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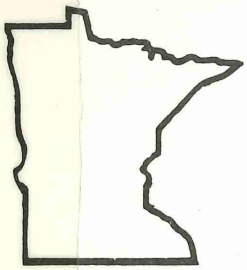
Department of Human Services Mental Health Division Three-Year Plan for Services for Persons with Mental Illness

January 1989



STATE OF MINNESOTA

Pursuant to 1987 Laws, Ch 403, Art 2, Sec 6 Coded as MS 245.461

DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH DIVISION
THREE-YEAR PLAN FOR SERVICES
FOR PERSONS WITH MENTAL ILLNESS

Prepared by Staff of the Mental Health Division
December 1988

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INDEX

GLOSSARY OF ACRONYMS

ADM:	Alcohol, Drug Abuse, Mental Health Block Grant (Federal)
AFDC:	Aid to Families with Dependent Children
AFDC-EA:	Aid to Families with Dependent Children - Emergency Assistance
CASSP:	Child and Adolescent Service System Program (NIMH-Federal)
CD:	Chemical Dependency
CMHC:	Community Mental Health Center
COBRA:	Consolidated Omnibus Budget Reconciliation Act of 1985
COLA:	Cost of Living Adjustment
CPI:	Consumer Price Index
CSP:	Community Support Program
CSSA:	Community Social Services Act; social services block grants to counties
DEFRA:	Deficit Reduction Act of 1984
DJT:	Department of Jobs and Training
DRG:	Diagnosis-Related Group Classification System
DH:	Department of Health
DHS:	Department of Human Services
DPW:	Department of Public Welfare (name prior to DHS)
DSM-MD:	Diagnostic and Statistical Manual of Mental Disorders
ED:	Emotionally Disturbed
EPSDT:	Early and Periodic Screening, Diagnosis and Treatment
ESL:	English as a Second Language
GA:	General Assistance
GA-EA:	General Assistance - Emergency Assistance (also known as EGA)
GAMC:	General Assistance Medical Care

GLOSSARY OF ACRONYMS
(Continued)

HHS: Department of Health and Human Services (Federal)

HMO: Health Maintenance Organization

HUD: Housing and Urban Development (Federal)

ICD: International Classification of Diseases

ICF: Intermediate Care Facility (Nursing Home Level of Care -- Includes Levels I and II)

IMD: Institution for Mental Disease

IV-D: Child Support

IV-E: Foster Care

JTPA: Job Training Partnership Act

LTC: Long Term Care

MA: Medical Assistance ("Medicaid" or Title XIX")

MA-ID: Medical Assistance - Identification Care

MA-AD: Medical Assistance - Aid to the Disabled

MA-BI: Medical Assistance - Aid to the Blind

MA-AFDC RELATED: Medical Assistance based on AFDC-related eligibility

MH: Mental Health

MI: Mentally Ill

MN: Minnesota

MHD: Mental Health Division, State Department of Human Services

MS: Minnesota Statutes

MSA: Minnesota Supplemental Assistance

NIMH: National Institute of Mental Health

OASDI: Old Age, Survivors and Disability Insurance (Social Security)

OBRA: Omnibus Budget Reconciliation Act (of a given year)

GLOSSARY OF ACRONYMS
(Continued)

OMB:	Office of Management and Budget (Federal)
PAS/ACG:	Preadmission Screening/Alternative Care Grants Program
OCSE:	Federal Office of Child Support Enforcement
RFP:	Request for Proposal
RIAD:	Refugee Immigration Assistance Department (State)
RRP:	Refugee Resettlement Program
RTC:	Regional Treatment Center (State Hospital)
RULE 5:	Program and Funding Rules for Child/Adolescent Mental Health Residential Programs
RULE 12:	Funding Rules for Mental Health Residential Programs
RULE 14:	Program and Funding Rules for Mental Health Community Support Programs
RULE 29:	Certification Rules for Community Mental Health Centers
RULE 36:	Program Rules for Mental Health Residential Programs
SED:	Severely Emotionally Disturbed
SNF:	Skilled Nursing Facility
SOBRA:	Second Omnibus Reconciliation Act (of a given year)
SSA:	Social Security Administration
SSI:	Supplemental Security Income
TEFRA:	Tax Equity and Fiscal Responsibility Act of 1982
TITLE I:	OAA (Old Age Assistance)
TITLE IV-A:	AFDC (Aid to Families with Dependent Children)
TITLE IV-D:	Child Support for AFDC
TITLE IV-E:	AFDC Foster Care
TITLE V:	Child Maternal Health (services to children with handicaps)
TITLE X:	Aid to Blind
TITLE XI:	Demonstration Grants

GLOSSARY OF ACRONYMS
(Continued)

TITLE XVI: SSI (Supplemental Security Income - former Aid to Disabled)

TITLE XVIII: Medicare

TITLE XIX: Medicaid

TITLE XX: Social Services

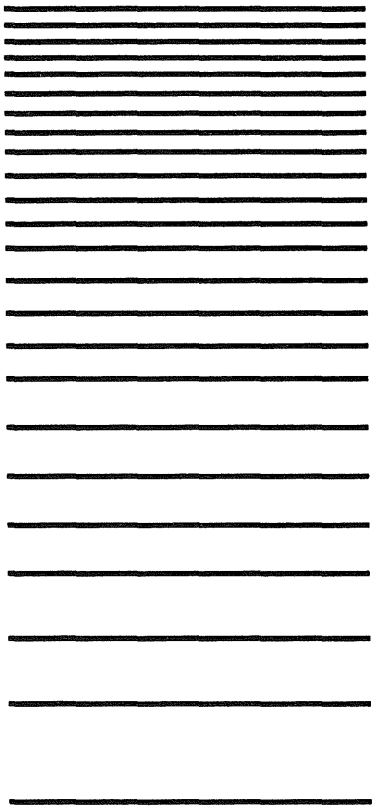
UCR: Usual, Customary and Reasonable

WIN: Work Incentive Program

WR: Work Readiness

I.

Executive Summary



I. EXECUTIVE SUMMARY

In its 99th session, Congress passed and the President signed into law the State Comprehensive Mental Health Services Planning Act (Public Law 99-660), related to the establishment by states of comprehensive community-based services for persons with mental illness. Among its provisions, P.L. 99-660 requires the submission of an annually updated three year plan for creating such a system to the National Institute of Mental Health (NIMH). The planning process must involve the state's mental health planning or advisory council and must identify, address, and plan to resolve major issues facing the establishment of a community-based system.

This document is the blueprint for community-based mental health services of the Department of Human Services of the State of Minnesota. For purposes of readability, the Executive Summary mirrors the format of the entire report.

Introduction

Minnesota is somewhat unique among the states in that its planning process originated at the grass roots level. The formation of the Governor's Commission on Mental Health in 1985 involved consumers, families, providers, the business community, legislators, advocates, county social service representatives, and others in comprehensively addressing the needs of Minnesotans with a mental illness. Ten hearings were held around the state with Governor Perpich in attendance, and significant new legislation and funding, which came to be known as the Comprehensive Mental Health Act, was approved by the 1987 and 1988 Legislatures. Planning functions that were unique to P.L. 99-660 were then taken into account in the formation of a permanent State Advisory Council on Mental Health.

Responsibility for implementing the Comprehensive Mental Health Act falls largely to the Mental Health Division (MHD) of the Department of Human Services. Without a doubt, the priority of the original Commission, the permanent Advisory Council, and the MHD has been the successful implementation of the array of community-based services required by the Act. This array, with an additional proposal for children's services to be submitted to the 1989 Legislature, provides the nucleus of the MHD's efforts to provide services for persons with a mental illness.

Minnesota's System of Services: Current Status

The Comprehensive Mental Health Act requires each of Minnesota's 87 counties to provide an array of services within specified timelines (Minnesota utilizes a county-administered social services system). Implementation of the array requires adequate local, state, and federal funding; ongoing consultation with counties and providers; training and educational programs for

direct care staff; and other elements. The MHD is committed to serving a variety of target populations in a quality manner by addressing these and other aspects of the delivery of services.

The array of services required by the Act includes:

- Education and Prevention Services
- Emergency Services
- Outpatient Services
- Community Support Programs
- Day Treatment
- Residential Treatment
- Acute Care Hospital Inpatient Treatment
- Regional Treatment Center Inpatient Treatment
- Case Management
- Screening for Admission to Inpatient/Residential Treatment

All must have been provided by counties by July 1, 1988, with the exception of case management services, which has a deadline of January 1, 1989, and screening, which has a deadline of January 1, 1991.

As implementation has proceeded, a number of issues have been identified as needing to be addressed both in the coming legislative session and over a longer timeframe. These components form the basis of the MHD's first year plan:

1. Children and Adolescents: development of services for children and adolescents with emotional disturbance. This effort is addressed more comprehensively below.

2. Housing: employment of a housing specialist and development of innovative housing demonstration projects to address the need for long term/permanent housing by persons with a mental illness.

3. Regional Treatment Centers: determination of the future role of regional treatment center (RTC -- formerly state hospitals) mental health programs.

4. Private Insurance Coverage: clarification of criteria for third-party coverage of outpatient mental health services. This was determined to be a need as a result of a separate piece of legislation passed in 1987 which required private payors to cover 80% of the first ten hours of treatment and, with prior authorization, 75% of the next 30 hours.

5. Community Support Programs: enhancement of community support program (CSP) funding to enable all 87 counties to provide an entire array of CSP services.

6. Refugee Assistance: extension of Medical Assistance (MA) coverage to language interpreters to improve access and appropriate use of mental health services.

7. Services for Persons in Community-Based Residential Programs: expansion of Minnesota's General Assistance Medical Care (GAMC) program to cover persons not eligible for MA because of their residence in an Institution for Mental Disease (IMD).

8. Vocational Services: the Division of Rehabilitation Services of the Department of Jobs and Training will enhance vocational training and employability programs for persons with a mental illness, through increased budget and staffing requests of the 1989 Legislature.

Children and Adolescents with Emotional Disturbance

Amendments to the Comprehensive Mental Health Act, designed to create a community-based system of services for emotionally and severely emotionally disturbed children and adolescents will be submitted to the 1989 Legislature. The legislation would:

- define the populations to be served;
- describe the array of services to be provided in all areas of the state;
- establish processes by which such services will be coordinated with educational, corrections, and other systems;
- establish a funding base; and
- establish timelines for implementing services.

The system of services described by these amendments are based upon the CASSP (Child and Adolescent Support Services Program) model of services developed by NIMH.

Special Populations

The MHD's plan goes beyond the requirements of P.L. 99-660 by addressing the unique needs of a variety of target populations in addition to those of persons with a mental illness who are homeless. In most cases, the development of services for these target populations will be based on the framework established by the Comprehensive Mental Health Act.

Target populations addressed by this plan include:

- refugees and immigrants;
- older adults;
- persons in rural areas of the state;
- American Indians; and
- persons with a mental illness who are homeless.

In most instances, services to these populations require substantial coordination with other agencies of state government.

Protection of Client Rights

Services to protect client rights do not fall under the purview of the MHD though the Department of Human Services is responsible for enforcement of programs rules which include client rights issues. However, the Advisory Council has reviewed the activities and plans of the Office of the Ombudsman for Mental Health and Mental Retardation, the responsibilities of which are described here.

Highlights of the Office's plans include:

1. additional staff and funding to carry out its statutory authority to protect client rights in all RTC and community residential care facilities; and

2. the addition of subpoena powers essential to the investigation of client complaints, deaths, and injuries.

In addition to the Ombudsman's Office, three non-state operated programs are discussed:

1. the Mental Health Law Project, which is the state's designated protection and advocacy program;

2. the Client Advocacy Project of the Mental Health Association of Minnesota; and

3. the Self-Help Information Program of the Alliance for the Mentally Ill of Minnesota.

Policy and Planning Coordination

Coordination of efforts among the various departments of the state is key to the successful implementation of any plan for services. An example of such coordination was briefly introduced in the overview of services for children and adolescents above. In addition, the MHD regularly interacts with the following state agencies and programs:

1. Department of Health:

   - residential facility licensing policies;
   - public education/anti-stigma efforts;
   - private sector issues;
   - services for persons with mental illness who are HIV positive, and for addressing mental health issues of people who are HIV positive.

2. Department of Jobs and Training:

   - vocational and employability services for adults with a mental illness.

3. Department of Education:

   - services for emotionally and severely emotionally disturbed children;
   - public education/anti-stigma efforts.

4. Department of Corrections:

   - services for emotionally and severely emotionally disturbed children.

5. Housing Redevelopment Authority:

   - services for homeless persons with a mental illness;
   - long term/permanent housing resources and programs for adults with mental illness.

6. University of Minnesota/Minnesota Extension Service:

   - services for persons with a mental illness in rural areas.

7. Interagency Board on Quality Assurance:

   - implementation of P.L. 100-203, the Federal Nursing Home Reform Act.

The MHD also conducts extensive coordination activities with other divisions of the Department of Human Services, including Divisions responsible for:

- chemical dependency programs;
- regional treatment centers;
- Medical Assistance policy;
- child protection services;
- services to families and children;
- services to the elderly; and
- services to persons with AIDS.
- licensing of programs;
- services for hearing impaired persons

Finally, in 1989 the MHD will initiate efforts to coordinate a variety of special projects advisory committees with the State Advisory Council on Mental Health. This will be pursued as part of an effort to establish the State Council as the umbrella advisory body to the MHD, the Department of Human Services, and the state.

Special projects advisory committees currently exist for programs addressing:

- homeless persons with a mental illness;
- rural residents;
- refugees;

- American Indians;
- elderly persons;
- human resource development issues;
- residential treatment programs and long-term housing issues

Financing

The MHD will ask the 1989 Legislature for substantial new funds for 1990 and 1991, particularly to continue to implement a comprehensive array of services for adults and to implement services required by the Children's Mental Health amendments. Budgets already approved by the 1987 and 1988 Legislatures will result in a 31% increase from 1987 to 1989 in DHS spending for mental health services. This includes an 84% increase in state and federal support for case management and community support services to persons with serious and persistent mental illness.

Overall, DHS is estimated to be responsible for $248,032,755 in mental health services funding in Calendar Year 1989. Of this, the state's share of Medical Assistance (MA) will provide $31,280,000 in services; Rule 14, $7,643,000; Rule 12, $10,894,000; and the state's share of Community Social Services Act (CSSA) block grant funds, $10,272,697.

Other estimates of funds for mental health services in 1989 include:

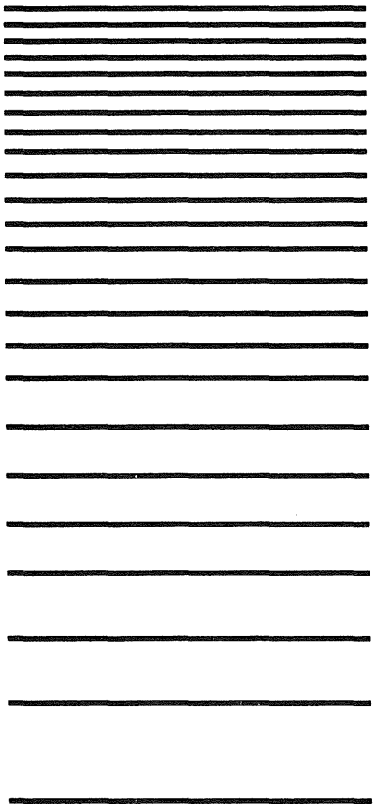
- federal MA funds:	$35,989,217
- federal non-MA funds:	$19,693,286
- county funds (including CSSA funds)	$59,036,248
- Department of Jobs and Training: (F.Y. 1987)	$ 3,136,583

Human Resource Development Issues

At this time, the MHD's plans for addressing the state's needs for mental health professionals and practitioners is just getting underway. One of the initial steps currently in progress is the formation of an advisory group to provide assistance with a grant application to NIMH for funds to research Minnesota's HRD needs.

II.

Introduction



II. INTRODUCTION

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 and 1988 Legislatures. This history dates back to June 14, 1985, when Governor Rudy 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, families advocates, mental health providers, professional groups, county government, county social services, businesses and the Legislature.

On February 3, 1986, the Commission released its report 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 (federal, state, and local) in terms of regulations, uniformity and flexibility."
2. "Responsibility is not well identified or fixed within either the sectors 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 of 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 service 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.

All of the critical attention paid to Minnesota's mental health system resulted in remarkable accomplishments during the 1987 Legislative Session. Because the Commissioner of Human Services was charged with the development of a comprehensive service system, legislation was introduced in 1987 which required all of Minnesota's 87 counties to make available an array of services (Minnesota has a county administered social service system). That legislation was passed largely intact, and became known as the 1987 Comprehensive Mental Health Act. A copy of the Act is attached (Appendix A), with a description of services beginning on page 11 of the attachment.

In the 1988 Legislative Session, the needs of emotionally disturbed children and adolescents were addressed. A mission statement for children was adopted that has led to the drafting of legislation to address their programming needs. That legislation will be submitted for the 1989 Legislature.

The mission statement for children is as follows:

The Commissioner of Human Services shall create and ensure a unified, accountable, comprehensive children's mental health service system that:

(a) identifies children who are eligible for mental health services;
(b) makes preventive services available to a wide range of children, including those who are not eligible for more intensive services;
(c) assures access to a continuum of services that:
    (1) educate the community about mental health needs of children;
    (2) addresses the unique physical, emotional, social, and educational needs of children;
    (3) are coordinated with other social and human services provided to children and their families;
    (4) are appropriate to the developmental needs of children; and
    (5) are sensitive to cultural differences and special needs;
(d) includes early screening and prompt intervention in order to:
    (1) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and
    (2) prevent further deterioration;
(e) provides services to children and their families in the context in which the children live and go to school;
(f) addresses the unique problems of paying for mental health services for children; including:
    (1) access to private insurance coverage;
    (2) public funding;
(g) to every extent possible, includes children and their families in planning the child's program of mental health services; and
(h) when necessary, assures a smooth transition to the adult service system.

(M.S. 245.698, Sec. 4)

Minnesota's renewed commitment to mental health services seemed to be acknowledged with the release of an updated report by the Public Citizen Health Research Group in September 1988. The PCHRG, which originally rated Minnesota's mental health programs 37th in the nation, moved the state up to 33rd and listed it among six states as "improving most impressively."

State Mental Health Advisory Council

Also during the 1987 session, legislation was passed (M.S. 245.697) which established a State Mental Health Advisory Council to assist in the planning and oversight of Minnesota's mental health system. The Council was given the authority to advise the

Commissioners of State Departments, the Legislature, and the Governor regarding unmet needs, issues and funding of the statewide mental health delivery system. On September 23, 1987, the Governor appointed twenty six members as required by law to serve on the new Council. The Council is currently 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.

Eleven of the Council's 26 members are state employees, state legislators, or providers. The remainder are consumers, family members, representatives of advocacy organizations, and local government social services representatives. The Council thus meets the membership requirements of P.L. 99-660. The Council meets monthly as a whole, and conducts committee meetings on the day previous to its regularly scheduled meetings.

Planning for a system of community based services had been accomplished in piecemeal fashion until formation of the Governor's Commission in June of 1985. The Commission's report, Mandate for Action (Appendix B), articulated a vision of a system of care and made specific recommendations (pp. 16-20 of the Mandate) toward developing that system. With the Council superceding the Commission, its duties have shifted to those of monitoring the implementation of the 1987 Mental Health Act, and of identifying and investigating issues that will have a long range impact on Minnesota's mental health system. The Council is required to report to the Governor and Legislature in October of each even-numbered year (the Legislature sets biennial budgets for the state). Its first report (Appendix C) makes specific recommendations on the budgets of the Departments of Human Services and Jobs and Training, and of the Office of the Ombudsman for Mental Retardation and Mental Health. The Council has also investigated long term housing issues; future role of Minnesota's regional treatment centers (formerly state hospitals); human resource development issues; and others.

Local Mental Health Advisory Councils

Finally, the 1987 Comprehensive Mental Health Act (M.S. 245.697) 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 council is 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.

III.

Mental Health Services in Minnesota: Current Status

III. Mental Health Services in Minnesota: Current Status

A. POPULATION ANALYSIS

1. Definition

Minnesota has adopted a statutory definition of mental illness upon which planning for a service system is based. All persons can access publicly-funded services either through eligibility for entitlement programs or through the use of sliding fee scales based on ability to pay.

The state's definition of mental illness is given below:

(a) "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) A "person with acute mental illness" means a person who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means a person who has a mental illness and meets at least one of the following criteria:

  (1) the person has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

  (2) the person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

  (3) the person:

    (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless an ongoing community support services program is provided; or

(4) the person has been committed by a court as a mentally ill person under Chapter 253B, or the person's commitment has been stayed or continued.

2. Incidence of Mental Illness in Minnesota:

In September 1987, the Mental Health Division (MHD) of the Department of Human Services contracted with the University of Minnesota for a study of the incidence of mental illness in Minnesota, broken down by age, sex, race, and county. The estimates were based on NIMH Epidemiologic Catchment Area (ECA) Program prevalence rates, and were computed with lower and upper limits.

University researchers estimated that between 22,000 and 29,000 Minnesotans suffer from serious and persistent mental illness. In addition, estimates are that between 63,000 and 154,000 persons aged 17 and under have a "childhood maladjustment," a concept used to describe a broad range of clinical phenomena.

When broken down by county, the estimates are one of the criteria the MHD uses to determine the need for services in each county. The complete report, with breakdowns, is included as Appendix D.

It should be understood that county estimates of specific psychiatric disorders indicate the population in need. Only a segment of the estimated population is diagnosed and receives treatment from different sources. An analysis of U.S. epidemiological studies on the ratio of treated to untreated cases in true prevalence estimates found that only about 25 percent of those found to be suffering from a clinically significant disorder had ever been in treatment. Large proportions, perhaps 75 percent, of individuals suffering from any psychiatric disorder have never been in treatment. For the more severe psychotic disorders, as many as 45 percent of cases, and for schizophrenia, about 20 percent of cases,

have never received treatment from a mental health professional. Furthermore, many individuals who receive treatment in the public sector are not true psychiatric cases. it is assumed that most of the true cases who receive treatment, are the acute and serious psychiatric cases. The county population with mental disorders should reflect these national trends.

A number of cells in the county tables give very small figures. The county estimates of specific psychiatric disorders should be read in terms of diagnosis, severity and duration. A low estimate figure may be associated with high severity, seriousness and cost of treatment. Furthermore, the prevalence estimates indicate that certain sex, age and race groups are more vulnerable to one or other type of mental disorder.

3. Service Principles for Persons with a Mental Illness

For many persons, mental illness is an unpredictable disease, both in its nature and its reoccurrence. Some persons may be able to adequately function in the community between crises or episodes of illness. Others may need varying degrees of support to assist them in maximizing their participation in society.

