously within this report, comes from a variety of sources. In reviewing county mental health plans, the following table summaries county estimated costs for each service component and the governmental funding source. Because the formal county plan reviews have not yet taken place, this data should be regarded as somewhat tentative. Nevertheless, the Mental Health Division is now in a better position to evaluate funding and the numbers of persons receiving services than it has been in the past.

SUMMARY

Calendar year 1987 has been busy and productive. The year was devoted to preparations for full implementation of the Comprehensive Mental Health Services Act. County plans were received during early January and will be modified as necessary and approved by May 1988. Except for regional treatment center services, all other mental health service components are not required until July 1, 1988 and beyond. Day treatment, case management and screening will be required during 1989. From the early plan reviews, Minnesota counties are making rapid progress to comply with state statute and improve the availability, accessibility and quality of mental health services for persons experiencing mental illness.

Estimated DHS Funding for Mental Health Services - Calendar 1989

Service - Funding Source	STATE	COUNTY	FEDERAL	OTHER	TOTAL	PERCENT
Education and prevention - CSSA	215,298	392,461	151,173	41,068	800,000	.4%
Emergency services - CSSA	699,717	1,275,500	491,313	133,470	2,600,000	1.2%
Outpatient services						
CSSA	5,113,320	9,320,960	3,590,366	975,354	19,000,000	8.9%
Medical Assistance	6,648,803	738,756	8,468,974	0	15,856,532	7.4%
Gen. Assist. Med. Care	1,540,622	171,180	0	0	1,711,803	.8%
Sub-total	13,302,745	10,230,896	12,059,340	975,354	36,568,335	17.2%
Case Management						
Rule 14 - CSSA	1,845,000	205,000	0	0	2,050,000	1.0%
Medical Assistance	2,201,378	244,598	2,804,025	0	5,250,000	2.5%
Sub-total	4,046,378	449,598	2,804,025	0	7,300,000	3.4%
Other Community Support Services						
Rule 14 - CSSA	5,083,000	6,200,000	230,000	0	11,513,000	5.4%
Gen. Assist. Med. Care	450,000	50,000	0	0	500,000	.2%
Medical Assistance	838,620	93,180	1,068,200	0	2,000,000	.9%
Sub-total	6,371,620	6,343,180	1,298,200	0	14,013,000	6.6%
Residential Treatment						
Rule 12/36 - CSSA	10,844,000	2,600,000	0	800,000	14,244,000	6.7%
Rule 36 - Gen. Assist.	2,625,000	875,000	0	0	3,500,000	1.6%
Rule 36 - Minn. Supp. Aid	5,525,000	975,000	0	0	6,500,000	3.0%
Rule 36 - Supp. Sec. Inc.	0	0	4,300,000	0	4,300,000	2.0%
Rule 5 - CSSA	4,575,076	8,339,806	3,212,433	872,685	17,000,000	8.0%
Sub-total	23,569,076	12,789,806	7,512,433	1,672,685	45,544,000	21.4%
Acute Care Hospital						
CSSA	376,771	686,808	264,553	71,868	1,400,000	.7%
Medical Assistance	10,170,918	1,130,102	12,955,301	0	24,256,322	11.4%
Gen. Assist. Med. Care	7,003,716	778,191	0	0	7,781,907	3.6%
Sub-total	17,551,405	2,595,100	13,219,855	71,868	33,438,228	15.7%
Regional Treatment Center						
RTC State $ - Co. Match	36,592,910	5,989,523	0	0	42,582,433	20.0%
Medical Assistance	5,342,226	593,581	6,804,709	0	12,740,516	6.0%
Other	0	0	3,523,915	4,835,920	8,359,836	3.9%
Sub-total	41,935,136	6,583,103	10,328,625	4,835,920	63,682,784	29.9%
Screening						
CSSA	80,737	147,173	56,690	15,400	300,000	.1%
Medical Assistance	461,241	51,249	587,510	0	1,100,000	.5%
Sub-total	541,978	198,422	644,200	15,400	1,400,000	.7%
Special Projects						
Indian MH services	0	0	387,000	0	387,000	.2%
Homeless services	268,000	0	243,000	0	511,000	.2%
Other	920,000	0	852,000	0	1,772,000	.8%
Sub-total	1,188,000	0	1,482,000	0	2,670,000	1.3%
Other MH services - CSSA	1,399,435	2,551,000	982,626	266,939	5,200,000	2.4%
Total DHS Funding	110,820,786	43,409,067	50,973,790	8,012,704	213,216,348	100.0%
Percent	52.0%	20.4%	23.9%	3.8%	100.0%	

Notes for Funding table - include in accompanying text

The above table does not include nursing home services; also, it does not include Income Maintenance payments for persons with mental illness who are in a Rule 36 facility.

In addition to the above, MH services are also funded by the Departments of Education, Corrections, Jobs and Training, plus direct federal funding to providers through Medicare and Veterans Administration, plus private insurance and private pay. Additional information on these funding sources will be obtained during 1988 for the 1989 report to the Legislature.