Like all Minnesotans, people with mental illness need food, clothing, shelter, medical or health services, transportation, education, recreation, and a secure income. The lack of one or more of these supports, in fact, may aggravate or stimulate the mental health problems experienced by the individual.

There are special needs as well. The Governor's Commission on Mental Health identified the following, which continues to guide the MHD in planning services:

> A comprehensive evaluation of individual strengths and weaknesses, and an opportunity to participate in setting goals and developing a plan for appropriate services;
>
> Appropriate and continuing medical, psychiatric, or psychological treatment as necessary, including periodic review and regulation of medication;

A place to go or a person to call for help in dealing with acute behavioral, emotional, or physical distress;

Training in "coping skills" to assist in tasks of daily living, and when appropriate, assistance in performing these tasks;

Dependable, available resources to provide assistance as needed or when crisis arise, who will protect the person from exploitation, represent the person as necessary, and espouse the person's cause in dealing with the system;

Opportunities for validation of personal worth, for being appreciated and valued as a human being;

A residential setting (a place to live) which provides additional support, practical assistance in daily living, and which resembles other community living arrangements as much as possible (in a family or a household composed of people of one's own choosing);

Assistance to family and significant others in relation to any difficulties they may experience as a result of the person's mental illness;

Vocational guidance, training, and assistance in securing and holding an appropriate job;

Provisions of work or other useful daily activities for those individuals who are currently incapable of holding a regular job;

Assistance in taking advantage of entitlements as citizens or residents of their respective communities; and

A clearly defined, accessible, and workable grievance procedure.

We must never forget, however, that the basic needs of people with mental health problems are the same for all people. In meeting their special needs, we must also pay close attention to their ordinary needs.

4. Mental Health Information System

Over the past several years information collected by the MHD has been in the form of annual reports from Community Support Program (CSP) grant programs and community residential facilities, both of which focus on serious

and persistently mentally ill clients. These reports gather aggregate information on the number of clients served, demographics, client mental health descriptors and general outcome information on hospital use, employment, income source and living arrangement. Each county must also gather and report information on the populations it serves as a requirement for receiving CSSA block grant funds.

With the 1987 Mental Health Act service requirements and the expansion of CSPs across the state, the MHD has developed an individual client reporting system for implementation by January 1, 1989. The reporting system is designed to build on existing systems such as the main system used by counties known as the CSIS. The intention of this system is not to replace existing information systems but rather to gather data that already exists on those systems. The MHD is contracting with the consulting firm which programs the CSIS to make the necessary changes for the new reporting system.

The reporting system will cover all publicly funded mental health services provided by the county or under contract to the county, and will involve quarterly reporting on the mental health services received by clients during that quarter. Each provider will be required to report on each mental health client served and the unit of services received by that client. The client descriptors will be very basic: birthdate, sex, race and type of mental health problem (serious and persistent, acute, or other). A client identifier will be supplied with the information, however, a unique client identifier system has not yet been set up in the state. The Department is investigating the development of a unique client identifier for all human services during the next two years. When that system is in place, tracking of client service use will be possible.

In addition to the new mental health reporting system, the MHD will also be using two other Department information systems: the Medicaid Management Information System (MMIS) and a new regional treatment center information system. The MMIS will be used to examine in more detail the use of Medicaid and General Assistance Medical Care (GAMC) reimbursed mental health services. In the past, the MHD has received an annual aggregate report on the number of clients served and amount of services received by type of service. In the future the MHD will directly use the data base itself for more detailed analysis. Two RTCs are in the process of pilot testing a new management information system which has been developed by Advanced Institutional Management Software, Inc. (AIMS) in conjunction with IBM. The plan

is to pilot test the MMIS in two centers and then to gradually expand to all facilities. This new information system will allow greater access to RTC facility information in a more timely manner.

With the new client reporting system, the MHD is in the process of examining what additional client information will be needed from CSPs and community residential treatment facilities. Some additional information will be needed from these programs to examine their effectiveness and the type of clients served. It is expected that a sampling approach of client records and staff time will be used to gain additional information.

B. IDEAL SYSTEM OF SERVICES:

As mentioned earlier, the 1987 Mental Health Act laid out a system of services. The law created deadlines for the implementation of the system, altered certain funding mechanisms, and for the first time required all counties to implement the system.

Counties were required by law to make available all of the services described below by July 1, 1988, with the exception of case management services, which has a deadline of January 1, 1989 and screening, which has a deadline of January 1, 1991.

In addition, though all counties must make available services in Regional Treatment Centers (RTCs - formerly called state hospitals), the Department is currently engaged in a comprehensive review of the role of RTCs in the overall system of mental health services. This review is being conducted with broad community participation, and an implementation plan is expected to be ready in time for submission to the 1989 Legislature. A more thorough discussion of RTC services appears under the heading Regional Treatment Center Inpatient.

Finally, components of the system of services were given priority ranking in the 1987 Mental Health Act, as follows:

(1) the provision of locally available emergency services;

(2) the provision of locally available services to all persons with serious and persistent mental illness and all persons with acute mental illness;

(3) the provision of specialized services regionally available to meet the special needs of all persons with serious and persistent mental illness and all persons with acute mental illness;

(4) the provision of locally available services to persons with other mental illness; and

(5) the provision of education and preventive mental health services targeted at high-risk populations.

The Act also incorporated the 1986 mission statement as the planning basis for a new service system. In that sense, the mission statement, along with the priorities stated above, also served as the goals around which the objectives or services of the Act were designed.

The system of services to be implemented in Minnesota includes:

Education and Prevention Services

Objective:

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

Education and prevention services:

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

2. Increase understanding and acceptance of problems associated with mental illness.

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

4. Prevent the development or deepening of mental illness.

Target Population:

All persons residing in the county.

Funding Mechanisms:

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

Emergency Services

Objective:

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. (M.S. 245.419)

Emergency services:

1. Promote safety and emotional stability.
2. Minimize further deterioration.
3. Assist in obtaining ongoing care and treatment.
4. 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 a mental health professional for consultation within 30 minutes.
4. Sliding fee schedules permitted.

Target Population:

All persons with an emotional crisis or mental illness.

Funding Mechanisms:

Funding for emergency services uses a combination of Rule 14 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.

<u>Outpatient Services</u>:

Objective:

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 (M.S. 245.470).

Outpatient services:

1. Provide diagnostic assessments.
2. Provide psychological testing.
3. Develop individual treatment plans.
4. Make referrals/recommendations regarding placements.
5. Provide ongoing treatment.
6. Provide medication management.

7. 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.

Target Population:

Persons with mental illness.

Funding Mechanisms:

Funding for outpatient services is available from third party reimbursers, MA, GAMC, client fees and CSSA.

Community Support Services:

Objective:

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 (M.S. 245.471).

Community support services 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 were provided Rule 14 funding to develop and maintain this service.

Target Population:

Persons with serious and persistent mental illness.

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 as to which of the subcomponents of the community support service programs it will fund.

Day Treatment:

Objective:

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 (M.S. 245.472). This requirement is waivable if counties can document that:

1. An alternative plan of care exists through the county's 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 infeasible.

Funding Mechanisms:

Funding for day treatment services is available through third party reimbursers, 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 was approved to allow MA to fund day treatment in county contracted providers other than Rule 28 approved community mental health centers.

Target Population: Persons with mental illness.

Residential Treatment:

Objective:

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:

1. Prevents placements in settings that are more intensive, costly or restrictive than necessary and appropriate to meet client needs.
2. Helps clients achieve the highest level of independent living.
3. Helps clients gain the necessary skills to be referred to a community support program or outpatient service.
4. Stabilizes crisis admissions.

In addition, residential treatment facilities must be licensed under Rule 36 for adults or Rule 5 for children and adolescents.

Target Population:

Primarily persons with serious and persistent mental illness.

Funding Mechanisms:

The 1987 Legislature appropriated new Rule 12 funds to develop three new Rule 36 facilities in rural areas of the state. 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

Objective:

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 (M.S. 245.473).

Acute care hospital inpatient services:

1. Stabilize the medical condition of people with acute or serious and persistent mental illness.
2. Improve functioning.
3. 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.

Target Population:

Persons with acute mental illness.

Funding Mechanisms:

Funding for acute care hospital inpatient services is available from third party reimbursers, 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

Presently, the Department of Human Services is engaged in a public negotiation process to determine the future role and configuration of its regional treatment center system. The negotiation, which involves representatives from local communities, labor groups, other governmental entities and client advocacy groups, is intended to generate a consensus around which legislation can be introduced in the 1989 Minnesota Session.

The Department's service proposal suggests the following mission for its RTCs: to provide inpatient psychiatric treatment to persons with major mental illness through active treatment programs designed to:

- stabilize the individual and his or her symptoms;
- improve functioning;
- strengthen family and community support; and
- facilitate discharge after care and follow up in the community.

It is proposed that the RTCs will offer:

- psychiatric hospital services
    - crisis stabilization and emergency services;
    - acute care inpatient services (< 30 days);
    - intense psychiatric programs (> 30 days).

- Other psychiatric services, including:
  - continued care for persons who have not stabilized to the point where transition to the community is clinically appropriate;
  - after care services to facilitate transition to the community;
  - services for persons committed by the courts;
  - professional consultative services through purchased services or shared services arrangements.

As indicated below, all counties are required by the 1987 Mental Health Act to make RTC services available. However, details of the types of services RTCs will offer will not be available until the completion of the public negotiations process.

Objective:

By July 1, 1987, the Commissioner shall make sufficient RTC inpatient services available to people with mental illness throughout the state (M.S. 245.474). Currently there are six RTCs providing inpatient treatment for people with mental illness.

RTC inpatient treatment:

1. Stabilizes the medical condition of persons with mental illness.
2. Improves functioning.
3. Strengthens family and community support.
4. Facilitates appropriate discharge, aftercare, and follow up placements in the community.

In addition, RTC inpatient treatment units must be licensed and the Commissioner must conduct biennial staffing studies to assess the staffing needs of the mental illness units of the regional treatment centers.

Target Population:

Persons with serious and persistent mental illness.

<u>Case Management</u>

Objective:

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

Case management:

1. assists with access to needed medical, social, education, vocational and other necessary services.
2. assists in obtaining a diagnostic assessment.
3. develops an individual community support plan.
4. refers clients to services.
5. coordinates services.
6. monitors the delivery of services.

Target Population:

Persons with serious and persistent mental illness.

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 and county funds (under CSSA).

Screening

Objective:

By January 1, 1991, 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 (M.S. 245.476).

Screening:

1. Ensures admission is necessary.
2. Ensures that the length of stay is as short as possible consistent with client need.
3. Ensures assignment of a case manager to persons with serious and persistent mental illness.

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

Target Population:

All persons using public funds admitted to residential or RTC or acute care inpatient.

Funding Mechanisms:

Originally, funding for screening services was planned to be available from diversionary savings from unnecessarily

expensive treatment modalities. Upon close examination, it is unlikely that diversionary savings will be made. Most psychiatric admissions to acute care hospital inpatient treatment and RTC 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 would be an enormously costly and cumbersome system. As a result, the 1988 Legislature delayed implementation of screening services until January 1991. The MHD will submit a report on implementation plans, affected individuals, and funding mechanisms to the 1990 Legislature.

C. ACTIVITIES TO REDUCE THE RATE OF HOSPITALIZATION OF SERIOUSLY MENTALLY ILL INDIVIDUALS.

A focus of the evaluation activities related to Community Support Programs (Rule 14) and Adult Residential Treatment (Rule 36) programs has been the psychiatric hospitalization of their clients. Both programs report in a summary form on the state hospital/regional treatment center and community acute inpatient care use by their clients before, during and after the program. The last legislative report on these programs covered state FY 1986.

The report for FY 1986 indicates that the hospitalization rates for both Rule 36 and Rule 14 participants are substantially reduced when compared to the year immediately preceding their admission. While in Rule 36 programs, the rate drops from 78% to 24%. While in Rule 14 programs, client rates drop from 50% to 14%. Both of these rates are based on data at discharge from the Rule 36 or Rule 14 programs.

TABLE 1

RULE 36 HOSPITALIZATION HISTORY

HOSPITALIZATION HISTORY FOR CLIENTS DISCHARGED

TYPE OF HOSPITAL	PERCENT OF CLIENTS HOSPITALIZED			
	ANYTIME BEFORE PROGRAM	ONE YEAR BEFORE PROGRAM	DURING PROGRAM	6 MONTHS AFTER PROGRAM*
REGIONAL TREATMENT CENTER	49%	29%	1%	15%
COMMUNITY INPATIENT	71%	58%	23%	28%
TOTAL- UNDUPLICATED	97%	78%	24%	37%

HOSPITALIZATION HISTORY FOR CLIENTS IN PROGRAM >1 YR AS OF 6/30/86

TYPE OF HOSPITAL	PERCENT OF CLIENTS HOSPITALIZED		
	ANYTIME BEFORE PROGRAM	ONE YEAR BEFORE PROGRAM	LAST YEAR DURING PROGRAM
REGIONAL TREATMENT CENTER	47%	30%	1%
COMMUNITY INPATIENT	51%	29%	13%
TOTAL- UNDUPLICATED	72%	47%	14%

TABLE 2

RULE 14 HOSPITALIZATION HISTORY

HOSPITALIZATION HISTORY FOR CLIENTS DISCHARGED

PERCENT OF CLIENTS HOSPITALIZED

TYPE OF HOSPITAL	ANYTIME BEFORE PROGRAM	ONE YEAR BEFORE PROGRAM	DURING PROGRAM	10 MONTHS AFTER PROGRAM*
REGIONAL TREATMENT CENTER	32%	16%	2%	5%
COMMUNITY INPATIENT	59%	38%	12%	18%
TOTAL- UNDUPLICATED	76%	50%	14%	22%

HOSPITALIZATION HISTORY FOR CLIENTS IN PROGRAM >1 YR AS OF 6/30/86

PERCENT OF CLIENTS HOSPITALIZED

TYPE OF HOSPITAL	ANYTIME BEFORE PROGRAM	ONE YEAR BEFORE PROGRAM	LAST YEAR DURING PROGRAM
REGIONAL TREATMENT CENTER	51%	26%	6%
COMMUNITY INPATIENT	45%	30%	13%
TOTAL- UNDUPLICATED	71%	43%	14%

*NOTE: These hospital rates were based on the 835 Rule 36 clients and 575 Rule 14 clients with follow-up data during FY 1986 after discharge.

For clients who were still in the program at the end of the year and who were in the program at least one year, there were also large reductions in hospitalizations. For clients in Rule 36 programs the drop was from 47% the year before to 14% their last year in the program. For Rule 14 clients the drop was from 43% the year before to 14% their last year in the program.

Tables 1 and 2 list the hospitalization percentages for both programs and also separates out hospitalizations in State Regional Treatment Centers and Community Inpatient Hospitals.

Table 1 and 2 also show figures on the hospitalization of clients who were discharged from the program in either FY 1985 or early FY 1986 and followed up during Fiscal Year 1986. As can be seen, the percent of clients hospitalized begins to rise after discharge. For the 835 Rule 36 clients with follow-up information for the 6 months after discharge, 37% had some type of hospitalization. Of the 575 clients from Rule 14 programs with follow-up information, 22% had been hospitalized during the 10 month period, on average, after leaving the program. The hospitalization rates from discharge to follow-up are still lower compared to the year before clients entered the programs. It should be noted that many of the clients followed up were not discharged during FY 1986 and therefore may not have the same hospitalization history as those listed in the tables.

This information demonstrates that the availability of Rule 36 programs and community support programs is effective in reducing hospitalization. Hospitalization is reduced to a much greater degree while the clients are in the program. The information on hospitalization after clients leave is much less complete. The available information indicates that hospitalization starts to increase after leaving the program. Part of this increase might be due to the fact that many of the clients left the program before completing it. It is possible that clients who left the program before they were ready, might then be more vulnerable to hospitalization. In addition, the continued reduction of hospitalization depends on appropriate services after or in conjunction with a Rule 14 type of program, such as supervised apartments or SILS-like services (Semi-Independent Living Services).

A factor of concern regarding Both Rule 14 and 36 programs is the apparent lack of supportive follow-up on many clients who have left the program. There could be several reasons for this lack of follow-up. If the follow-up does not occur and/or other appropriate supportive services are not available, once a client leaves a program he/she is probably likely to return to a hospital setting.

While these data indicate that the programs were effective in reducing the number of clients hospitalized, there are some cautions which should be observed. First, some of the data may be based on client recollections and estimates made by the staff. Also, the data for hospitalization during the program is probably the most accurate since the programs have more first hand information for that period compared to before and after the program.

While reduction in hospitalization has been measured in aggregate reports by Rule 14 and Rule 36 programs previously, over the next year a sampling of individual

client records will be used. This mechanism should allow more uniform and accurate collection of hospital data. The goal is to reduce the total amount of time spent in RTC and community inpatient facilities for each client entering a Community Support Program or a Rule 36 residential facility. The baseline for the target will be the amount of time each client spent in such facilities during the previous year before entering the program.

D. PROJECTED UTILIZATION OF SERVICES

Detailed county-specific data was obtained regarding the use of Medical Assistance for mental health services and the use of state RTCs and residential treatment. County-specific mental illness incidence data utilizing the NIMH incidence studies mentioned earlier was also used. All available data was provided to each county to assist in their mental health planning.

Counties used this and other historical data to project service use for the coming year (Table 3). It should be emphasized that these projections are based partly on historical data predating implementation of services required by the Mental Health Act of 1987. As many of these services begin operation, revisions to the projections given here are likely.

E. IDENTIFIED NEEDS

1. Housing

Adults in Minnesota with mental illness who are able to live in less restrictive settings than RTCs or community residential treatment facilities, compete with other low income populations, the elderly, and the physically disabled for available subsidized housing units. A 1986 Metropolitan Council Subsidized Housing Report described a dramatic decrease in the number of new subsidized units during the past six years, from 2,195 new units in 1980 to 1,422 new units in 1981, to 135 new units in the three years from 1983 to 1986. In addition, the number of subsidized units could decrease significantly in the 1990's when contracts for buildings reach their 20 year expiration date. In 1991, 20 such contracts will expire, and the owners may, without government approval, repay the mortgages and dispose of the property as they wish. Those 20 contracts represent 1,864 units.

Additionally, in recent years, the number of rooms available in residential hotels and rooming houses in Minneapolis and St. Paul has decreased because of

DRAFT-7/11/88

TABLE 3

PLANNED SERVICE USE PER 10,000 POPULATION FOR 1989 FROM MENTAL HEALTH PLANS

COUNTY	COUNTY POPULATION	EMERGENCY CONTACTS PER 10,000 POP	OUTPATIENT CLIENTS PER 10,000 POP	RULE 36 ADULTS PER 10,000 POP	RULE 5 CHILD. PER 10,000 POP	ACUTE HOSP ADULTS PER 10,000 POP	ACUTE HOSP CHILD. PER 10,000 POP	RTC ADULTS PER 10,000 POP	RTC CHILD. PER 10,000 POP
ANOKA RTC									
ANOKA	219,230	172.8	74.6	5.7	8.9	13.3	3.5	2.7	0.0
DAKOTA	228,716	191.5	99.7	6.6	1.1	7.9	1.7	2.3	0.2
HENNEPIN	967,455	807.9	160.2	10.4	4.3	15.5	2.4	5.2	0.1
RAMSEY	465,287	743.6	168.1	18.2	21.5	0.0	2.9	5.7	0.2
SHERBURNE	35,781	17.0	257.1	2.8	1.7	10.6	2.8	4.5	2.2
WASHINGTON	127,912	45.0	159.1	4.9	1.8	6.4	1.3	3.0	0.3
TOTAL/AVG	2,044,381	329.7	153.1	8.1	6.6	9.0	2.4	3.9	0.5
BRAINERD RTC									
AITKIN	13,421	171.4	69.3	2.2	2.2	7.5	1.5	11.9	0.7
BELTRAMI	33,720	62.3	188.0	5.9	2.1	1.8	1.2	14.5	1.5
BENTON	27,455	32.8	80.9	4.4	2.9	5.8	2.9	10.9	1.1
CASS	21,300	14.1	183.1	7.0	1.4	11.7	0.9	17.8	0.9
CLEARWATER	9,018	4.4	108.7	2.2	3.3	8.9	4.4	13.3	3.3
CROW WING	43,508	27.6	149.4	6.2	0.7	20.7	9.2	27.6	4.6
HUBBARD	15,529	64.4	39.9	3.2	0.0	7.7	0.6	7.7	0.6
LAKE OF WOODS	3,895	0.0	77.0	2.6	2.6	2.6	2.6	15.4	2.6
MORRISON	30,228	113.5	253.7	3.0	2.6	4.6	4.6	9.3	2.6
TODD	25,456	4.7	174.8	4.3	0.4	2.7	1.2	4.3	0.8
WADENA	13,748	36.4	87.3	14.5	0.7	21.8	4.4	8.7	0.0
TOTAL/AVG	237,278	48.3	128.4	5.1	1.7	8.7	3.0	12.9	1.7
FERGUS FALLS RTC									
BECKER	31,258	64.0	192.0	1.6	0.6	2.6	0.0	22.4	1.3
CLAY	49,256	23.3	183.5	4.1	6.1	15.8	1.0	13.4	0.4
DOUGLAS	29,953	50.1	140.2	9.7	2.7	12.0	6.7	10.0	0.0
GRANT	7,055	14.2	153.1	2.8	1.4	5.7	1.4	7.1	0.0
KITTSON	6,589	151.8	45.5	3.0	1.5	6.1	3.0	7.6	0.0
MAHNOMEN	5,561	64.7	143.9	3.6	5.4	7.2	7.2	21.6	1.8
MARSHALL	12,675	86.8	29.2	1.6	3.9	5.5	0.8	7.9	0.0
NORMAN	9,062	55.2	82.8	5.5	2.2	8.8	4.4	16.6	1.1
OTTER TAIL	54,970	91.0	196.1	4.7	1.1	1.8	0.9	20.0	0.7
PENNINGTON	13,683	657.8	62.1	3.7	0.7	83.3	21.9	9.5	0.0
POLK	34,102	26.4	132.0	5.0	2.6	17.6	1.5	11.7	1.2
POPE	11,698	42.7	128.2	4.3	1.7	4.3	0.9	3.4	0.9
RED LAKE	5,062	49.4	35.6	5.9	2.0	7.9	2.0	11.9	2.0
ROSEAU	13,736	72.8	29.1	1.5	0.7	5.8	0.7	7.3	0.0
STEVENS	11,128	35.9	71.9	9.0	1.8	18.0	3.6	18.0	0.9
TRAVERSE	5,088	39.3	29.5	3.9	2.0	3.9	2.0	15.7	0.0
WILKIN	8,157	63.7	91.9	6.1	3.7	4.9	2.5	15.9	2.5
TOTAL/AVG	309,033	93.5	102.7	4.5	2.4	12.4	3.6	12.9	0.7

DRAFT-7/11/88

TABLE 3 (continued)

PLANNED SERVICE USE PER 10,000 POPULATION FOR 1989 FROM MENTAL HEALTH PLANS

COUNTY	COUNTY POPULATION	EMERGENCY CONTACTS PER 10,000 POP	OUTPATIENT CLIENTS PER 10,000 POP	RULE 36 ADULTS PER 10,000 POP	RULE 5 CHILD. PER 10,000 POP	ACUTE HOSP ADULTS PER 10,000 POP	ACUTE HOSP CHILD. PER 10,000 POP	RTC ADULTS PER 10,000 POP	RTC CHILD. PER 10,000 POP
MOOSE LAKE RTC									
CARLTON	28,541	105.1	227.7	9.8	0.7	3.5	2.1	15.1	0.4
CHISAGO	28,668	39.1	26.2	3.1	2.1	3.5	2.1	4.2	0.3
COOK	4,350	275.9	827.6	4.6	4.6	4.6	9.2	11.5	0.0
ISANTI	26,299	9.5	456.3	1.9	5.7	1.5	0.8	7.6	0.8
ITASCA	43,914	400.8	45.5	7.3	0.9	12.3	1.6	5.5	0.0
KANABEC	12,630	7.9	133.0	5.5	1.6	5.5	4.8	11.1	1.6
KOOCHICHING	16,155	128.8	53.2	6.8	4.3	11.1	0.6	15.5	0.0
LAKE	11,425	45.5	192.6	0.9	0.9	13.1	2.6	1.8	0.0
MILLE LACS	18,671	27.9	160.7	4.3	3.2	10.7	2.1	9.6	1.1
PINE	20,900	12.0	124.4	4.8	1.0	5.7	1.4	12.0	2.4
ST LOUIS	203,069	41.9	246.2	5.2	2.0	18.7	3.2	9.4	0.3
TOTAL/AVG	414,622	99.5	226.7	4.9	2.4	8.2	2.8	9.4	0.6
ST. PETER RTC									
BLUE EARTH	52,768	663.3	180.4	3.0	2.3	6.6	0.0	11.6	0.2
BROWN	28,015	53.5	133.9	3.6	2.5	7.1	0.7	7.9	0.7
DODGE	15,210	3.9	197.2	9.2	1.3	0.7	0.7	5.9	1.3
FILLMORE	21,443	28.0	63.0	15.4	2.3	8.9	1.4	4.7	0.5
FMW	54,141	3.9	67.2	3.7	1.7	6.5	1.5	7.4	0.6
FREEBORN	34,587	17.3	172.3	4.9	4.0	7.2	1.4	4.6	0.0
GOODHUE	40,075	56.1	239.6	8.2	7.5	3.5	0.7	5.2	0.2
HOUSTON	19,072	220.2	209.7	10.5	1.0	5.2	9.4	7.9	1.0
LE SUEUR	23,607	44.1	403.3	5.5	1.3	8.5	4.2	16.1	1.7
MOWER	39,243	254.8	254.8	9.4	6.9	10.2	2.5	7.6	0.0
NICOLLET	28,278	0.0	212.2	3.5	5.3	2.8	1.8	5.3	0.0
OLMSTED	98,850	186.6	253.2	14.9	0.0	11.1	0.5	8.8	0.2
RICE	47,599	0.0	45.2	3.4	2.1	1.7	0.6	4.8	0.2
STEELE	30,726	9.8	260.4	15.0	1.6	6.5	2.6	10.1	0.7
WABASHA	19,352	25.8	180.9	3.1	2.6	2.6	1.6	3.1	1.0
WASECA	18,644	2.1	182.4	4.3	2.1	7.5	2.1	5.4	1.1
WINONA	46,795	42.7	235.1	11.1	7.1	25.6	2.1	6.8	0.6
TOTAL/AVG	618,405	94.8	193.6	7.6	3.0	7.2	2.0	7.2	0.6

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TABLE 3 (continued)

PLANNED SERVICE USE PER 10,000 POPULATION FOR 1989 FROM MENTAL HEALTH PLANS

COUNTY	COUNTY POPULATION	EMERGENCY CONTACTS PER 10,000 POP	OUTPATIENT CLIENTS PER 10,000 POP	RULE 36 ADULTS PER 10,000 POP	RULE 5 CHILD. PER 10,000 POP	ACUTE HOSP ADULTS PER 10,000 POP	ACUTE HOSP CHILD. PER 10,000 POP	RTC ADULTS PER 10,000 POP	RTC CHILD. PER 10,000 POP
WILLMAR RTC									
BIG STONE	7,760	38.7	54.1	9.0	1.3	11.6	1.3	11.6	0.0
CARVER	41,586	86.6	158.7	3.6	8.4	5.8	2.6	4.8	0.2
CHIPPEWA	14,560	92.7	278.2	13.0	4.8	10.3	2.1	8.9	1.4
COTTONWOOD	13,640	448.7	203.8	12.5	7.3	11.7	3.7	8.8	0.7
JACKSON	13,239	9.1	56.7	2.3	3.8	7.6	0.8	0.8	0.0
KANDIYOHI	39,879	1363.1	234.5	38.9	20.8	17.6	3.0	51.2	0.8
LAC QUI PARLE	10,129	69.1	143.2	9.9	3.9	2.0	2.0	9.9	0.0
MCLEOD	30,415	184.1	139.7	2.0	1.0	11.5	3.3	14.5	0.7
MEEKER	21,110	379.0	293.7	23.7	21.3	3.8	1.4	15.6	2.8
NOBLES	21,395	738.5	144.9	16.4	2.8	13.6	2.8	7.0	0.5
PIPESTONE	11,155	237.6	197.2	7.2	2.7	8.1	2.7	1.8	0.9
REDWOOD	18,443	35.2	204.4	2.7	2.2	10.8	2.2	13.6	1.1
REGION 8 NORTH	44,242	40.2	182.2	4.1	2.0	9.0	1.8	10.2	0.0
RENVILLE	19,213	338.3	234.2	18.2	12.5	0.0	0.0	10.4	2.1
ROCK	10,442	507.6	181.0	7.7	3.8	7.7	1.0	4.8	0.0
SCOTT	52,255	5.7	200.9	4.6	3.8	4.6	0.8	3.1	0.0
SIBLEY	15,461	7.8	200.5	3.9	2.6	2.6	1.3	7.8	0.0
STEARNS	115,786	34.5	229.7	3.5	0.7	7.3	2.0	11.2	1.2
SWIFT	12,445	128.6	401.8	9.6	6.4	3.2	1.6	8.8	0.8
WRIGHT	64,455	16.1	153.6	1.2	2.6	7.8	2.8	7.8	1.2
YELLOW MEDICINE	12,684	24.4	197.1	2.4	2.4	1.6	1.6	11.0	0.0
TOTAL/AVG	590,294	227.9	194.8	9.3	5.6	7.5	1.9	10.6	0.7
STATE TOTAL/AVG	4,214,013	139.6	168.1	6.7	3.5	8.8	2.6	10.1	0.8

significant redevelopment activities in the center city areas. Outstate areas also face shortages of low income housing and long waiting lists for subsidized housing.

Other factors influencing Minnesota's ability to provide subsidized housing include:

1. Housing and Urban Development's (HUD) budget has dropped 60 percent since 1980, from $35.7 billion to $14.2 billion.

2. HUD's focus has shifted from new subsidized housing construction to providing those in need of housing assistance with housing vouchers.

3. The Metropolitan Council forecasts a need for approximately 121,000 additional units by 1995.

4. Housing costs have increased 47 percent over the past decade in the metropolitan area (constant dollars).

The Department has developed a mission statement to address the housing needs of persons with mental illness.

- "All people with mental illness should live in decent, stable, affordable housing, in settings that maximize community integration and opportunities for acceptance. People should actively participate in the selection of their housing from those living environments available to the general public. Necessary support should be available regardless of where people choose to live."

- Success in accomplishing this mission will occur "when Minnesota has a variety of housing and support options for persons with mental illness that are affordable and that can be accessed through generic means." The state goes on to identify, "Housing options would include low income houses and apartments for individuals and their families, long term supportive care, foster care, semi-independent living situations and whatever else would meet the individual's needs and choices."

- "In moving toward that mission, legislation for a comprehensive system of mental health services requires each county's community service program to develop an individual client housing plan, to aid in accessing an appropriate living situation, and

to provide outreach and support to those living independently."

The MHD will hire a housing specialist, beginning early in 1989, to develop objectives to meet the goals described in the mission statement above. Also to help implement this mission, the MHD worked with the Minnesota Legislature to obtain funding for housing support services for adults with serious and persistent mental illness.

The goal of these projects is to provide a wide array of housing support services for people when they are discharged from Rule 36 facilities, RTCs and those already living in the community. This means developing alternative or "pilot projects" which will address the needs of individuals who do not need a supervised 24-hour type of living environment.

These projects will promote stable long term housing for adults with serious and persistent mental illness, and maximize dignity and self respect. The projects will be designed to allow people to remain and develop their lives and skills in the most appropriate and normal housing available.

Though funding for the projects is on a one-time basis, knowledge gained from the projects will be used to present an evaluation of the housing program to the 1991 Legislature.

Proposals were reviewed in October 1988 with start up dates projected for December 1988.

2. Services for Children and Adolescents

The 1987 Mental Health Act referenced its applicability to children with mental health needs but did not define severely emotionally disturbed children nor include specialized services to meet their needs. The fact that it did not specifically address the needs of children was pre-agreed to by the Legislature, the Governor's Mental Health Commission and the MHD with the understanding that legislation would be developed for the 1989 session. To assure that this happened, the 1988 Legislature passed a children's mental health mission statement which requires the Commissioner to develop a comprehensive, coordinated system of care for emotionally disturbed, behaviorally disturbed and mentally ill children with implementation to begin by 1990 and be completed by 1992. In addition, the 1988 Legislature created a childrens' mental health subcommittee to the State Mental Health Advisory Council

to provide input to, advocate for, and oversee the implementation of such a comprehensive, coordinated system of care. The Children's Mental Health Initiative, PACER Center, the Alliance for the Mentally Ill, the Minnesota Mental Health Association and the State Mental Health Advisory Council as well as providers and counties have all been working toward and planning for this legislation.

A more thorough description of the Department's plans for designing and implementing a system of children's services appears in the chapter "Mental Health Services for Children and Adolescents".

3. Third-Party Coverage for Outpatient Mental Health Services

The 1987 Legislature amended the state's insurance bill to require 80% coverage of the first 10 hours for outpatient mental health services. The amendments also require 75% coverage for additional hours of treatment, which could be limited to 30 total hours and require prior authorization. Despite these alternatives, insurance carriers continue to deny outpatient mental health benefits to their subscribers. Amendments will clarify the conditions under which the additional 20 sessions of outpatient mental health care must be granted rather than leaving this to the discretion of the carrier.

It is essential in providing adequate mental health care to Minnesota's population that both the public and private sectors join in their respective responsibilities regarding funding. Minnesota is fortunate to have a mandated outpatient mental health benefit as a requirement to HMO and group policies. Despite these requirements, carriers often deny the full scope of benefits to their subscribers. When this happens, the public sector becomes needlessly burdened in funding this care.

While these developments take place, the MHD will also be monitoring the recommendations of the Governor's Commission on Health Plan Regulatory Reform, due mid-February 1989. The Commission was formed to address issues of competitiveness as they relate to the uneven application of health coverage mandated across different models of private payers.

4. Clarification and Revision of Licensing Laws for Mental Health Programs

During the past eight years, a number of new types of mental health programs have been developed which were

not fully considered when Minnesota's Licensing Act was written. During the summer of 1988, the Department of Human Services conducted an intensive study and analysis to determine which mental health programs should be licensed and to develop legislative recommendations accordingly.

5. Determine the Future Role of Regional Treatment Centers

   The Department is currently in the midst of a comprehensive negotiation process for determining what role in the treatment system ought to be played by Minnesota's RTCs. A more thorough discussion of this process is found on pp. 25-27.

6. Address the Administration of RTC and Community-Based Mental Health Programs

   Currently, mental health programs delivered by Minnesota's RTCs are administered by the DHS Assistant Commissioner for Health Care and Residential Programs, while community-based mental health programs are administered by the Assistant Commissioner for Mental Health. Problems associated with program coordination have been identified by the Advisory Council and a number of other entities. The Department will explore discussions to improve program coordination among RTC and community-based programs over the next year.

7. Address County Administration of Local Mental Health Programs

   As discussed earlier, Minnesota utilizes a state-funded, county-administered social services system. Because counties must contend with a variety of competing uses for social services block grant funds, there have been criticisms that they may not consistently be able to make the needs of persons with a mental illness a priority. The Department of Human Services will continue to address these concerns with county social services administrators in conjunction with local and state mental health advisory council members.

8. The MHD will be addressing the Federal Nursing Home Reform Act (P.L. 100-203), which states that a nursing facility must not admit, on or after January 1, 1989, any new resident who is mentally ill, unless the state mental health authority has determined prior to admission that because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental illness.

In addition, as of April 1, 1990, the State, via DHS, must establish an annual review process for mentally ill residents to determine whether or not the resident requires the level of services provided by a nursing facility; an inpatient psychiatric hospital (for individuals under age 21); or of an institution for mental diseases that is providing medical assistance to individuals 65 years of age or older; and whether or not the resident requires active treatment for mental illness. The reviews and determinations must first be conducted for each resident by not later than April 1, 1990.

As of April 1, 1990, all individuals who are inappropriately residing in a nursing facility must be discharged in a safe and orderly manner, unless the individual needs active treatment, has continuously resided in a nursing facility for at least 30 months, and chooses to remain in the nursing facility. The State must provide or arrange for the provision of active treatment for the mental illness, wherever the individual chooses to reside. The MHD's Alternative Disposition Plan, submitted as required by P.L. 100-203, is included as Appendix D-2. An instructional bulletin is also attached as Appendix D-3.

F. THREE-YEAR GOALS AND OBJECTIVES FOR IMPLEMENTING A SYSTEM OF SERVICES:

Much of the time and effort of the MHD is currently devoted to implementation of services required by the 1987 Mental Health Act, delineated in the previous pages. Full implementation of the Act remains the priority goal of the MHD.

The MHD will also be addressing the need for services to specific subpopulations. Details of these services, including goals and objectives, are listed in the chapters that follow.

Finally, in implementing the services required by the 1987 Mental Health Act, several specific objectives have been identified for action by the 1989 Legislature. These include:

1. Administration:

Goal:

Create two positions and continue two others now funded by one-time NIMH grants, including:

a. A mental health professional in the community based services unit to improve current efforts to provide oversight and technical assistance to counties and providers in the planning, development, implementation and coordination of mental health services as prescribed by the 1987 Mental Health Act (new position).

b. A research analyst and data entry position to implement a mental health information system as required by M.S. 245.721 (new position).

c. A health care professional to address the mental health needs of the state's growing elderly population and to implement 1987 federal legislation which requires the state mental health authority to screen all applicants to nursing facilities and to conduct an annual review of all nursing facility residents who are mentally ill (continued position).

d. A clerical position, .75 of which will be assigned to the financial and support services divisions in recognition of their growing responsibilities relating to the 1987 Mental Health Act (continued position).

Objective: Legislative approval by May 1989.

2. Enhanced Community Support Services Funding:

Goals:

a. Provide a full array of CSP services in all 87 counties and reduce caseloads in counties with existing CSPs. Currently, not all counties provide all CSP services, but will be required to by January 1, 1990. Enhanced funding is needed to comply with this mandate.

b. Continue housing support service pilot projects now funded by one time state funds; and

c. Provide cost of living increases for staff of community support programs and residential facilities for adults with serious and persistent mental illness.

d. Hire full time housing specialist for work on housing issues for persons with mental illness.

Objective: Legislative approval by May 1989. Implementation by July 1989.

e. Host a day long conference on CSP issues for providers, consumers, and county representatives.

Objective: Conference held April 1989.

3. Public Education Services to Reduce Stigma:

Goal:

Implement a cooperative public education/anti-stigma effort with the Minnesota Department of Health.

Objective: Seek legislative approval by May 1989 for a two year extension of current efforts.

4. Language Interpreters to Improve Access and Appropriate use of Services:

Goal:

Implementation of MA reimbursement for bilingual paraprofessionals.

Objective: Legislative approval by May 1989.

5. Institutions for Mental Diseases (IMDs):

Goal:

Expand Minnesota's GAMC program to cover persons denied MA coverage due to their residing in facilities determined by the federal Health Care Financing Administration (HCFA) to be IMDs.

Objectives:

a. Allow automatic GAMC eligibility for MSA recipients who would be eligible for the MA program, except for the fact that they reside in a facility certified by HCFA or the Department of Human Services as an IMD. MSA will have to pay for the residential costs and GAMC will cover other health care expenses.

b. Allow GAMC eligibility for children residing in facilities certified by HCFA or the department as IMDs through June 30, 1991 to allow current residents and the state sufficient time to consider other alternatives.

c. Continue as a covered GAMC service case management for seriously and persistently mentally ill

individuals who reside in an IMD. An appropriation rider in the 1988 Minnesota Health and Human Services Omnibus bill allowed GAMC to provide this service for these persons through June 30, 1989.

d. Legislative approval by May 1989.

6. Vocational Services (NOTE: The Division of Rehabilitation Services of the Department of Jobs and Training provides these services. The MHD coordinates activities with the DJT via an interagency agreement.)

Goals of the DRS:

a. Increase vocational training programs for persons with a mental illness.

b. Enhance the employability and improve the work records of persons with a mental illness.

Objectives:

a. Increase the number of vocational rehabilitation staff persons in the Department of Jobs and Training who work with persons with a mental illness by eight FTE's.

b. Reduce caseload sizes of such workers.

c. Create vocational placements for an additional 650 persons with a mental illness in the 1990-91 biennium.

d. Legislative approval by May 1989.

7. Federal Nursing Home Reform Act

Goal:

To implement the Federal Nursing Home Reform Act (P.L. 100-203) which states that a nursing facility must not admit, on or after January 1, 1989, any new resident who is mentally ill, unless the state mental health authority has determined prior to admission that because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental illness.

Objectives:

1. Screen all applicants to nursing facilities and conduct diagnostic assessments of persons identified as possibly having a mental illness.

2. Establish an annual review process for mentally ill residents to determine whether or not the resident requires the level of services provided by a nursing facility or requires the level of services provided by an inpatient psychiatric hospital for individuals under age 21 or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older and whether or not the resident requires active treatment for mental illness. The reviews and determinations must first be conducted for each resident by no later than April 1, 1990.

3. By April 1, 1990, arrange for the safe and orderly discharge of all persons who are inappropriately residing in a nursing facility, unless the individual needs active treatment, has continuously resided in a nursing facility for at least 30 months, and chooses to remain in the nursing facility. The law permits states to submit an Alternative Disposition Plan (ADP) in order to request additional time beyond April 1, 1990, to arrange for safe and orderly discharge of individuals determined to be inappropriately residing in a nursing facility. Minnesota has submitted an ADP, requesting approval to relocate and provide or arrange for the provision of appropriate community based or residential services to such persons, according to the following schedule:

   - <u>January 1, 1990 to March 30, 1990</u>:

     Relocate and provide or arrange for the provision of appropriate community based or residential services for 50 persons.

   - <u>April 1, 1990 to March 30, 1991</u>:

     Relocate and provide or arrange for the provision of appropriate community based or residential services for 100 additional persons. (Total: 150 persons.)

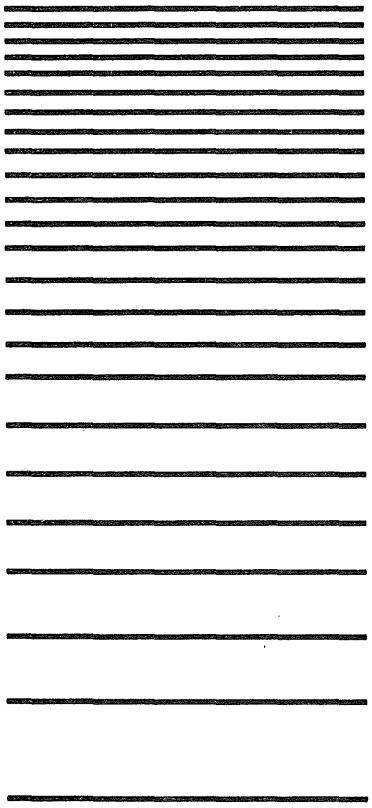
   - <u>April 1, 1991 to June 30, 1992</u>:

     Relocate and provide or arrange for the provision of appropriate community based or residential services for 150 additional persons. (Total: 300 persons.)

4. Provide or arrange for the provision of appropriate mental health services including active treatment, wherever the individual chooses to reside.

IV.

Mental Health Services For Children and Adolescents



IV. MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS

A. Introduction

Minnesota has resisted the thought that children can be mentally ill, and consequently has only recently taken the initiative to define and address the mental health and other service needs of these children. As a result, gaps and overlaps in services have evolved in Minnesota as the children's mental health system largely "created itself". It is only recently that it has been recognized that the mental health needs of children are very different than those of adults, and that mental health services designed for children must be equally different to reflect their special needs. The greatest common ground of mental health needs in Minnesota is the uniform need for all persons, regardless of age, to overcome the stigma that prohibits individuals from seeking mental health services.

In January, 1988, the MHD of the Department of Human Services began a major planning effort on behalf of children and adolescents. The 1988 Minnesota Legislature mandated the creation of a "unified, accountable, comprehensive children's mental health system" (M.S. 245.698). As a result, the MHD has undertaken a participatory planning process with a broad spectrum of advisory committees, advocacy groups, and state agency representatives.

The legislation provides Minnesota with an opportunity to develop a truly progressive system of mental health care for children and adolescents. As part of the 1988 legislation, a Children's Mental Health Subcommittee to the State Mental Health Advisory Council was established. The Subcommittee advises the Council, the MHD, the Governor, and other state agencies on all matters related to children's mental health. The Subcommittee includes representatives of the Departments of Human Services, Health, Education, Corrections, and Commerce, as well as parents, advocacy groups, minority representatives, county personnel, elected officials, consumers, and mental health professionals and providers that treat emotionally disturbed youth. The Minnesota legislation is unique in that it sets forth a philosophic basis of care for children that should drive the planning effort. (See 2. "Mission".)

The legislation also provides the Department of Human Services with the capacity to forge creative interagency agreements and cooperation by mandating quarterly meetings of state department commissioners of Corrections, Health, Commerce, and Human Services for the purpose of "coordinating services and programs for children with mental illness and children with emotional or behavioral disorders" (M.S. 245.698, subd. 2).

1. Philosophical Base and Values of Children's Plan

At the center of the system for children will be their health needs. It is widely recognized that services, in order to truly meet the child's needs, must be available and accessible to the child in his or her community. Child centered and community based care are then objectives for Minnesota's system of care. Another objective is family involvement. The child and family must be involved in the service planning process whenever possible, in order to assure that services are designed to meet the specific and unique needs of the child and family. In addition, this maximizes the family as a resource to the child and sends a clear message that they must be an intimate part of the treatment process. Services must be delivered in the least restrictive environment appropriate to the needs of the child to allow the child the greatest advantage for remaining in or reintergrating into the family and community.

The philosophical beliefs from which the system of care will be developed in Minnesota are as follows:

> As a system of mental health services for children is designed and developed the MHD will assure that the unique, individual needs of children in the the state of Minnesota are recognized and supported. These needs will be at the heart of the children's mental health system in Minnesota. This system should strive to teach youth to care for their own mental health needs.
>
> The MHD should fight the stigma that mental health services are something to be ashamed of seeking. Instead, children should be taught that a basic part of being healthy is building and caring for mental and emotional health.
>
> In designing and managing a comprehensive and coordinated system of mental health care for Minnesota youth, these objectives must drive all efforts:
>
> 1. Families should be considered the greatest treatment resources available to children and should be empowered and supported to care for their children to the best of their ability. Services should be focused on maximizing each family's potential for meeting the mental health needs of their children. The involvement of the child and family in the

service planning (case management) and treatment process is critical.

2. The system of care must be comprehensive and coordinated. It should include a complete array of coordinated services so that the mental health needs of children are met in the educational, social service, correctional, and mental health systems. This neutralizes the "pass the buck" system which occurs when each system is motivated to identify services needed in other systems, and thereby pass fiscal and service delivery responsibilities on as well.

3. Services to children with emotionally disturbance should be individualized. The needs of the child and his/her family should be at the heart of the service plan rather than trying to "fit" the child into preexisting services.

4. Services should be provided in the least restrictive and most normal environment appropriate to the needs of the child. Whenever possible, services should be available to the child within the home community, so that reintegration is facilitated and services are as minimally disruptive as possible.

5. Children should not be denied the services they need because of the seriousness of those needs. Services and resources should be made available to meet the unique needs of every child with severe emotional disturbance in the state of Minnesota.

6. The system should promote early identification of children at risk of developing emotional disturbance. The system should ensure early intervention in order to assist children with their mental health needs at the onset or in early stages of emotional disturbance. This would eliminate a situation which often requires children to exhibit severe symptoms of emotional disturbance before intervention is available.

7. Recognizing that children have needs in a variety of service systems, they should be assisted and supported with movement between systems when necessary. This includes movement from the child to the adult system.

8. All children should have access to services without regard to race, religion, national origin, sex or physical disabilities. Culturally appropriate treatment within the home community should be a goal for the system of care.

9. The rights of children with emotional disturbance should be protected and effective advocacy efforts should be supported.

2. Mission

Children are at the center of Minnesota's plan. The 1988 Children's Mental Health Legislative Initiative set forth an explicit mission to guide the creation of Minnesota's plan. An overview of the 1988 legislation relating to the development of a children's mental health service system is below:

The Commissioner of Human Services shall create and ensure a unified, accountable, comprehensive children's mental health service system that:

(a) identifies children who are eligible for mental health services;
(b) makes preventive services available to a wide range of children, including those who are not eligible for more intensive services;
(c) assures access to a continuum of services that:
    (1) educate the community about mental health needs of children;
    (2) addresses the unique physical, emotional, social, and educational needs of children;
    (3) are coordinated with other social and human services provided to children and their families;
    (4) are appropriate to the developmental needs of children; and
    (5) are sensitive to cultural differences and special needs;
(d) includes early screening and prompt intervention in order to:
    (1) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and
    (2) prevent further deterioration;
(e) provides services to children and their families in the context in which the children live and go to school;
(f) addresses the unique problems of paying for mental health services for children; including:
    (1) access to private insurance coverage;
    (2) public funding;
(g) to every extent possible, includes children and their families in planning the child's program of mental health services; and
(h) when necessary, assures a smooth transition to the adult service system.

(M.S. 245.698, Sec. 4)

The MHD's goal is to work as partners with the Children's Subcommittee and other interested parents, consumers, advocates and providers in order to improve the delivery of services to children and adolescents. In conjunction with proposed legislation for 1989 (Appendix E), the Department is seeking financial support for planning, development and service delivery. In addition, the Department intends to submit grant requests to the National Institute of Mental Health's Child and Adolescent Service System Program (CASSP) to organize and empower parents to conduct research, planning, evaluation, and training, and to develop interagency collaboration and funding structures.

B. POPULATION ANALYSIS

1. General Demographic Characteristics of Children

One of the preliminary challenges in planning mental health services for children in Minnesota is to identify the population to receive services. Due to a historic emphasis on adult services in the MHD, and the lack of recognition that children have mental health needs, data collection and analysis focused on the adult population. Historically, the MHD has not had programmatic responsibility for any of the mental health services for children. Along with the passage of the 1987 Mental Health Act, the Minnesota Legislature placed the residential treatment facilities for children and adolescents with emotional disturbance under the supervision of the MHD. This will allow the division to research demographic, programmatic, treatment and other data on this population.

In Minnesota, there are approximately 1,160,000 children under the age of 18 (State Demographers Report, 1988). One in four Minnesotans is a child. Although Minnesota is an agricultural state, over two thirds of the population live in urban settings (67%) and one third live in rural settings (33%). The population is divided approximately in half between those living in the major metropolitan area of St. Paul/Minneapolis and those living in greater Minnesota. This makes the planning process for children's mental health services pertinent to both urban and rural solutions.

People of color comprise 5% of Minnesota's total population. Minority children are probably a larger proportion of the children's population, however, because of the younger age distribution of Minnesota's minority population (State Department of Health). Minnesota's largest minority group is Black. Most of Minnesota's minority children live in the large metropolitan area of

St. Paul/Minneapolis and in the metropolitan area which encompasses Duluth. The Twin Cities are also home to one of the largest urban Indian populations in the United States. However, many Indian children also live in densely populated areas in or near the eleven Indian reservations in the state. Minnesota organizations have also relocated many refugees in the state in the last ten years, and expect to be the home for planned settlement of Amerasian children. St. Paul is home to a sizable Hispanic community. There is general agreement that census data underestimates the true number of the minority population.

In addition, it must be recognized that children of color are disproportionately represented in the mental health/social service sector due to the nature of society and the way resources which allow access to goods and services are distributed across cultural groups. While children of color comprise less than 5% of the total population, they comprise 26% of the residential treatment population.

2. Definition of Children with Mental Health Needs

The MHD is proposing to develop a balanced children's mental health delivery system which will provide services in accordance with need. This will be reflected by specifying that education, early identification, and prevention services are available to all children; that emotionally disturbed children may obtain a number of services in the children's mental health delivery system and that children with SED may obtain some specific, specialized, intensive home and community based services to divert the need for out of home placement where possible.

For purposes of the legislation emotionally disturbed children are those who meet the criteria as defined below:

(a) "Mental illness: means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

(b) A "person with acute mental illness" means a person who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means a person who has a mental illness and meets at least one of the following criteria:

(1) the person has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months;

(2) the person has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the person:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has a written opinion from a mental health professional stating that the person is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless an ongoing community support services program is provided; or

(4) the person has been committed by a court as a mentally ill persons under Chapter 253B, or the person's commitment has been stayed or continued.

For purposes of the legislation severely emotionally disturbed children are those who meet the criteria in I, II, and III or IV below:

I. Age

The child must be under the age of 18.

II. Diagnosis

As determined by a mental health professional, and as listed in the clinical manual of the International Classification of Diseases (ECD-9-CM), current edition, Code range 290.0 - 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and statistical Manual of the Mental Disorders (DSM-MD), current edition, axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation.

III. Emotional Impairment: (Must have A or B):

A. Symptoms:

Must have one of the following, as determined by a mental health professional:

1. Psychosis or clinical depression
2. Risk of harming self or others

B. Functional Impairment

The child, as a result of his or her emotional disturbance, has significantly impaired home, school or community functioning which has had a duration of at least one year, or which, in the written opinion of a mental health professional, presents substantial risk of a duration of at least one year.

IV. Separation From Family (Must have one of the following:)

A. The child has been admitted to inpatient treatment or residential treatment for an emotional disturbance within the previous three years.

B. The child is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance.

C. The child is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact.

C. IDENTIFIED NEEDS:

All children have mental health needs, and children of all ages can be at risk of developing mental health problems. A recent survey conducted in a Minnesota metropolitan county (Ramsey) showed that between 9-14% of parents have sought professional help for emotional, behavioral, or mental problems of their children.

In the school age group, 32% of low income parents and 19% of the middle/high income parents felt their children needed help with problems of this nature in the previous year (Wilder, September, 1987). This proportion is higher than national figures. The Wilder study also established a relationship between levels of family stressors and children's mental health needs. Finally, it is difficult to say anything specific about the geographic distribution of mental health problems with children in Minnesota.

In addition, teenage suicide in Minnesota is a major concern for the state. The suicide rate for teenage youth aged 15-19 increased from 8.3 events per 100,000 in 1980 to 24.0 events per 100,000 in 1986. Suicides are declining nationwide; in Minnesota they are increasing (MCHS Report, Vol. 8, No. 1, Summer 1988).

It is clear that there is a tremendous amount of work to do in our state on meeting those needs. The current system of mental health care for children requires that a child fit into a service or program which is available. There is an urgent need in the state to meet the individual needs of children and stop slotting them into preexisting services which may not be designed to meet their needs.

The MHD is currently collecting data via a needs assessment survey (see Appendix F) which was distributed in July 1988 to all county social service directors. The purpose of the needs assessment is to educate counties about the CASSP system of care and to ask for their input on the components of the system of care they have in their communities. The survey was designed to collect information about each county's system of care. The survey asks for information about mental health services as well as children's social services, chemical dependency services, correctional services, educational services, health services, and other services. Counties have been asked to rate those services based on availability, accessibility, quality, and other miscellaneous variables.

Data from this needs assessment will be used extensively both at the state and local levels in developing a system of care. The data will provide the base from which programs and services are developed, and will be critical in the evaluation effort designed to assess the MHD's efforts.

D. SERVICE SYSTEM PROBLEMS

Minnesota's social service system operates on a state supervised, county administered basis. Each county thus holds a great deal of capacity for creating, funding and operating services. It does, however, also present a challenge when addressing systems change issues across the state. Many counties are approaching the work in children's mental health progressively and enthusiastically, while other counties express the opinion that the current system of care in their community is adequate and needs no modification. Education, the opportunity for enlightenment, legislative mandates, and technical assistance are tools the state possesses to assist counties in balancing their systems of care.

The complexities of a county administered system are compounded by the many diverse agencies that serve children with emotional disturbance. Coordination at the state level is complicated, but extending that coordination throughout the system is vastly complex.

In conjunction with interagency efforts mentioned earlier will be efforts to unravel an extremely complicated funding system for services to children and their families. Children in Minnesota frequently often receive services based upon available funding rather than based upon needs. Redesigning this system will require complex interagency agreements, close work with the Department of Commerce, flexible county participation, and clear written legislation. Once interagency agreements have been finalized and departments are working jointly on a truly coordinated system of care, collaborative funding will be explored and may be presented in legislative form.

Lack of adequately trained staff is a problem in Minnesota, primarily in the rural areas of the state. As home and community based services are implemented, staffing programs with persons experienced in providing mental health services to children and their families will provide a challenge.

Finally, the current system of mental health services for children in Minnesota is both out of balance and lacks completeness. Many new, progressive treatment approaches must be researched and implemented. The structure of services for emotionally disturbed children currently consists primarily of outpatient services and residential treatment programs. While some less restrictive services exist in other systems (primarily social services), they are not available as mental health services to children with serious emotional disturbance.

E. IDEAL SYSTEM OF SERVICES

An ideal system of care for children and adolescents with severe emotional disturbance will be developed from the CASSP model of care. This will be designed from Minnesota's philosophy of care, which was adapted from the CASSP philosophy. Legislation for the 1989 Legislature is being drafted by the MHD to mandate a comprehensive and coordinated system of care in every county in the state. It is anticipated that some waivers will be granted to the smallest and most rural counties, where it is impractical to run programs such as day treatment, but overall the guiding principles and service system components are taken directly from the CASSP monograph by Stroul and Friedman. See Appendix B for the current draft of legislation.

Beginning in January, 1989, the MHD will fund six to ten counties to demonstrate the CASSP model of interagency coordination and service delivery. With about three quarters of a million dollars, a combination of urban and rural counties will model the CASSP model of interagency coordination and service delivery at the county level. With decreasing match dollars over a three year period, counties will have an opportunity to develop a system for children at the local level. At the end of the three year project, these counties will have tenured systems in place, in addition to providing the rest of the state with models of how CASSP service systems operate.

F. GOALS FOR A CHILDREN'S MENTAL HEALTH SERVICE SYSTEM

Three primary goals for developing a mental health system for children and adolescents are:

1. Development of a comprehensive, balanced system of services in every community in the state. Services will address the mental health needs of all children, including early identification and intervention services, and will focus most new resources on youth with the most severe emotional disturbance.

2. Creation of a mental health system that functions as a coordinated set of services across all agencies that provide services to children.

3. Establishment of a system of services that is child/family based.

In order to accomplish these goals, the following objectives will be addressed over the coming three years:

1. Pending the passage of the 1989 legislation, a children's mental health unit will be established within the MHD to oversee the development of the system of care and to enact the 1989 legislation. This unit would provide expertise on children's mental health and would handle all other matters related to children's mental health such as:

   - interagency coordination;
   - technical assistance to counties in conjunction with regional consultants;
   - coordination with NIMH and other states;
   - grant projects both to the state and to the counties;
   - legislative activities; and
   - public information including parents, advocates, and providers;
   - creative funding streams.

2. The Children's Mental Health Unit will apply to NIMH in 1989 to become part of the CASSP network of states in order to improve the quality and depth of work currently underway.

3. The Children's Mental Health Unit will work with the 1989 Legislature to develop comprehensive legislation to support the mental health needs of all children in Minnesota.

4. The MHD will provide pilot funding to counties to develop community based systems of care based upon the CASSP model. Close collaboration will take place with these counties, making information from their experiences available to all counties in Minnesota. This will be accomplished using a combination of state dollars and ADM block grant dollars.

5. The Commissioner of Human Services will launch a thorough, extensive interagency effort in Minnesota on behalf of the mental health needs of all children. Departments to be involved in this effort include Education, Social Services, Corrections, Health, Commerce and Human Services. This effort will build upon the mandates of the 1988 legislation and the proposed 1989 legislation, which would bring the interagency effort to the county level.

6. An information management system will be established to provide clear, usable information for decision making. Client outcome and system evaluation data will be utilized whenever possible in all work with service providers.

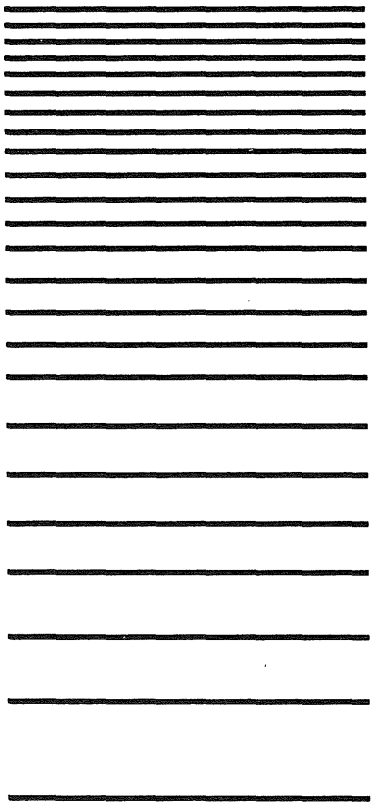
7. The continued involvement of parents, advocates and minority groups in all aspects of program development and monitoring will be assured.

In the chapters that follow (Chapters V - VIII) services to subpopulations of persons with mental illness are described. Each program seeks to coordinate with those services described in Chapters III and IV as well as provide for special needs as described in the coming pages. In addition, the 1987 Mental Health Act requires that services be based upon "cultural and ethnic needs, and other special needs of individuals being served" [M.S. 245.467, Subdivision 1, part 92)]. Finally, the MHD has in the past utilized special project funds to provide training to providers to enhance their knowledge of the needs of persons with dual or multiple disabilities. The MHD will continue to emphasize to providers the need for continuing education in serving such persons.

The programs that follow are part of the MHD's effort to implement this goal.

V.

Mental Health Services for Refugees



V. MENTAL HEALTH SERVICES FOR REFUGEES

A. INTRODUCTION

1. Service Philosophy

The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable mental health services for all residents. Services are to be based on clinical needs and delivered in a manner consistent with and sensitive to the cultural and ethnic background of the population to be served.

In conjunction with the above and for the purpose of this plan we recommend that the following definition and its components be given consideration when developing programs for refugee and immigrant populations:

"Culturally sensitive programs" means programs whose policies, programs, and practices are respectful and responsive to the culture, traditions, feelings, attitudes, needs or circumstances of the clients in the community served.

Culturally sensitive programs referred to in this plan should:

(a) have on staff bilingual/bicultural persons or have access to trained interpreters/translators;
(b) have non-refugee mental health professionals and staff who are willing and trained to provider services to refugee and immigrant clients in a culturally sensitive manner;
(c) provide ongoing in-service training in cross cultural sensitivity and issues for staff who work with refugee and immigrant clients;
(d) apply cultural considerations in the helping process of ethnic clients;
(e) have a provision for the involvement of family members and/or community in the process of helping;

"Bilingual/bicultural staff" are individuals who provide culturally appropriate mental health or social adjustment services to refugees and immigrant clients under strict clinical supervision of a mental health professional. Bilingual/bicultural staff should be:

(a) fluent in spoken and written ethnic language as used by clients served, in addition to fluency in English language;
(b) be familiar with and have access to the ethnic community at large and various community organizations and groups;

(c) have the respect and trust of the ethnic community at large;
(d) have sufficient evidence of previous mental health related employment experience; and
(e) have more than basic knowledge of and willingness to accept western mental health concepts and practices.

2. Mission Statement

Mental health services to the refugee population are considered part of the unified comprehensive mental health services system in Minnesota

B. BACKGROUND

Minnesota is one of twelve states participating in the Refugee Assistance Program - Mental Health (RAP-MH). This program is funded by the Federal Office of Refugee Resettlement and administered by the National Institute of Mental Health. RAP-MH funds were available to Minnesota for a three year period and will end in the spring of 1989. As a result of this funding, the Refugee Mental Health Program was established in January of 1986 within the MHD in order to work toward the goals established by RAP-MH. The major tasks of the Program are:

1. to identify the mental health needs of refugees;

2. to ascertain gaps in service provision;

3. to identify system changes needed to improve refugee access to mental health services

4. to identify and design model programs

5. to identify resources in the state

6. to coordinate and provide training to mainstream and bicultural staff

7. to provide a mechanism for networking and resource development; and

8. to make recommendations about service provision to refugees.

The Refugee Mental Health Program is staffed by a director and various technical assistants as needed. In addition, an advisory council was developed to assist in providing feedback throughout the project, obtaining contacts and entree into the refugee community, evaluation and program planning, and assuring cultural relevance and sensitivity throughout the project. The council is composed of refugees

from a variety of ethnic backgrounds, refugee service providers, Mutual Assistance Associations (MAAs), Department of Human Services personnel, and representatives from other human service organizations.

The project builds upon extensive experience and research in the area of refugee mental health in Minnesota. Through the RAP-MH funding, the project designed and conducted a three part needs assessment which consisted of: a review of refugee mental health data resources with Minnesota' an agency survey combined with on-site interviews; and, a key informant survey of refugee service personnel. Information gathered from this activity combined with feedback from the ORMH advisory council and other groups provided direction for future planning and implementation. Major efforts were made to provide technical assistance, including education and training, to a large number of service providers, educators, legislators and other decision makers. training levels varied from basic cultural sensitivity to specific application In addition, a "Statewide Comprehensive Refugee and Immigrant Mental Health Services Plan" has been developed, which summarizes current available services, identifies existing gaps in services, and finally makes recommendations for system improvement, addressing the nine service components mandated by the 1987 Comprehensive Mental Health Act. The purpose of this plan is to assist the DHS and county boards with the development of a statewide refugee mental health service delivery system which is sensitive, comprehensive, cost effective, and which directly correlates with the new mental health legislation.

While the RAP-MH project has assisted Minnesota to move toward a better awareness of refugee mental health issues improving mental health services to refugees, there is still much to do. For example, funding mechanisms continue to need to be identified and pursued which will provide opportunity for program development and continuity of services; technical assistance and training must be made available at all levels to ensure that refugee issues are widely known so as to continue moving toward a mental health system that is culturally sensitive and delivers culturally appropriate mental health services; inter and intra division and department coordination needs to continue to be developed, whereby improved communication and linkages ensure a coordinated effort in service development for this population in Minnesota.

Throughout the project, the Refugee Mental Health Program has endeavored to work within the mission, philosophy and service system of the 1987 Mental Health Act.

C. POPULATION ANALYSIS

1. Definition of Population

For the purposes of RAP-MH, NIMH has defined refugees as people who have left their home country and are unable to return because of persecution or a well founded fear of persecution. RAP-MH also includes Cuban and Haitian entrants (those arriving during the Mariel Boatlift between 4/21/80 and 10/10/80) in the definition of refugees.

2. Numbers Affected & Geographic Location

As of July, 1987 there were an estimated 33,696 refugees in Minnesota. This figure is considered to be a substantial under estimate of the population due to factors such as secondary migration. The ethnic breakdown of Minnesota's refugee population is as follows:

13,059	Hmong
8,019	Vietnamese
6,399	Cambodians
4,890	Laotians
561	Ethiopians
357	East Europeans
270	Middle East
141	Others

The metropolitan area surrounding Minneapolis and St. Paul houses the vast majority of the state's refugee population. Together, Hennepin and Ramsey counties contain 27,094 refugees (80%). Olmsted county has the next largest concentration with about 2944 refugees (9%). In addition, in fiscal year 1988, 2700 new refugees were resettled in Minnesota. The majority of these new arrivals were Hmong (Wilder Foundation, 1987).

Minnesota will soon be accepting more Amerasian youths and their families. Amerasian youths will present several challenges to service providers because of the extreme prejudice they lived under in their native countries. Even though their average age is seventeen, they have almost no education or employment experience.

Accurate estimates of the incidence of mental illness among the refugee population are elusive for a number of reasons. First, refugees are reluctant to seek out mental health services, because of the stigma associated with it in their societies. Further, mental health problems are often presented and treated as physical ailments. Finally, cultural differences make the accurate diagnosis of mental health problems exceedingly difficult. There are only a small number of agencies with staff capable of conducting cross cultural mental health assessments.

While concrete figures on the incidence of mental illness in the refugee population are difficult to ascertain, estimates are that between 30 to 80% of this population will experience severe mental health problems. These estimates would indicate that 10,000 to 30,000+ refugees will be in need of mental health services by 1991. Assuming that refugee experiences are comparable to those experienced by Vietnam War veterans, one estimate would be that fifty percent of the refugee population of Minnesota will experience post traumatic stress disorder.

A study conducted by the Minnesota Dept. of Health, Minnesota Center for Health Statistics states that the teenage suicide rate among the state's Southeast Asians is seven times that of the state's Caucasian population (71.9 per 100,000 vs. 10.7 per 100,000).

Drs. Neal Holtan and James Jaranson of the St. Paul Ramsey Medical Center's International Clinic have been conducting an epidemiological study of the prevalence rate of psychiatric distress among Cambodians and Laotians in Minnesota. Their research shows these groups to suffer from two to three times the incidence of psychiatric distress than the majority population suffers.

These figures make it clear that Minnesota's refugee population is at a high risk for mental illness.

While the incidence of mental illness within the refugee population has been difficult to determine, the relative incidence of various diagnoses has revealed itself fairly quickly. Depression and anxiety disorders (most notably Post Traumatic Stress Disorder) head the list of mental health problems experienced by refugees. Difficulties related to the process of acculturation also prevail among this population. Isolation, homesickness, intergenerational conflict, and a disruption of interpersonal relationships are all common among refugees.

Despite these difficulties, refugees are much less likely to use walk-in or inpatient services than other persons in comparable economic circumstances (e.g. AFDC recipients). It has been estimated that 80% of the Indochinese are "highly disinclined to go to a Community Mental Health Center" for care. If those refugees estimated to be at risk for mental health disorders were to avail themselves of appropriate services, this would place a tremendous strain on limited public dollars.

There is a need to address the complex issue of providing appropriate services to a group which tends to under utilize traditional mental health services, but who appear to need services of some type more appropriate to their culture. At the same time cost containment is a serious concern.

3. Service System Principles for Refugee Mental Health Service

The victimization and traumatic experiences which refugees endure in their home countries and while fleeing their countries for safe refuge are incredibly stressful. So is the process of trying to establish a new life in a foreign land. This process of social adjustment is particularly difficult for the rural Southeast Asian refugees. Urban Minnesota could hardly have been designed to be more different than rural Indochina.

Because of the inordinate stress in their lives, refugees are at risk to a wide range of mental health problems. Depression, anxiety, paranoia, familial and marital dysfunction, and substance abuse are all common problems. Of course, refugees are susceptible to any form of mental illness; it is their unique life experiences which predispose them to these particular problems.

Because they come from vastly different cultures, the services provided to help refugees overcome their mental health problems must be sensitive to these differences to be effective. The most basic need is for services to be provided in their native languages. Mental health assessment and therapy requires a great deal of precise communication. It is unreasonable to expect that a refugee will attain the necessary language proficiency in the short time they have been in the United States. Typically, a refugee needs more than services which are in his/her native language. The services should also be provided in a manner which is sensitive to the refugee's culture of origin. Social norms, ethics, traditions, faiths, and perceptions differ between cultures. Services which are not sensitive to the clients own culture have a poor prognosis for success.

D. IDENTIFIED SYSTEMIC PROBLEMS

1. Insufficient Service Provision

While some components of the comprehensive mental health system are provided in a culturally sensitive manner, they are few and mostly located in Ramsey, Hennepin and Olmsted Counties. In addition, these agencies continuously experience heavy caseloads, while their resources are stretched thin. The RTCs, for instance, have admitted refugees as patients, but do not have the staff to provide cross cultural diagnostic and assessment services, develop treatment plans and provide treatment as needed.

2. Inappropriate Use/Or Ineffective Resource Utilization

Unfortunately, there are many barriers which impede the provision of culturally sensitive services to refugees by

the mental health system. First, the services of an interpreter/translator have not been reimbursable under current Medical Assistance rules. The system has been reluctant to provide this service from the administrative budget since refugees and immigrants represent a rather small portion of the population. Secondly, agencies providing culturally sensitive services commonly use trained bilingual/bicultural staff persons to provide culturally sensitive services. It has proven less expensive in the short term to teach persons from refugee cultures cursory mental health skills, rather than to use cross culturally trained mainstream professionals (or even to upgrade mainstream professionals' skills with cross cultural training). However, these bilingual/bicultural staff persons rarely have the necessary training and credentials, nor has there been an adequate evaluation of the quality of care provided in this manner, to allow their services to be covered by mainstream funding sources. Furthermore, these bilingual/bicultural staff persons do not have easy access to mainstream professional training programs to upgrade their skills in order to obtain the needed training and credentials. These individuals tend to remain in low paying jobs with limited opportunities for advancement, which contributes to experiences of "burn out". Currently, our state is in the position of treating one of our most at risk subpopulations with the least trained staff who, for the most part, do not have professional credentials.

Another inappropriate use of resources seems to be occurring through a combination of limited cross cultural experience in medical professionals and the tendency of Southeast Asian refugees to somaticize their mental health problems. Frequently, refugees will seek out medical care for somatic problems with a mental health origin. Without interpreters or cross cultural mental health experience, medical professionals often will try to treat the refugee's presenting symptomatology without recognizing the mental health issues present.

Treating refugees without using culturally sensitive techniques is also an inefficient use of resources. It results in a reduced rate of successful treatment with the accompanying increase in chronicity and acuity among those needing mental health treatment.

3. Inadequate Number of Trained Staff

Many of the barriers which have impeded funding of bilingual/bicultural staff persons have also prevented the training of such staff. These positions often do not pay well and are usually only attractive to those

already active in voluntary service to their refugee communities. Also, western mental health treatment is foreign to Southeast Asians and they are often unaware the field exists as a career option. Further, educators in counseling and other mental health services are ill equipped to teach persons with poor English skills and incomplete acculturation to western life.

Training is vital for American service providers as well. They need to be familiarized with cultural issues; with the skills needed to make effective use of trained interpreters; and with the tools adapted for cross cultural assessment and therapy.

4. Insufficient Accountability

Accountability measures are typically exercised through the mental health system funding and the licensing/quality assurance requirements which accompany this funding. Culturally specific services provided to refugees may operate outside these funding channels; and therefore they are not accountable to the controls that go along with the funding.

E. EXISTING COMPONENTS, IDENTIFIED NEEDS, AND LONG RANGE PLANS FOR IMPLEMENTATION

While a broad range of mental health services are available throughout the state, there are few agencies providing culturally sensitive and language specific services to refugees. Refugee service agencies are funded through a combination of funding sources such as county, federal block grant funds, federal and private grants, with the majority originating from the Office of Refugee Resettlement (ORR) and administered through the State Refugee and Immigrant Assistance Division (RIAD).

<u>Education and Prevention Services</u>:

Identified Need:

These services are not available to the refugee community as a whole, but only to clients and family via providers.

Education and prevention services are not available to all persons residing in a county. There is a certain amount of informal education on mental health issues and resources being done by Mutual Assistance Associations, ESL teachers, and voluntary agencies.

Goal: As stated in the 1987 Mental Health Act.

Objectives:

1. The MHD will work with local mental health authorities to make culturally sensitive and appropriate education and prevention services available.

2. The MHD will incorporate culturally sensitive and appropriate materials into the statewide anti-stigma campaign.

Emergency Services.

Identified Need:

Emergency services must quickly make an assessment, perform the proper intervention and refer the client on to the appropriate services. The language and cultural barriers presented by the refugee community hinder mainstream providers ability to execute emergency services. There is a shortage of bilingual/bicultural staff involved in emergency services in this state. Even those that are available, work only at the previously identified providers (usually at a nine to five schedule). Therefore, after business hours, or outside of the metropolitan areas, culturally sensitive emergency services are not available.

Goal: As stated in the 1987 Mental Health Act.

Objectives:

1. The MHD will work with local mental health authorities (especially Ramsey, Hennepin and Olmsted Counties) to provide culturally sensitive and appropriate 24-hour emergency crisis services, including language capability.

2. The MHD will explore using federal block funds to develop a 24 hour statewide hotline to provide access to emergency staff trained in cross cultural assessment and intervention.

Outpatient Services.

Identified Need:

While outpatient services comprise the bulk of culturally sensitive mental health services provided to refugees, they suffer from the same problems that plague the other levels of service. There are few providers, even fewer mainstream providers offering this service, and no providers of culturally sensitive outpatient services outside of Ramsey, Hennepin, or Olmsted counties. This is especially important in that refugees have been shown to work best in outpatient treatment rather than inpatient settings which are

uncomfortably foreign to them and overly stigmatizing in their cultures.

Goals: As stated in 1987 Mental Health Act.

Objectives:

1. The MHD will explore the feasibility and funding of culturally appropriate and sensitive services in counties with a sizeable refugee population.

2. The MHD will explore the development of a standardized cross cultural assessment procedure to aid professionals in assessing refugee clients.

3. The MHD will explore the development of training programs for mental health professionals in cross cultural assessment techniques.

4. The MHD will explore the development of diagnostic team to conduct assessments while programs are being developed.

Community Support Program Services.

Identified Need:

Community support program services have not appropriately adapted to meet the needs of refugees and immigrants. For example, only one mental health day treatment program in the state is designed to accommodate refugees. This is at the University of Minnesota Clinic. The development of more culturally appropriate community support services has been hindered by the lack of trained staff and the nonavailability of funding for bilingual paraprofessionals.

Goal: As stated in the 1987 Mental Health Act.

Objective:

1. The MHD will provide technical assistance to counties with sizeable refugee populations to develop culturally appropriate services for this population.

2. The MHD will work with the three counties (Olmsted, Hennepin and Ramsey) which have a high concentration of refugees to explore the development of day treatment programs as needed that are fundable and reimbursable MA services.

Residential Treatment.

Identified Need:

One facility in Minnesota has begun to adapt its programs to accommodate refugee residents. This facility is located in St. Paul.

Goal: As stated in the 1987 Mental Health Act.

Objective: The MHD will work with Hennepin, Ramsey, and Olmsted Counties to identify needs and plan for the best way to serve the refugees and immigrants, especially those with serious and persistent mental illness.

Acute Care.

Identified Need:

Again, acute care hospitals with staff trained in cross cultural treatment only exist within Hennepin and Ramsey counties. Because refugees tend to avoid seeking help for mental health concerns they often are first seen in acute condition and require hospitalization.

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD, through the regional mental health program consultants, will provide technical assistance to counties with sizeable refugee populations on culturally appropriate assessment and treatment services.

Regional Treatment Centers.

Identified Need:

None of the state's RTCs have developed a specialized program to accommodate refugees in a culturally appropriate and sensitive treatment setting.

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with Residential Facilities Division to explore adapting at least one RTC unit in order to develop a culturally appropriate and sensitive residential treatment setting.

Screening.

Identified Need:

The screening functions of the state's mental health service system are dependent on the availability of staff skilled in cross cultural assessment and the availability of appropriate services to which refugee clients can be referred.

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will review and evaluate efforts to conduct screening in a culturally appropriate and sensitive manner.

Case Management.

Identified Need:

Case management rules prescribe minimum qualifications much the same as those required by statue for mental health practitioners. Bilingual/bicultural case managers are imperative for the provision of case management to the refugee population. At the present time, many of the persons acting as bicultural case managers do not have these mandated qualifications.

Goal: As stated in the 1987 Mental Health Act.

The MHD will propose a waiver for those persons working within the role described as a "Case Manager" in the 1987 Mental Health Act. This will allow for reimbursement of bilingual staff for case management activities, which will give the paraprofessionals time to obtain credentials and experience as defined in the Act.

Administration:

The Refugee Mental Health Program will have federal funding through spring of 1989. There are no current plans to continue funding for refugee mental health positions in the MHD beyond this time.

Goal:

The MHD will consider the refugee population through multicultural planning for a comprehensive mental health system.

Objectives:

1. The MHD will encourage multicultural programming for county mental health plans of those counties which have sizeable refugee populations.

2. The MHD will monitor and evaluate the effectiveness of multicultural mental health services.

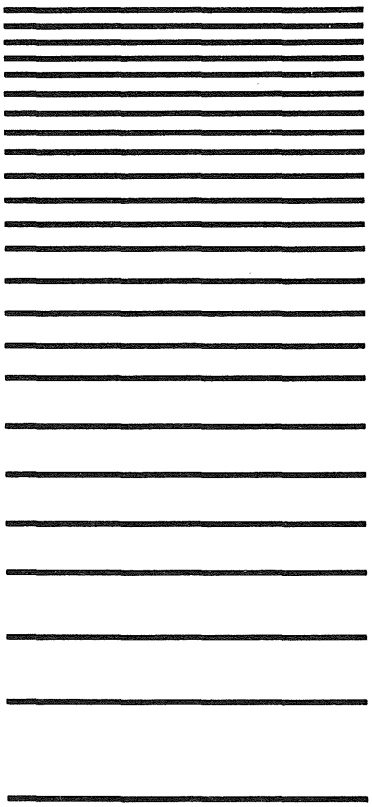
3. The MHD will encourage that counties with sizeable refugee populations include refugee representation on local mental health advisory councils.

4. The MHD will continue the work of the Refugee Mental Health Advisory Council, which currently advises the Refugee Mental Health Program through establishment as a subcommittee of the Minnesota State Mental Health Advisory Council. This would assure that the refugee community and providers skilled in serving refugees would continue to have input into Minnesota's mental health system. This restructuring will occur when the Refugee Mental Health Program ends in the spring of 1989.

5. The MHD will explore the possibility of expanding the MIRS data system to include data on the separate refugee populations so that patterns of refugee placements can be monitored whereby providing more inclusive data for service planning.

VI.

Mental Health Services for Older Adults



VI. MENTAL HEALTH SERVICES FOR OLDER ADULTS

A. INTRODUCTION

1. Service Philosophy

In Minnesota, county boards are responsible for using all available resources to develop and coordinate a system of locally available and affordable mental health service for all county residents, and make these services accessible to all age groups (M.S. Chapter 22, section 245.467, subd. 4). In order to adequately address the mental health needs of older adults, counties need to assure the coordination of formal linkages among health and social service agencies with mental health providers and the mental health service system.

2. Mission Statement

Mental health services to older adults are included in the unified, accountable, comprehensive mental health service system mandated by the 1987 Mental Health Act.

B. POPULATION ANALYSIS

1. Statutory Definition of Population

There is no consensus on the definition or minimum age to be considered an "older adult" or "elderly". The minimum age varies from 55 to 60 to 62 to 65. The Minnesota State Planning Agency Trend Reports (November, 1987) defines senior citizen status as 65 and older, which is consistent with the Medicare definition of elderly M.S. 256E.03, subd. 2(d) (Community Social Services Act) identifies one of the target populations as "persons age 60 and over who are experiencing difficulty living independently and are unable to provide for their own needs."

2. Numbers Affected and Geographic Location

According to 1985 population estimates, there are 489,646 Minnesotans aged 65 and older. About 49,000 are in nursing or board and care homes, leaving about 440,646 living in the community; 6,000 of whom are receiving community and in-home long term care services. National studies indicate:

1) 50-65% of elderly persons in nursing homes have serious mental health problems, or 24,500 to 31,850 people in Minnesota;

2) 15-25% of elderly persons in the community have moderate to severe mental health problems, or 66,096 to 110,162 people in Minnesota;

3) about 85% of persons living in the community have received no diagnostic assessment or treatment;

4) about 3% of persons with moderate to severe mental health problems who are living in the community are using community based mental health services, or 1,947 to 3,278 Minnesotans;

5) at least 50% of the major mental disorders of old age can be attributed to physical causes such as Alzheimer's Disease (33,048 to 55,081 Minnesotans);

6) Roybal (1984) estimates that 65% may have depression (318,270 Minnesotans); 16% of all suicides in 1978 occurred among persons over 65.

If the prevalence rates from the NIMH Epidemiologic Catchment Area Program are applied to Minnesota's population estimate of persons aged 65 and older, the following prevalence estimates for this population would be expected:

Schizophrenia:	1,154
Affective Disorder:	13,531
Personality Disorder:	802
Cognitive Impairment:	22,828
Phobia:	23,931
Total:	62,246

Hennepin and Ramsey Counties, Minnesota's two large urban counties, have the largest 65 and older population (104,103 and 53,613 respectively). While rural counties have smaller numbers of residents 65 and older. This compares to 14.4% in Hennepin and 15.9% in Ramsey Counties.

In 1987, persons 65 and older accounted for 10% of clients served and 17% days of service at state regional treatment centers (RTCs). During the same period, 17,424 (43%) persons aged 65 and over, who ha mental illness diagnosis lived in nursing facilities (SNF, ICFI, ICFII); 23,352 (57%) of those 65 and older, in nursing facilities did not have a mental illness diagnosis.

At this time data on mental health needs of older adults are inadequate. One cannot readily or accurately ascertain how many older adults need mental health services of any type. The lack of uniformity and

comparability in epidemiological data is compounded due to different diagnostic criteria and ages used in such studies. All older adults in need of mental health services are not diagnosed as such.

3. Methodology Used to Determine Incidence

Incidence among older adults have proved particularly difficult to study (Kay & Bergmann, 1980). There likely are generational reasons for older adults not seeking service and therefore not being "counted". Data used for planning purposes tends to be estimates, such as that obtained by using the NIMH ECA rates.

4. General Description of Needs of the Population

One must consider four groups of persons when planning mental health services for older adults. Each group has somewhat different needs and the system must address these different needs. These groups are:

1) Persons with mental illness who have come into old age with their illness. The mental illness may be of many years standing and now may be more difficult to cope with due to loss and isolation from family and friends, and increasing frailty and physical disorders which may accompany aging.

2) Persons who develop mental illness after age 60 or 65, but not a dementing disorder. The most common disorder is depression, often misdiagnosed or simply missed, but very treatable.

3) Persons who develop a dementing disorder after age 60 or 65.

4) Persons who are at risk of developing mental health problems due to the stresses of growing old.

Older adults are often disabled by their mental health problems before the problems are recognized. Older adults with mental health problems are at increased risk of institutionalization. Depression, suicide, alcohol abuse, polydrug use and misuse of prescription medications, serious and persistent mental illness, phobias, dementia and cognitive impairment are common problems. Since behavioral changes can be the first manifest as physical complaints, providers need to be aware of the interplay of physical, emotional and social factors. One must work with the client as a whole, not just the biomedical or psychological aspects.

Client related barriers to receiving needed services include:

a. misunderstanding of mental health system/resources;

b. lack of knowledge regarding treatability of mental illness;

c. stigma of mental illness;

d. mental health care viewed as a luxury;

e. inability or reluctance to ask for help or admit problems;

f. physical limitations.

C. SERVICE SYSTEM PROBLEMS

Systemic problems are both provider and system-related:

1. Provider related:

a. Lack special preparation or access to consultation.

b. Negative attitudes, including pessimism regarding treatability or wisdom of investing services in older persons, lack of peer support.

c. Frustration regarding slow progress and fear client may die during treatment.

d. Anxieties regarding own aging.

2. System related:

a. Duplication of some services, gaps in others.

b. Shifting from agency to agency with fragmentation of available treatment services.

c. Problems in professional level of communication.

d. Lack of systematic coordination: little outreach, little routine interaction and poorly developed relationships between mental health system (including community mental health center, county mental health authority), aging services (including State Office on Aging, Area Agency on Aging, and county division responsibility for full range of services to older adults) and the community health system (individual provider and county health authority).

3. Other Barriers:

   a. Transportation.

   b. Facilities not physically accessible.

   c. Funding limitations -- the MHD funds eight demonstration grants (using federal mental health block grant funds) to address these barriers (see pp. 80-81).

D. IDEAL SYSTEM OF SERVICES

1. Education and Prevention Services

   Goal: As stated in the 1987 Mental Health Act.

   Objectives:

   A. The MHD will work with local mental health authorities to assure that appropriate outreach methods are used to reach older adults most at risk.

   B. The MHD will explore the incorporation of materials specifically designed for older adults into the statewide anti-stigma campaign.

2. Emergency Services

   Goal: As stated in the 1987 Mental Health Act.

   Objective:

   The MHD will explore with local mental health authorities the feasibility of adapting the mobile crisis response team (from the NIMH demonstration project) to other areas of the state.

3. Outpatient Services

   Goal: As stated in the 1987 Mental Health Act.

   Objective:

   The MHD will work with local mental health authorities to explore options to enhance availability of outpatient services to older adults who have a mental illness; i.e., in-home services, transportation, peer counselors.

4. Community Support Program Services

Minnesota was one of 16 states funded in late 1986 to conduct a demonstration community support program for older adults with serious and persistent mental illness. See attachment at end of chapter for project description.

Community support programs have not universally been adapted to meet the needs of older adults. One day treatment model (in the NIMH demonstration project) has been developed, and there are a few medication management clinics. An objective of the NIMH demonstration is to disseminate the model. Alternative care grant services (MA waivered services) have been used when persons also have physical needs.

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with local mental health authorities to identify special requirements and to adapt community support program services for older adults with serious and persistent mental illness.

5. Residential Treatment Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with local mental health authorities to determine the need for residential treatment service for older adults with mental health illness, especially those with serious and persistent mental illness.

6. Acute Care Hospital

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with local mental health authorities to evaluate the need for specialized geropsychiatric units in acute psychiatric care settings.

7. Regional Treatment Center Inpatient Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with appropriate DHS units to identify the need for and define the role of RTCs and other state

operated facilities in providing services to older adults with mental illness, especially those with serious and persistent mental illness.

8. Screening

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will incorporate needs of older adults with mental illness and adapt the screening process and methods as needed to appropriately screen this population.

9. Case Management

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will incorporate special issues relevant to providing case management services to older adults with serious and persistent mental illness in case management training and will monitor for inclusion of such at the local level.

10. Administration and Service Delivery

Objectives:

1) The MHD will seek legislative approval for an Older Adult Specialist position within the Division, to become effective at termination of NIMH funding.

2) The MHD will work with NIMH demonstration project staff and federal block grant demonstration project staff to describe, evaluate and recommend implementation strategies for the models developed.

PROJECT SUMMARY: Community Support Program Services for Older Adults with Serious and Persistent Mental Illness

The project includes a rural demonstration in St. Louis County, Minnesota, a sparsely populated, large county in northeastern Minnesota. The population of 210,000 (19% are 60 year of age or older) live in 6,000 square miles, with 45% of the population residing in the 5,000 square mile area of northern St. Louis County. Most of the population of northern St. Louis County (25,000) lives in the Virginia-Hibbing area, the site of the demonstration project. (Forty-one percent of Minnesota's older adults live in rural areas: 35% in small towns, 5% on small farms and 1% in heavily forested and widely scattered areas.) The primary economic activity of the county has revolved around the iron range. Depletion of natural resources (iron and lumber) and industry-related declines have produced extremely high rates of unemployment.

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 Services 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 the 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 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 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.

Minnesota has a state supervised, county administered human services system. 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 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.

PROJECT MODELS: Community Based Mental Health Services for Older Adults (Funded by Federal ADM Block Grant)

1. Lead Agency: Community Mental Health Center

   Other Agency(ies): Community Health Services

   Focus: "to tie together existing providers, provide for special needs and not be costly" (addresses system barriers)

*2. Lead Agency: Community Health Nursing

   Other Agency(ies): Community Mental Health Center
   County Mental Health Center
   County Chemical Dependency Unit
   County Senior Services
   Area Agency on Aging

   Focus: Training and coordination in a "resource (manpower) rich" area (addresses provider barriers)

*3. Lead Agency: Community Mental Health Center and Community Health Nursing

   Other Agency(ies): Area Agency on Aging
   County Mental Health Service
   Baccalaureate Nursing Program
   County Senior Services

   Focus: to develop a comprehensive, coordinated interagency system to provide a continuum of services: outreach, assessment, treatment, education (addresses system behavior)

*4. Lead Agency: County Social Services Board

   Other Agency(ies): Community Mental Health Center
   Community Health Nursing
   Area Agency on Aging/County Senior Services

   Focus: to provide coordination (developing a combined Mental Health and Aging Advisory Council), service (outreach, assessment and treatment case management) and consultation (addresses system barriers)

*5. Lead Agency: County Human Services Department (includes Social Services, Mental Health, Community Health and Aging)

   Other Agency(ies): Community Mental Health Center

   Focus: to address client, provider and system barriers through education and outreach in order to assist older adults to utilized services available.

*6. Lead Agency: County Social Services and County Mental Health Services (CSP)

Other Agency(ies): County Extension Service
Community Health Services

Focus: to provide coordination, case management and education

*7. Lead Agency: County Social Services, County Senior Services and Community Mental Health Center (CSP)

Other Agency(ies): Community Health Services

Focus: to address client barriers through education to older adults and their families.

*8. Lead Agency: Community Mental Health Center

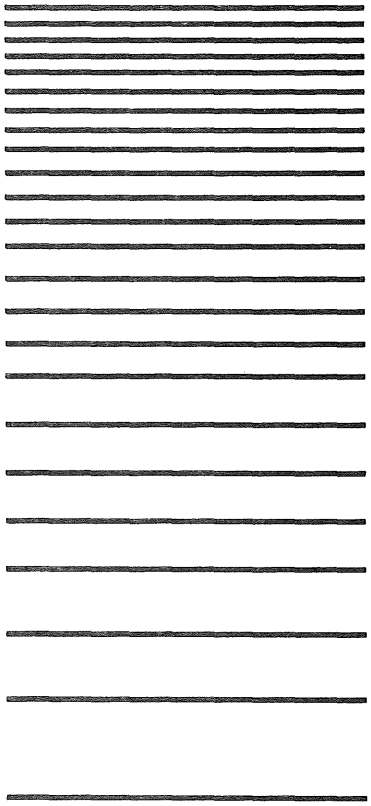
Other Agency(ies): Senior Services Division of County Social Services
Community Health Nursing

Focus: to address client and provider barriers through education and training: peer counselors, older adults and their families, health care providers, older adults as spokepersons.

*Denotes rural project.

VII.

Rural Mental Health Services



VII. RURAL MENTAL HEALTH SERVICES

A. INTRODUCTION

Minnesota is one of four states participating in an 18 month NIMH Rural Mental Health Demonstration Project. The Demonstration is limited to 15 counties in the southwest area of the state and is funded through the MHD, sharing the Division's mission and purpose.

The goals of the project are twofold: 1) to demonstrate innovative service delivery to hard-to-reach rural populations adversely affected by unstable economic events in agriculture; and 2) to demonstrate interorganizational planning and coordination of such services.

The project was designed specifically to be time-limited; there is no expectation that the project will continue after August 1989. Additionally, the project is geographically limited; it only serves the southwest portion of the state. This is due to the specific objectives outlined in the grant. In the course of the project there is a federal and state expectation it will generate recommendations for statewide improvements and innovations in rural mental health service delivery as a result of experiences and knowledge generated by the grant (see pp.87-88 for project summary).

B. POPULATION ANALYSIS

1. Definition of the population

Minnesota is a rural state. Approximately 50% of the population lives in less than 5% of the geographic area. Although the geographic area served by the demonstration project is primarily agricultural, including both small communities and farms (there are about 87,000 farms in Minnesota according to Department of Agriculture estimates), other rural regions of Minnesota included heavily forested areas with small communities and widely scattered, often isolated home sites.

The rural Minnesota population is heterogeneous, characterized by a high incidence of poverty, presence of dependent (large proportion of older adults) and high risk groups; recent and continuing stress (especially economic), geographic and social isolation due to distances, and reluctance to utilize mental health services. Some attitudes and values such as self-reliance and distrust of outsiders have been ascribed to persons living in rural areas and have been theorized to lead to a different pattern of mental health problems. Therefore, delivering mental health services in rural areas probably requires models which differ from those applied in urban areas. The models must recognize

that, due to a shortage of providers, staff providing services frequently "wear many hats" with clinical consultation or supervision and professional peer support not readily available. These models must also build on rural strengths such as community ties, the potential for a more manageable system due to smaller size and natural helpers (self-help groups, personal networks, community helpers, voluntary and religious organizations, and agency volunteers).

Rural Goals and Objectives:

Goals:

1. Education and Prevention

   Goal: As stated in the 1987 Mental Health Act.

   Objectives:

   a. The MHD will work with the contractor for the anti-stigma campaign (Minnesota Department of Health) to develop materials which will reach rural residents.

   b. The MHD will work with local mental health authorities in rural areas to conduct education and prevention activities which will address the mental health problems most common in rural areas and which will build on local referral networks.

2. Emergency Services

   Goal: As stated in the 1987 Mental Health Act.

   Objective:

   The MHD will work with local mental health authorities in rural areas to assure that emergency services continue to be available to all county residents.

3. Outpatient Services

   Goal: As stated in the 1987 Mental Health Act.

   Objective:

   The MHD will work with local mental health authorities in rural counties to develop outpatient services which are appropriately adapted to rural settings.

4. Community Support Program Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with local mental health authorities in rural counties to assess needs for CSP services and to develop programs which are adapted to meet the needs of rural residents who have serious and persistent mental illness.

5. Residential Treatment Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with local mental health authorities in rural counties to assess residential treatment services needs and to develop and/or adapt services to meet those needs.

6. Acute Care Hospital Inpatient Treatment Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with local mental health authorities in rural counties to determine need and availability of services, providing technical assistance as needed to develop and/or adapt appropriate and adequate services for all rural residents with acute mental illness.

7. Regional Treatment Center Inpatient Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with appropriate DHS units to assure that residents of rural areas have appropriate regional treatment center inpatient services available.

8. Screening

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will review and evaluate efforts to develop screening processes to ensure that screening is

implemented as required by the 1987 Mental Health Act.

9. Case Management

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD, recognizing unique rural concerns (distances, fewer mental health professionals), will work with local mental health authorities in rural counties to ensure that rural residents with serious and persistent mental illness have access to case management services.

SUMMARY: Rural Mental Health Demonstration Project

Minnesota is one of four states participating in an 18 month Rural Mental Health Demonstration Project, funded by congress and administered through NIMH. The demonstration is limited to 15 counties in the southwest area of the state.

The Rural Mental Health Demonstration Project is housed in the Minnesota Department of Human Services, Mental Health Division. The goals of the project are two-fold: 1) to demonstrate innovative service delivery to hard to reach rural populations adversely affected by unstable economic events in agriculture, and 2) to demonstrate interorganizational planning and coordination of such services. In addition, the project has endeavored when possible to work within the overall philosophy and service mission of the Minnesota Comprehensive Mental Health Act. The project is characterized by an emphasis upon:

A. systems of rural service delivery;
B. supportive services to non-seriously and persistently mentally ill populations; and
C. the process of service delivery, rather than the product of that delivery.

Additionally, the project was designed specifically to be time limited; there is no expectations that the project will continue after August 1989. Finally, the project is geographically limited; it serves 15 counties in the southwest portion of the state.

In the course of the project there is a federal and state expectation that the grant can make recommendations for statewide improvements and innovations in rural mental health delivery, as a result of experiences and knowledge generated by the grant.

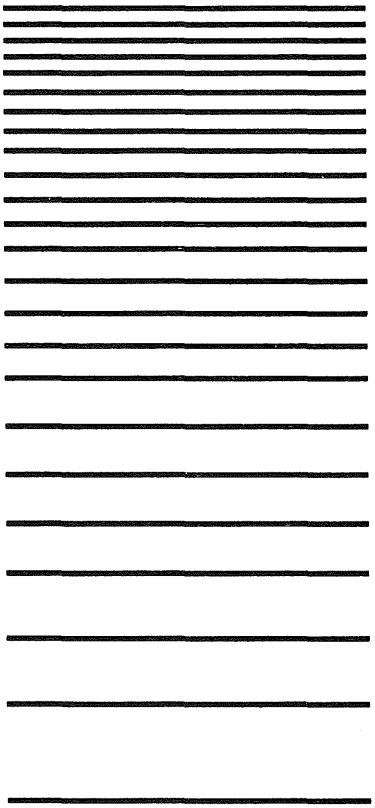
The project provides a full time mental health/community organizer staff person at each of three demonstration sites in southwestern Minnesota. The primary functions of these staff persons would be to build networks between local agencies and persons currently working with persons affected by the farm crisis, such as mediators, farm advocates, Job Services, lenders, physicians, and to train the "front-line" workers in early intervention techniques. In addition, each center is provided program development funds.

The state level component of this project ensures coordinated planning to meet rural mental health needs, assists in strengthening state plans in this regard, and develops a centralized focus for technical assistance. The major partners in this effort are the Department of Human Services, Mental Health Division, the Minnesota Extension Services, and the Department of Agriculture, working together with the three demonstration site CMHCS. The demonstration utilizes a "process" model, with sufficient flexibility to permit local solutions to local problems. This approach is consistent with other state initiatives, such as the McKnight Rural Foundation Initiative, which successfully operates using a grassroots model.

A state level advisory committee consisting of the major public and private agencies working with rural crisis issues would meet regularly with the major study partners to examine methods of working with one another, leverage prior experiences and seed monies, and plan coordinated strategies to address short and long term needs of rural residents at risk. Training materials are being developed, using the local experiences as the basis for written and videotaped materials, for distribution statewide at the close of the project, using teleconferencing methods previously employed by Extension Services. Promising models will be publicized through this means, and a permanent record of program training activities would be available for future use in other areas of the state. State DHS staff oversee and manage the project, as a whole, which is projected to continue until August 1989.

VIII.

American Indian Mental Health Services



VIII. AMERICAN INDIAN MENTAL HEALTH SERVICES

A. INTRODUCTION

1. Service philosophy

The County Board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable mental health services for all residents. Services are to be based on clinical needs and delivered in a manner consistent with and sensitive to the cultural and ethnic background of the population to be served.

2. Mission

Mental Health services to American Indian people are a part of the 1987 Mental Health Act.

B. POPULATION ANALYSIS

1. Statuary definition of population:

For the purpose of this chapter the term "Indian" shall include all persons of Indian descent who are members of any recognized Indian Tribe now under Federal jurisdiction, and all persons who are descendents of such members.

2. Number affected and geographic location:

The Minnesota American Indian population live primarily on 11 reservations and in the major urban areas of Minneapolis, St. Paul, Duluth and Bemidji. (See map and population breakdown.)

3. Methodology used to determine incidence:

Information on the incidence of mental illness in the American Indian population is inadequate for a number of reasons:

a) mental health problems are often mislabeled as alcoholism;
b) Indian people are often reluctant to seek mental health services because of the stigma of mental illness;
c) cultural differences make the diagnosis of mental health problems difficult;
d) mental illness may be masked by alcohol use making it difficult to determine whether an individual is mentally ill, chemically dependent or both.

4. Description of needs of American Indians:

Due to the every day stress in their lives, American Indians have been characterized as "aliens in their own land". Cultural epidemiologists claim that acculturation to urban living increases psychological problems, due to the heightened stress when Indians attempt to adapt to the dominant culture. The needs for mental health services are demonstrated by the high incidence of families in crisis, foster homes placements, school drop out and school adjustment problems, alcohol misuse, depression, and violent deaths. Severe economic problems, plus the many cultural problems, result in a much higher than normal incidence of a whole range of mental health related problems for Indian persons. Indian persons also suffer from the dual problem of mental illness and chemical dependency.

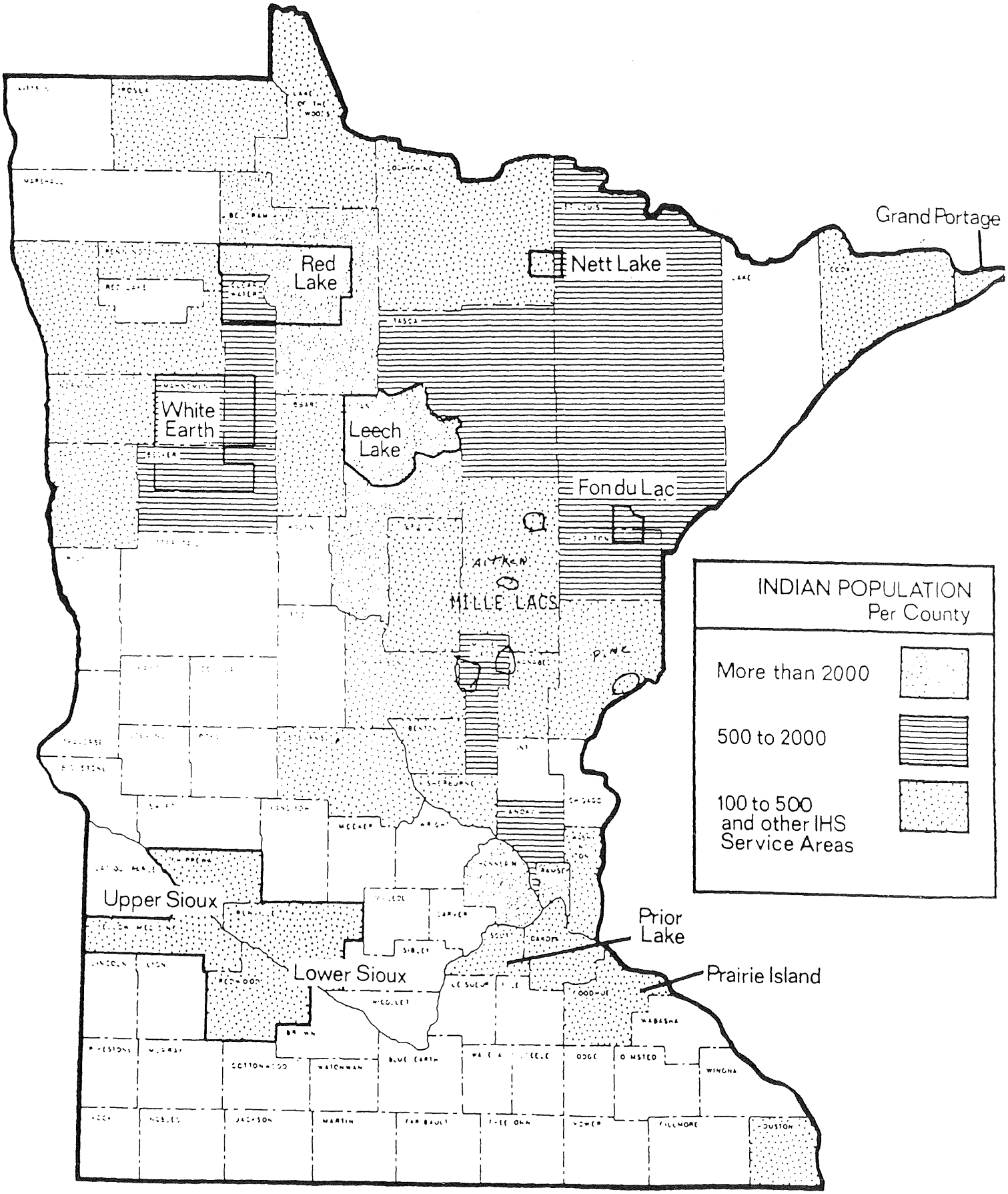
C. SERVICE SYSTEM PROBLEMS

In a recent report on Indian Mental Health services at the Senate Select Committee on Indian Affairs hearing held July 7, 1988, it was stated that inadequate funding, and fragmentation between substance abuse and mental health programs have resulted in inefficiency and ineffectiveness of programs.

D. IDEAL SERVICE SYSTEM, IDENTIFIED NEEDS, GOALS AND OBJECTIVES

Agencies that provide culturally relevant services for the American Indian population are limited. Efforts have been made to increase the capacity of Indian communities within this state to care for mental health needs of Indian people. There have been significant changes made within the past eight years in the delivery of mental health services for the Indian people of Minnesota. The federal block grant set aside funds for mental health services for the Indian population make it possible for the Indian communities to develop their own mental health programs. The Minnesota Indian Mental Health Advisory Council plays a very important part in the overall delivery of mental health services in providing input to the Minnesota Mental Health Advisory Council. Through their efforts the funding increased from 12% to 25% which allowed for new and expanded programs in their communities and for the new position in the Department of Human Services, Mental Health Division of an Indian Mental Health Program Advisor.

The overall Comprehensive Mental Health Act of 1987 called for a unified effort for counties to develop a mental health plan which would include all citizens of their counties to participate and address their mental health needs. Members of the Indian Mental Health Advisory Council are members of


Grand Portage
Nett Lake
Red Lake
White Earth
Leech Lake
Fon du Lac
MILLE LACS
INDIAN POPULATION
Per County
More than 2000
500 to 2000
100 to 500
and other IHS
Service Areas
Upper Sioux
Lower Sioux
Prior Lake
Prairie Island

Population of American Indians
in Minnesota

Reservation Population	Number	Outstate Percentage	Overall Percentage
Fond Du Lac	1,486	8.13%	3.30%
Grand Portage	308	1.68%	0.68%
Leech Lake	4,930	26.96%	10.96%
Lower Sioux	237	1.30%	0.53%
Mille Lacs	942	5.15%	2.09%
Nett Lake	1,491	8.15%	3.31%
Prairie Island	191	1.04%	0.42%
Red Lake	4,069	22.25%	9.04%
Shakopee	218	1.19%	0.48%
Upper Sioux	148	0.81%	0.33%
White Earth	4,268	23.34%	9.48%
Reservation Total	18,288	100.00%	40.64%

Urban Population	Number	Urban Percentage	Overall Percentage
Bemidji	1,112	4.16%	2.47%
Duluth	2,600	9.73%	5.78%
Minneapolis	17,000	63.64%	37.78%
St. Paul	6,000	22.46%	13.33%
Urban Total	26,712	100.00%	59.36%

Overall Total	45,000	100.00%	100.00%

their county mental health committees and attend the meetings, making every effort to bring about the necessary changes to make this law work.

Indian mental health workers are identifying the mental health needs in their communities and are implementing programs which are based on clinical needs and delivered in a culturally sensitive and appropriate manner. The programs are hiring more Indian mental health providers and are coordinating with local mental health authorities and providers.

In Minnesota, seven reservations currently have contracts with the State to provide mental health services. These programs provide informational and educational services to help their communities better understand the problems of mental illness and to help them to access available services.

In addition, the services mandated by the 1987 Mental Health Act are to be provided by the counties and are to be available to all persons who are mentally ill and who reside in a county, including American Indians.

Finally, the Indian mental health program advisor who has been hired by the MHD is responsible for providing technical assistance and program consultation to Indian service providers and to local mental health authorities.

The following Minnesota reservations provide mental health services:

Fond Du Lac is located in Cloquet, near Duluth. Provides individual couples, family, and group counseling and psychiatric, and psychological evaluations through a contract with the Human Development Center in Duluth.

Bois Forte is located in the most northern part of the State in St. Louis and Koochiching Counties, serving the Vermilion and Deer Creek communities. Mental health services include education and prevention, crisis assistance, outpatient treatment services, outreach and supportive services. The Range Mental Health Center, located in Virginia, Minnesota, provides the consultation and treatment services.

Grand Portage is located in Cook County, in the far northeastern corner of the state. Their services include information and education, case management, independent living skills training, client outreach, consultation.

Leech Lake is located 14 miles east of Bemidji. Mental health services include: case management, client outreach, crisis assistance, medication management, education and prevention, and advocacy.

White Earth is located in the northwestern part of the State in Mahnomen, Clearwater, and Becker counties. Mental health services are provided through Indian Health Services and include family therapy, marriage counseling, child/adolescent behavioral evaluation. Fergus Falls Regional Treatment Center is used for extended mental health treatment.

Mille Lacs is located in the four north central counties of Aitkin, Mille Lacs, Pine and Kanabec. Mental health services include outpatient counseling, consultation, education, and coordinating services with the three counties of Aitkin, Mille Lacs and Pine.

Red Lake is located in northwestern Minnesota. The reservation has an Indian Health Service Hospital and provides a comprehensive health care program for enrolled members. The reservation is called a "closed" reservation and is not subject to state law.

There are four Sioux communities located south of the Minneapolis-St. Paul area.

Lower Sioux Community at Morton, Minnesota, in Redwood and Renville counties. Services include outreach services and information and referral to West Central Community Services Center and to the Rural Rainbow Project at Marshall, Minnesota.

Upper Sioux Community is located in Yellow Medicine County. Mental health services include outreach, advocacy services and coordination of services with the Harley Clinic, Western Human Development Center in Marshall, Minnesota.

Shakopee Mdewakanton Sioux Community is located in Scott County, 25 miles from Minneapolis. They provide case management, counseling, information, education and prevention and advocacy.

Prairie Island Community is located in Prairie Island in Goodhue County. Mental health services are funded through Indian Health Services.

Goals and Objectives:

Identified needs and long range plans for implementation.

1. Education and Prevention Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

a. In counties where there is a significant Indian population, the MHD will work with local mental health

authorities to develop and disseminate education and prevention materials to reach Indian persons at risk of mental illness.

b. The needs of Indian persons will be reviewed as the MHD works with the contractor for the statewide anti-stigma campaign (Minnesota Department of Health).

2. Crisis Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with local mental health authorities in counties to encourage incorporation of culturally sensitive and appropriate methods in providing crisis services.

3. Outpatient Services

Goal: As stated in the 1987 Mental Health Act.

Objectives:

a. In counties where there is significant Indian population, the MHD will work with local mental health authorities to explore the possibility of hiring Indian mental health workers and/or including Indian traditional healers in service continuum.

b. The MHD will work with Indian mental health providers to encourage collaboration with county mental health authorities to enhance outpatient services and make them culturally appropriate.

c. The MHD will work with the Division of Rehabilitation Services and Indian CSP staff to develop an employability services program on reservations for Indian people with serious and persistent mental illness.

4. Community Support Program Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with Indian mental health providers to assist in adapting day treatment model for Indian persons with serious and persistent mental illness.

5. Residential Treatment Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with Indian mental health providers and county mental health authorities to conduct an assessment of need on each reservation/Indian community.

6. Acute Care Hospital Inpatient Services

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with counties where there is a significant Indian population to develop culturally sensitive and appropriate acute care services.

7. Regional Treatment Centers

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with appropriate DHS units to develop culturally relevant mental health programs to meet the needs of Indian persons in the RTCs.

8. Case Management

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with Indian mental health providers and county mental health authorities to ensure that culturally sensitive and appropriate case management services are offered and available to every Indian person with serious and persistent mental illness.

9. Screening

Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will work with Indian mental health providers and county mental health authorities to ensure the culturally sensitive and appropriate screening is implemented by January 1, 1991.

10. Children's Mental Health Services

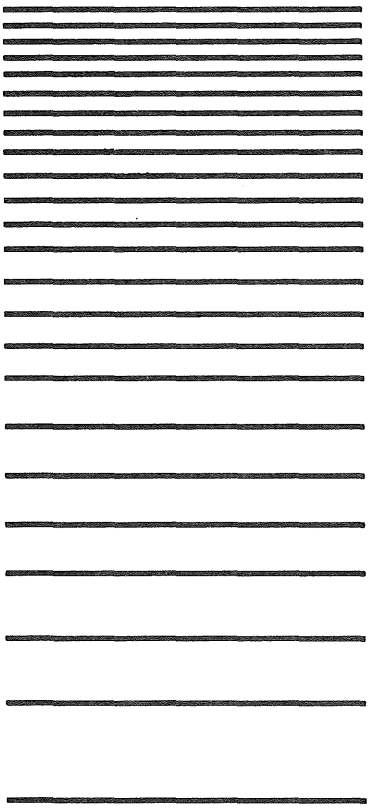
Goal: As stated in the 1987 Mental Health Act.

Objective:

The MHD will explore the possibility of developing at least one reservation program for children and adolescents who are emotionally disturbed or seriously emotionally disturbed.

IX.

Services for Homeless Persons with a Mental Illness



IX. SERVICES FOR HOMELESS PERSONS WITH A MENTAL ILLNESS

A. POPULATION ANALYSIS

The number of homeless persons increased dramatically in Minnesota in the early 1980's. In response to this need, the religious community opened several church basements for the use of overnight shelters. Since many thought the increase in homelessness to be a result of the economic recession, an upturn in the economy should have solved the problem. It did not. As the economy recovered in the mid-1980's, the number of homeless persons continued to grow. Shelters designed to meet short term emergency needs became a type of permanent housing for many of the homeless. The lack of support services in these shelters left individuals trapped in a day to day crisis.

Detecting this problem, providers responded by developing transitional housing programs. These programs provided 24 hour housing, counseling, referral, advocacy and other services. These services helped remove some, but not all, of the barriers that kept homeless persons from regaining their self sufficiency. A shortage of affordable housing, a lack of living wage jobs, a lack of specialized housing and a host of other "systems" barriers made transition from homelessness to independent living exceedingly difficult. Individual barriers also stood in the way, such as illiteracy, lack of job skills, and the need for day care and transportation.

According to the Minnesota Department of Jobs and Training (DJT) 2,016 individuals received some type of temporary shelter on May 28, 1987. This represents a 73% increase over the first statewide survey conducted by DJT in August, 1985. Many individuals counted in the shelter survey are only episodically homeless. They may find temporary shelter with a friend or relative or rent a place of their own. Over the course of a year, more people will experience a bout of homelessness than a one night shelter survey reveals. Further, an unknown number of the homeless fail to stay in shelters, sleeping in cars or outdoors. The Metropolitan Council, a regional planning council, estimates that 34,000 to 53,000 individuals will go without regular housing in the metropolitan area in the course of a year.

Just as it is difficult to accurately determine the number of persons who are homeless, it is also difficult to estimate the proportion of that population who have a mental illness. However, two studies provide an estimate of the number of persons in need.

A Wilder Foundation survey (February 1987) conducted in shelters in the Twin Cities found:

- 14.5% of the individuals surveyed had once lived in a state hospital

- 24.1% individuals said that they thought they had a mental health problem.

Shelter providers frequently claim they have difficulty serving individuals with mental illness. State institutions serving the mentally ill have difficulty in locating appropriate placements for individuals reentering the community. A State Legislative Auditor's report (February 1986) found that 15.8% of the individuals leaving state mental hospitals had no discharge destination specified in their service programs.

Homeless providers, public officials, and law enforcement representatives acknowledge that there is a problem of mentally ill/emotionally disturbed children and adolescents who are homeless. However, the extent of the problem is not known at this time.

B. CURRENT SERVICES FOR MENTALLY ILL HOMELESS PERSONS

The MHD is currently receiving McKinney Act funds of $572,235 for fiscal year 1988-89 for mentally ill homeless persons. The state has matched these funds with $350,000 in Rule 14 monies. The program will:

1. provide outreach services to persons experiencing serious and persistent mental illness who are homeless or who are subject to a significant probability of becoming homeless;

2. provide community mental health services, diagnostic services, crisis intervention services, and habilitation and rehabilitation services to individuals described in paragraph (1) above;

3. refer such individuals as appropriate to medical facilities for necessary hospital services and to entities that provide primary health services and substance abuse services;

4. provide, in accordance with (b), below, appropriate training to individuals who provide services to individuals described in paragraph (1), including the training of individuals who work in shelters, mental health clinics, and other sites where homeless individuals receive services;

5. provide appropriate case management services to homeless individuals including:

   a. preparing a community support plan for the provision of community mental health services to the homeless individual involved and reviewing such plans not less than once every three months;

   b. providing assistance in obtaining and coordinating social and maintenance services for the individual, including services related to daily living activities, transportation services, and habilitation and rehabilitation services, prevocational and vocational services, and housing services;

   c. providing assistance to the individual in obtaining income support services, including housing assistance, food stamps, and supplemental security income benefits;

   d. referring the individual for such other services as may be appropriate; and

6. provide supportive and supervisory services to homeless individuals in residential settings not supported under:

   a. the transitional housing demonstration program carried out by the Secretary of Housing and Urban Development pursuant to Section 101 (g) of Public Law 99-500 or Public Law 99-591; or

   b. the supportive housing demonstration program established in Subtitle C of Title IV of the Stewart B. McKinney Homeless Assistance Act.

The funds further assure that the training required in (4) above will include:

1. identifying individuals who are experiencing serious and persistent mental illness.

2. referring individuals to services available to them, including job training services, literacy education, community health centers, community mental health services, and noninpatient substance abuse treatment and support programs; and

3. identifying programs that provide benefits to homeless individuals and referring such individuals to these programs.

This program has funded eight projects throughout the state ranging from rural to small town and suburban to large city. Providers range from the counties to consultants and in delivery of services from primarily outreach to primarily supportive services.

Through this project the state will identify more closely who are the homeless, how many are mentally ill and what types of services work best. Each of the counties involved will network quarterly over the duration of the funding.

Currently, there are no services targeted specifically to children and adolescents with emotional disturbance who are homeless.

C. THREE YEAR GOALS AND OBJECTIVES FOR THE MENTALLY ILL HOMELESS

The MHD will continue to provide Rule 14 match funds for the McKinney Act and will continue the eight demonstration programs throughout the state. Through program evaluation, other counties will be able to interact with mentally ill homeless persons.

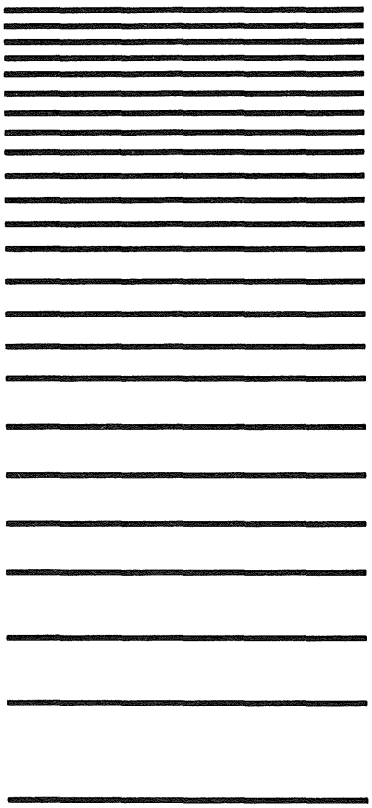
A statewide mental health homeless training program will be developed and implemented for all community support program staff, focusing on prevention and case management.

A part of the McKinney Grant will be devoted to research needs of the emotionally disturbed children and adolescents who are homeless. Current demonstration project sites will also be asked to provide information on, and address the needs of children and adolescents.

Finally, the MHD will work together with other divisions of the Department of Human Services and the other state departments to develop a comprehensive plan and implementation of homeless services.

X.

Services to Enable the Protection of Client Rights



X. SERVICES TO ENABLE THE PROTECTION OF CLIENT RIGHTS

1. Office of the Ombudsman for Mental Health and Mental Retardation

Minnesota has enacted separate statutes enumerating the rights of clients of mental health programs. M.S. 144.651 is the Patients and Residents of Health Care Facilities Bill of Rights; M.S. 253B.03 grants certain rights to persons committed under the Minnesota Commitment Act. Both require the patient to be informed of his/her rights upon admission to mental health programs. Both statutes are attached as Appendix F-2.

While these statutes establish the rights of patients, the Minnesota Legislature determined during the 1987 session that the formal state responsibility for protecting the rights and dignity of persons receiving care for mental illness should be independent and distinct from those state agencies, including the MHD, that provide and/or fund such care. As a result, the state Office of Ombudsman for Mental Health and Mental Retardation was created (M.S. 245.91 et. seq., 1987).

The office was formed out of the advocacy function originally serving Minnesota's eight regional treatment centers (RTCs). To ensure its independence, the office reports directly to the Governor. The duties and function of the office are best described by reviewing its authorizing statute:

A. Office of Ombudsman; Creation; Qualifications; Function:

The ombudsman for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance shall promote the highest attainable standards of treatment, competence, efficiency and justice. The ombudsman may gather information about decisions, acts, and other matters of an agency, facility or program. The ombudsman is appointed by the Governor, serves in the unclassified service and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

B. Powers of Ombudsman; Reviews and Evaluations; Recommendations:

1. Powers:

(a) The ombudsman may prescribe the methods by which complaints to the office are to be made,

reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman may mediate or advocate on behalf of a client.

(c) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients, other than clients in acute care facilities who are receiving services not paid for by public funds.

(d) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of a client who is not capable of requesting assistance have been adversely affected, the ombudsman may gather information about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(e) The ombudsman may examine, on behalf of a client, records of an agency, facility or program to which the client is entitled to access if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with mental retardation or a related condition.

(f) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of any agency, facility, or program.

(g) The ombudsman may attend Department of Human Services review board and special review board proceedings; proceedings regarding the transfer of patients or residents, as defined in section 246.50, subdivisions 4 and 4a, between institutions operated by the Department of Human Services; and subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with mental retardation or a related condition.

(h) The ombudsman shall have access to data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 12 and 13, regarding service provided to clients with mental retardation or a related condition.

(i) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility.

(j) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

2. Matters appropriate for review.

(a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program; or actions of an agency or facility, or program that:

(1) may be contrary to law or rule;
(2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;
(3) may be mistaken in law or arbitrary in the ascertainment of facts;
(4) may be unclear or inadequately explained, when reasons should have been revealed;
(5) may result in abuse or neglect of a person receiving treatment; or
(6) may disregard the rights of a client or other individual served by an agency or facility.
(7) may impede or promote independence, community integration, and productivity for clients; or
(8) may impede or improve the monitoring or evaluation of services provided to clients.

(b) The ombudsman shall, in selecting matters for review and in the course of the review, avoid duplicating other investigations or regulatory efforts.

3. Complaints.

The ombudsman may receive a complaint from any source concerning an action of an agency, facility, or program. After completing a review, the ombudsman shall inform the complainant and the agency, facility, or program. No client may be punished nor

may the general condition of the client's treatment be unfavorably altered as a result of an investigation, a complaint by the client, or by another person on the client's behalf. An agency, facility, or program shall not retaliate or take adverse action, as defined in Section 626.557, subd. 17, paragraph (c), against a client or other person, who in good faith makes a complaint or assists in an investigation.

4. Recommendations to agency.

(a) If, after reviewing a complaint or conducting an investigation and considering the response of an agency, facility, or program and any other pertinent material, the ombudsman determines that the complaint has merit, or the investigation reveals a problem, the ombudsman may recommend that the agency, facility, or program:

(1) consider the matter further;
(2) modify or cancel its actions;
(3) alter a rule, order, or internal policy;
(4) explain more fully the action in question; or
(5) take any other action.

(b) At the ombudsman's request, the agency, facility, or program shall, within a reasonable time, inform the ombudsman about the action taken on the recommendation or the reasons for not complying with it.

C. Recommendations and Reports to Governor:

The ombudsman may send conclusions and suggestions concerning any matter reviewed to the Governor. Before making public a conclusion or recommendation that expressly or implicitly criticizes an agency, facility, or program, or any person, the ombudsman shall consult with the Governor and the agency, facility, program, or person concerning the conclusion or recommendation. When sending a conclusion or recommendation to the Governor that is adverse to an agency, facility, or program, or any person, the ombudsman shall include any statement of reasonable length made by that agency, facility, program, or person in defense or mitigation of the office's conclusion or recommendation.

D. Ombudsman Committee.

1. Membership

The ombudsman committee consists of 15 members appointed by the Governor to three year terms.

Members shall be appointed on the basis of their knowledge of and interest in the health and human service system subject to the ombudsman's authority. In making the appointments, the Governor shall try to ensure that the overall membership of the committee adequately reflects the agencies, facilities, and programs within the ombudsman's authority and that members include consumer representatives, including clients, former clients, and relatives of present or former clients; representatives of advocacy organizations for clients and other individuals served by an agency, facility, or program; human services and health care professionals, including specialists in psychiatry, psychology, internal medicine, and forensic pathology; and other providers of services or treatment to clients.

2. Compensation; Chair.

Members do not receive compensation, but are entitled to receive reimbursement for reasonable and necessary expenses incurred. The Governor shall designate one member of the committee to serve as its chair at the pleasure of the Governor.

3. Meetings.

The committee shall meet at least four times a year at the request of its chair or the ombudsman.

4. Duties.

The committee shall advise and assist the ombudsman in selecting matters for attention; developing policies, plans, and programs to carry out the ombudsman's functions and powers; and making reports and recommendations for changes designed to improve standards of competence, efficiency, justice, and protection of rights. The committee shall function as an advisory body.

5. Medical Review Subcommittee.

At least five members of the committee, including at least three physicians, one of whom is a psychiatrist, must be designated by the Governor to serve as a medical review subcommittee. Terms of service, vacancies, and compensation are governed by #2. The Governor shall designate one of the members to serve as chair of the subcommittee. The medical review subcommittee may:

(1) make a preliminary determination of whether the death of a client that has been brought to its attention is unusual or reasonably appears to have resulted from causes other than natural causes and warrants investigation;

(2) review the causes of and circumstances surrounding the death;

(3) request the county coroner or medical examiner to conduct an autopsy;

(4) assist an agency in its investigations of unusual deaths and deaths from causes other than natural causes; and

(5) submit a report regarding the death of a client to the committee, the ombudsman, the client's next of kin, and the facility where the death occurred and, where appropriate, make recommendations to prevent recurrence of similar deaths to the head of each affected agency or facility.

6. Terms, Compensation, and Removal.

The membership terms, compensation, and removal of members of the committee and the filling of membership vacancies are governed by M.S. 15.0575.

2. Other Services to Enable the Protection of Client Rights:

a. Mental Health Law Project

The Minnesota Mental Health Law Project has been in existence since 1983, when the McKnight Foundation provided funding to the Mental Health Association/Legal Aid Society of Minneapolis to conduct legal advocacy on behalf of persons with mental illness. For the first three years, the Project, although statewide, had a staff of two lawyers. The Project received funding late in 1986 under the federal Protection and Advocacy Act and hired a new staff attorney and three mental health advocates, including regional advocates for Northwest and Northeast Minnesota.

According to the Project's latest annual report, legal assistance was provided to clients in the following categories:

1. admission/commitment to institution
2. facility conditions

3. aversive practices
4. facility treatment/training
5. community alternatives
6. refusal of treatment
7. release/discharge from institution
8. right to less restrictive alterative
9. patients'/residents' rights
10. abuse/neglect/exploitation
11. transportation
12. guardianship conservatorship
13. consumer/finance/wills
14. education/special education
15. employment discrimination/other employment
16. Medicaid/SSI/income maintenance
17. other health
18. housing/zoning discrimination
19. family custody/termination of parental rights, and

served almost 600 persons in 1986-87.

The Project also conducts legislative advocacy, as do the following two groups.

b. Client Advocacy Project, Mental Health Association of Minnesota

The Client Advocacy Services program was created in 1983 by the Mental Health Association with funds from the Minnesota based McKnight Foundation. There are currently three staff advocates and 8 volunteers. Staff advocates handle casework, outreach, and supervision. Volunteers are used to conduct telephone intake and initial interviews. Volunteer interns are used for actual casework after training. Requests for assistance are made by telephone or in person at the Mental Health Association Minnesota office.

The West Metro staff advocate is partly funded by the United Way of Minneapolis Area and the East Metro staff advocate is partly funded by the United Way of St. Paul Area.

The Client Advocacy Services program practices "client-centered" advocacy -- that is, representing the client's interest as clients define it. This is an important distinction when compared with "best interest" advocacy which imposes the advocate's view of what is best upon the client.

Volunteer interns are rigorously trained in client centered advocacy and are carefully screened and tested to make sure that the program retains its creditability and consistency within the client community. Experience

has shown that the concept of client centered advocacy is particularly difficult for many service providers and others trained in social work. Therefore most training sessions are done with lay citizens and past consumers.

Posters and brochures are placed in treatment facilities, hospitals, workshops, board and lodging facilities and other places frequented by mental health consumers. Brochures are also made available at these facilities and, in addition, are mailed to service providers.

The Project served approximately 600 persons in 1987, with interventions occurring in the following areas:

- 27% treatment issues
- 24% welfare, financial
- 19% civil issues
- 7% housing
- 4% employment
- 4% SSI/SSDI
- 4% social services
- 3% living skills
- 3% criminal
- 5% other

C. Self-Help Information Program, Alliance for the Mentally Ill of Minnesota

The goal of the Self-Help Information Program (SHIP) network is to provide consumers, family members and providers with support, information and referrals relating to mental health issues. Volunteers trained in communication skills and familiar with mental health resources encourage empowerment of callers in dealing with the mental health system. By connecting callers with volunteers who have "walked in their shoes", or have a particular area of expertise, it is hoped that callers will gain support so they do not feel alone, as well as develop steps of action so they can find the resources which can help them gain a sense of hope. The SHIP is an opportunity for volunteers to share the information they have gained from moving through the mental health system. Hopefully callers, once they have found support and resources which help them, will go on to play a role in speaking out to improve the mental health system.

The objectives of the SHIP are:

- To connect people who call the Alliance for the Mentally Ill with trained volunteers who have similar experience or a specific area of expertise.

- To meet the needs of callers, whether it be for information and referral or peer support.

- To document calls that come into the AMI office and the referrals that are made.

- To follow-up with the caller and the person or agency the called is referred to and to document follow-up information.

- To grow into a statewide SHIP network with an "800" number.

From January to October 1988, the SHIP received over 550 calls from providers, family members, consumers, friends, and others. Topics which have been addressed include:

- Commitment Law

- Medication Concerns

- Counseling Referrals

- Insurance Issues

- Changing Psychiatrists

- Housing Needs

- Family Support

- Vitamin Therapy

- Medical Assistance

XI.

Inter/Intradepartmental Coordination

XI. INTER/INTRADEPARTMENT COORDINATION

A flowchart (Appendix G) illustrates the MHD's position within the Department of Human Services. The Commissioner of the Department is appointed by the Governor, as are commissioners of all state departments. Because of this structure, 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 individuals with mental illness. When the coordination effort involves agencies other than the Department of Human Services, efforts are made to develop written interagency agreements. When the coordination effort involves other divisions of the Department of Human Services, staff of the involved divisions make ongoing efforts to jointly address issues.

The following is a list of key departments and the activities which have occurred or are planned. In addition, three examples of the MHD's cooperative efforts with other divisions of the Department of Human Services are cited: the Health Care Programs, Long Term Care, and Children's Services Divisions. Finally, the MHD plans to pursue in 1989 greater coordination with the State Advisory Council on Mental Health those advisory committees serving special projects. Such committees include:

- rural mental health program;
- homeless persons with a mental illness;
- refugees;
- older adults;
- American Indians;
- human resource development issues;
- long term housing and residential treatment issues.

A. INTERDEPARTMENTAL COORDINATION:

<u>Multidepartmental Coordination</u>

The MHD is working with a statewide Human Immunodeficiency Virus (HIV) Issues Team to develop consistent policies for facilitating and/or providing services to persons who are HIV- positive. This includes persons with a mental illness who are HIV-positive as well as persons who may require mental health services as a result of being infected with the HIV. The Supervisor of Special Projects for the MHD is acting as the AIDS Policy Coordinator for the Department of Human Services.

<u>Department of Education</u>

As described in Chapter III, a number of efforts have been made with the Department of Education to coordinate planning for a system of children's mental health services. The

Commissioner of Education is involved in quarterly meetings with the Commissioner of Human Services, Corrections, Health and Commerce as part of the interagency agreement described in Chapter III. In addition, the Manager of the Unique Learner Needs Section of the Department of Education has a seat on the Subcommittee on Children's Mental Health.

Department of Corrections

During 1988, preliminary discussions occurred between the MHD and the Department of Corrections regarding care 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. In 1989 the MHD will pursue the development of an interagency task force to address the mental health needs of those incarcerated in jails and prisons and with those on probationary status. The needs of juveniles on probationary status and in juvenile and adult detention facilities also needs to be explored.

Department of Jobs and Training

The MHD and the Division of Rehabilitative Services of the Department of Jobs and Training 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 in establishing persons with serious and persistent mental illness as a priority for Title VI-C funds; methods for standardizing the definitions of populations to be served; and enhancing the number of vocational rehabilitation workers within DRS who serve persons with a mental illness.

In 1989, the MHD will pursue discussions with DJT to address the vocational needs of adolescents with emotional disturbance.

Department of Health

The MHD continues to work with the Department of Health on two issues directly related to community residential facilities.

The Department of Health was mandated by Chapter 197, Subd. 1b, 1987 Session of the Legislature, to develop a plan in cooperation with the Department of Human Services, by January 1, 1989 that will ensure monitoring of licensed boarding care, board and lodging, and supervised living facilities. This monitoring would assure that facilities not specifically

licensed for people with mental illness not have more than four residents with mental illness. 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.

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.

Department of Agriculture

The Rural Mental Health Demonstration Project of the MHD initiated an interagency agreement with the Minnesota Department of Agriculture (MDA) in February 1988. Since that time the MDA has consulted on the grant administration and specific strategies for implementation and funding distribution. Additionally, the two agencies have worked with those of the Rural Mental Health Demonstration Project's outreach workers. The MHD and the MDA continue to work together on grant related activities via an interagency committee convened once every three months.

Minnesota Extension Service

Through the auspices of the Rural Mental Health Demonstration Project the Minnesota Extension Service (MES) entered into an interagency agreement with the MHD in February 1988. MES has assigned an education coordinator to assist with dissemination of information around the grant, and write training materials generated by the Project. The education coordinator has served as both a resource and a link between the county extension offices and the Project's community mental health centers. MES is planning a large conference on rural mental health with the MHD for the summer of 1989.

B. INTRADEPARTMENTAL COORDINATION

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 MA funding 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 GAMC and 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 Management 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.

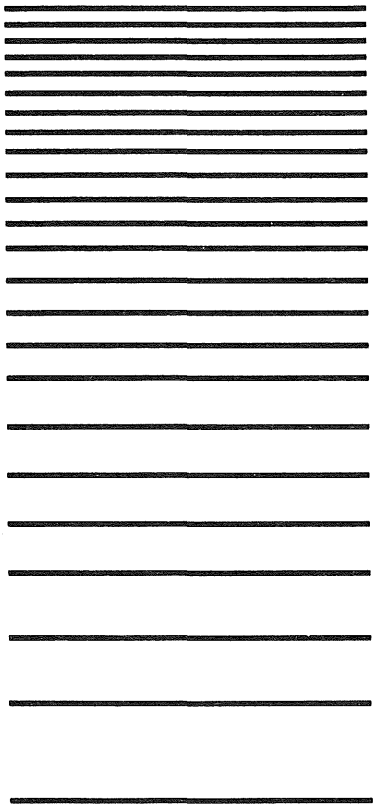
The MHD has been working with the Long Term Care Management and Developmental Disabilities Divisions to plan for the implementation of P.L. 100-203 (OBRA-87 and the Nursing Home Reform Act). This includes development of a pre-admission screening and annual resident review process for persons with mental illness and/or mental retardation, as well as the development of alternative disposition plans.

Multi-Division Coordination for Children's Services

The MHD has been working with the Division responsible for the state Medical Assistance plan, the Children's Services Division, and the Child Protection Division to coordinate efforts to serve children and adolescents with emotional disturbance. Representatives of the Medical Assistance program and the Children's Services Division sit on the Children's Mental Health Subcommittee of the State Advisory Council on Mental Health.

XII.

Funding For Mental Health Services



XII. FUNDING FOR MENTAL HEALTH SERVICES

A. Introduction:

The state of Minnesota intends to continue to aggressively pursue all available funding sources to provide the ideal service system for persons with mental illness. Due to complex federal and state legislative requirements, this requires working with a large number of agencies and funding sources.

B. DHS Funding for 1989:

As described elsewhere in this plan, the MHD is an integral part of the Department of Human Services. The Assistant Commissioner for Mental Health works closely with the Assistant Commissioners for state institutions, Medical Assistance, income maintenance and social services. This close cooperation has resulted in significant mental health funding from a number of DHS funding sources.

Table 4 projects DHS funding for mental health services for calendar year 1989. The total for 1989 is 31% higher than the comparable total for 1987.

The largest percentage increases are budgeted for case management and community support programs (CSP) for persons with serious and persistent mental illness. State support for these two services (including federal share of Medical Assistance) is expected to increase 84% from 1987 to 1989. However, DHS recognizes that further improvement is still needed in CSPs to meet client needs and the standards established in the 1987 Mental Health Act. Accordingly, DHS has prepared a budget request for the 1989 Legislature to increase state funds for CSPs from the current minimum of $25,000 per county or $1.00 per capita (whichever is greater) to $50,000 per county or $1.80 per capita.

However, the largest dollar increase -- $17 million from 1987 to 1989 -- is budgeted for regional treatment center (RTC) (formerly state hospital) inpatient services. The percentage increase projected for RTCs from 1987 to 1989 is 36%, much less than the 84% for case management and CSPs. But the total 1987 state budget for case management and CSPs was only $9.7 million, compared to $48 million for the RTCs. The budget for community services is beginning to catch up to the RTC budget, but it is a long and difficult process. A major reason for the current increase in RTC costs is a 1987 HCFA audit which required the state to hire 175 more positions to meet federal standards for inpatient care.

These major budgetary changes are allowing at least 200 more persons with serious and persistent mental illness to be

served in the community in 1989 than in 1987. But this is not reducing the need for RTC beds because the total demand for services is also rising. The average daily population of persons with mental illness in the RTCs has been relatively stable for the last five years and is expected to continue at about the same level for the next three years.

Table 5 provides a funding flow chart for DHS funding for mental health services. Table 6 provides the same information in specific dollar terms. Under the 1987 Mental Health Act, the county is the local mental health authority which is responsible for provision of a comprehensive array of mental health services. Therefore, most funds flow through the counties. However, due to federal requirements, Medical Assistance is paid directly to providers. Medical Assistance will begin paying January 1, 1989 for statewide case management services for persons with mental illness; the case management payments will go only to county designated providers.

As required by the Comprehensive Mental Health Act, the Mental Health Division has closely supervised the counties in the implementation of the Mental Health Act. Most of the fiscal data in this section of the state plan is based on the approved county mental health plans for 1989. The Mental Health Division reviewed each plan in detail, developed comparative analyses of the adequacy of each county's budget for each mandated service, and required changes as needed to assure availability of services. However, even without the specific intervention of state staff, most counties chose to budget much more in local funds in 1989 than in 1987.

The Comprehensive Mental Health Act included a maintenance of effort requirement, based on counties' 1987 planned spending for mental health from county taxes and discretionary state and federal social service block grants. In their county plans for 1989, counties statewide budgeted $73,000,000 in local (CSSA) funds for mental health, compared to $57,000,000 in 1987.

TABLE 4

Estimated DHS Funding for Mental Health Services - Calendar 1989

Service - Funding Source	STATE	COUNTY	FEDERAL	OTHER	TOTAL	PERCENT
Education and prevention - CSSA	124,481	542,228	107,742	0	774,450	.3%
Emergency services - CSSA	404,432	1,761,669	350,047	0	2,516,148	1.0%
Outpatient services						
CSSA	3,169,455	13,805,878	2,743,254	0	19,718,587	7.9%
Medical Assistance	7,266,980	807,442	9,215,561	0	17,289,984	7.0%
Gen. Assist. Med. Care	2,148,913	238,768	0	0	2,387,681	1.0%
Sub-total	12,585,348	14,852,088	11,958,815	0	39,396,251	15.9%
Case Management						
Rule 14	800,000	0	0	0	800,000	.3%
CSSA	351,044	1,529,118	303,838	0	2,184,000	.9%
Medical Assistance	2,026,687	225,187	2,570,126	0	4,822,000	1.9%
Sub-total	3,177,731	1,754,305	2,873,964	0	7,806,000	3.1%
Community Support Services, including Day Treatment						
Rule 14	6,200,000	0	0	0	6,200,000	2.5%
CSSA	1,009,745	4,398,362	873,963	0	6,282,070	2.5%
Gen. Assist. Med. Care	513,334	57,037	0	0	570,371	.2%
Medical Assistance	840,600	93,400	1,066,000	0	2,000,000	.8%
Sub-total	8,563,679	4,548,800	1,939,963	0	15,052,441	6.1%
Residential Treatment						
Rule 12/36	10,844,000	0	0	800,000	11,644,000	4.7%
Rule 36 - CSSA	417,909	1,820,378	361,712	0	2,600,000	1.0%
Rule 36 - Gen. Assist.	2,625,000	875,000	0	0	3,500,000	1.4%
Rule 36 - Minn. Supp. Aid	5,525,000	975,000	0	0	6,500,000	2.6%
Rule 36 - Supp. Sec. Inc.	0	0	4,300,000	0	4,300,000	1.7%
Rule 5 - CSSA - IVE	3,211,101	12,987,282	3,779,299	0	19,977,681	8.1%
Sub-total	22,623,010	16,657,660	8,441,011	800,000	48,521,681	19.6%
Acute Care Hospital						
CSSA	512,290	2,231,490	443,401	0	3,187,181	1.3%
Medical Assistance	12,593,788	1,399,310	15,970,709	0	29,963,807	12.1%
Gen. Assist. Med. Care	7,987,674	887,519	0	0	8,875,193	3.6%
Sub-total	21,093,752	4,518,319	16,414,110	0	42,026,181	16.9%
Regional Treatment Center						
RTC State $ - Co. Match	48,821,973	8,562,709	0	0	57,384,682	23.1%
Medical Assistance	5,832,152	648,017	7,395,996	0	13,876,165	5.6%
Other	0	0	3,171,001	5,885,883	9,056,884	3.7%
Sub-total	54,654,126	9,210,726	10,566,997	5,885,883	80,317,732	32.4%
Pre-petition and Other Screening						
CSSA	952,413	4,148,631	824,341	0	5,925,385	2.4%
Medical Assistance	0	0	0	0	0	.0%
Sub-total	952,413	4,148,631	824,341	0	5,925,385	2.4%

TABLE 4 (Continued)

Estimated DHS Funding for Mental Health Services - Calendar 1989

Service - Funding Source	STATE	COUNTY	FEDERAL	OTHER	TOTAL	PERCENT
Special Projects						
Indian MH services	0	0	387,000	0	387,000	.2%
Homeless services - R14/Fed.	300,000	0	400,000	0	700,000	.3%
Housing support pilots	540,000	60,000	0	0	600,000	.2%
Public education	350,000	0	0	0	350,000	.1%
Training projects	330,000	0	0	0	330,000	.1%
Children's demos	0	66,667	600,000	0	666,667	.3%
Elderly demos	0	33,333	300,000	0	333,333	.1%
Other	0	0	80,000	0	80,000	.0%
Sub-total	1,520,000	160,000	1,767,000	0	3,447,000	1.4%
Other MH services - CSSA	202,443	881,823	175,220	0	1,259,485	.5%
State Administration	600,000	0	390,000	0	990,000	.4%
Total DHS Funding	126,501,413	59,036,248	55,809,210	6,685,883	248,032,755	100.0%
Percent	51.0%	23.8%	22.5%	2.7%	100.0%	

Notes for Funding table - include in accompanying text

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.

The above table does not include Income Maintenance payments for living expenses of persons with mental illness who are not residents of Rule 36 facilities.

The above table does not include nursing home services.

TABLE 5

CURRENT STATE MENTAL HEALTH FUNDING

7/88

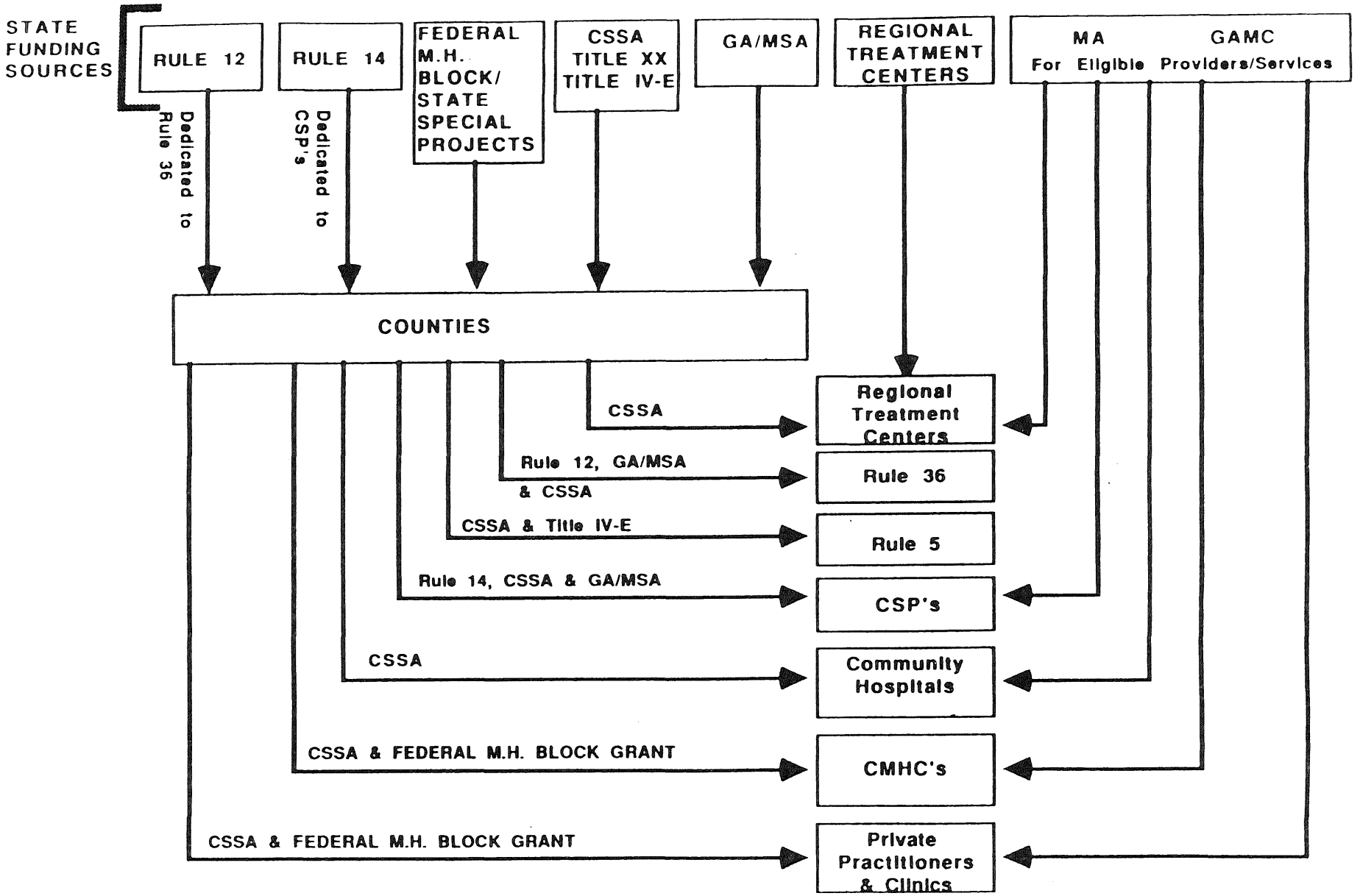


TABLE 6

Estimated DHS Funding for Mental Health Services - Calendar 1989

Service - Funding Source	Rule 12 State $	Rule 14 State $	Fed. Block Grant/State Spec. Proj.	State CSSA County Tax Title XX/IV-E	GA/MSA Neg. Rates	RTC State $	Medical Assistance	GAMC	Other	Total	Percent
Education and prevention	0	0	0	774,450	0	0	0	0	0	774,450	.3%
Emergency services	0	0	0	2,516,148	0	0	0	0	0	2,516,148	1.0%
Outpatient services	0	0	0	19,718,587	0	0	17,289,984	2,387,681	0	39,396,251	15.9%
Case Management	0	800,000	0	2,184,000	0	0	4,822,000	0	0	7,806,000	3.1%
Community Support Services, including Day Treatment	0	6,200,000	0	6,282,070	0	0	2,000,000	570,371	0	15,052,441	6.1%
Residential Treatment - R36	10,844,000	0	0	2,600,000	10,000,000	0	0	0	5,100,000	28,544,000	11.5%
Residential Treatment - R5	0	0	0	19,977,681	0	0	0	0	0	19,977,681	8.1%
Acute Care Hospital	0	0	0	3,187,181	0	0	29,963,807	8,875,193	0	42,026,181	16.9%
Regional Treatment Center	0	0	0	8,562,709	0	48,821,973	13,876,165	0	9,056,884	80,317,732	32.4%
Pre-petition and Other Screening	0	0	0	5,925,385	0	0	0	0	0	5,925,385	2.4%
Special Projects	50,000	643,000	2,594,000	160,000	0	0	0	0	0	3,447,000	1.4%
Other MH services	0	0	0	1,259,485	0	0	0	0	0	1,259,485	.5%
State Administration	0	0	390,000	0	0	0	0	0	600,000	990,000	.4%
Total DHS Funding	10,894,000	7,643,000	2,984,000	73,147,696	10,000,000	48,821,973	67,951,956	11,833,245	14,756,884	248,032,755	100.0%
Percent	4.4%	3.1%	1.2%	29.5%	4.0%	19.7%	27.4%	4.8%	5.9%	100.0%	

12/13/88

The following is a brief description of the major DHS funding sources for mental health services.

State Rule 12 monies ($10,844,000 for FY 1989) fund treatment and programs at Rule 36 community residential facilities for adults. Counties must provide a minimum 25 percent match, but the match can come from non-county sources.

State Rule 14 monies ($7,200,000 for FY 1989) fund community support services for adults with serious and persistent mental illness, other than residential or medical services. Counties provide a minimum ten percent match, but the match can come from non-county sources.

Funding for community support programs also comes from client fees, third party reimbursement, Community Social Service Act (CSSA) funds and from the Department of Jobs and Training for vocational services.

Federal Mental Health Block Grant funds to Minnesota ($1.5 million in FY 1989) are targeted to underserved populations, including American Indians, children, and the elderly.

National Institute of Mental Health Demonstration Grants amount to less than $1 million annually, including special projects for rural mental health, refugee mental health and CSPs for the elderly.

CSSA funds combine Federal Title XX block grant monies ($45 million annually), state CSSA monies ($50 million annually) and county tax dollars ($200 million annually). An average of twenty percent of CSSA funds per county goes toward mental health services, approximately $70 million in 1989. CSSA funds are the most flexible funding component available to counties and are used to supplement both Rule 12 and Rule 14 monies. CSSA funds are the primary funding source for children's residential treatment (Rule 5).

Case managers and CSPs funded by DHS are legally mandated to assist persons with serious and persistent mental illness to obtain all public assistance or other public benefits to which they are legally entitled.

Supplemental Security Income (SSI) and General Assistance (GA) dollars finance meager living expenses for many persons with mental illness. SSI is supplemented by Minnesota Supplemental Aid (MSA) payments to Rule 36 facilities for residents' care. Social Security Disability Insurance (SSDI) provides income maintenance for those persons with mental illness who worked a minimum period before becoming disabled.

Recent information regarding total statewide SSI and SSDI payments has been very difficult to obtain. Despite inquiries to a number of federal offices, the most recent

data available is for 1982. The National Association of State Mental Health Program Directors (NASMHPD) obtained special computer analyses of Social Security Administration payments by state. Their data indicated that SSI paid $24,525,000 for persons with mental illness in Minnesota in 1982; and that SSDI paid $40,309,000. DHS compared this data to comparable data for Wisconsin and determined that Minnesota should be able to qualify for 40% more SSI funding and 14% more SSDI. Subsequently, Minnesota conducted, and continues to conduct, major efforts to assist clients in applying for the benefits to which they are legally entitled. Newer data should indicate significantly higher amounts of funding from SSI and SSDI for Minnesota residents.

Regional treatment centers (RTCs -- formerly state hospitals) are funded separately from community services. Approximately $55 million (net cost) is expected to be appropriated by the state for mentally ill patients in 1989.

Medical Assistance (MA) covers outpatient and day treatment programs, inpatient services in community hospitals, and will cover case management for persons with serious and persistent mental illness. State General Assistance Medical Care (GAMC) pays for inpatient, outpatient and day treatment services. In FY 1987, GAMC and MA spent about $59,000,000 on mental health services for approximately 45,000 individual patients with a diagnosis of mental illness.

C. DHS Funding for 1990 and 1991

Projections for 1990 and 1991 will depend on actions taken by the 1989 Legislature in response to the unmet needs and three-year goals and objectives described earlier in this state plan. A copy of the detailed DHS budget proposal to the Legislature for 1990 and 1991 is available from:

John Zakelj, Supervisor
Technical Support Unit
Mental Health Division
Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155-3828
(612) 296-4426

During the coming year, the MHD also plans to work with the DHS MA staff to explore the feasibility of funding more CSP type services for both children and adults under MA.

D. DHS Funding for Children Vs. Adults

During the past ten years, DHS has focused most new mental health funds on services to adults with serious and persistent mental illness. Table 7 projects 1989 DHS expenditures by children vs. adults. On average, 20% of DHS

mental health expenditures are projected to be for children. This compares to census data indicating that children are 26% of the state's population. As indicated earlier in this plan, DHS will present a major initiative to the 1989 Legislature for children's mental health. The most significant increase proposed is an expansion of MA coverage to pay for a statewide program of intensive home based mental health services for children with serious emotional disturbance. When fully operational in 1991, MA will pay over $7,000,000 per year for this new service.

E. Fiscal Incentives for Community Placement

The complexity of Minnesota's funding system for mental health services, and particularly the division between institutional vs. community funding, raises a legitimate issue as to whether the funding system provides fiscal incentives for institutional vs. community placement. Despite efforts by DHS, the Governor and others to integrate and simplify the funding system, the Legislature has chosen to maintain funding which is targeted to particular types of services, particular client groups and even particular agencies. This complexity is also partially due to congressional decisions at the federal level.

The 1987 Mental Health Act places counties in a central role with the client in making placement decisions for persons with serious and persistent mental illness. Three major fiscal factors affect these decisions: county share in percentage terms, county share in absolute dollar terms, and availability of alternative placements.

As described below, F.Y. 1987 data indicates that there was a legitimate concern that the funding system had a strong built in incentive for counties to place persons with serious mental illness in the state RTCs and not in the community. However, the changes described below represent major steps to occur by 1990 which will significantly alter the fiscal disparity between community vs. institutional placements. For persons who are eligible for MA or GAMC, the funding system in 1990 will actually be in favor of a community placement.

What about persons who are not eligible for MA or GAMC? F.Y. 1986 statistics indicate that 23% of Rule 36 residents and 38% of Rule 14/CSP clients were not eligible for MA or GAMC. This represents up to 2,000 persons with serious and persistent mental illness who have low paying jobs or who recently had jobs and still have assets exceeding MA/GAMC criteria. The DHS budget proposal to increase Rule 14 funds in 1990 should assure adequate CSP and case management services for this group, with a county match of only 10%. There will be other non-Rule 14 services needed, such as outpatient mental health services, where CSSA funding will be

TABLE 7

Estimated DHS Funding for Mental Health Services - Calendar 1989

Service - Funding Source	CHILDREN	ADULTS	TOTAL
Education and prevention - CSSA	115,545	658,905	774,450
Emergency services - CSSA	375,401	2,140,747	2,516,148
Outpatient services			
CSSA	4,124,022	15,594,565	19,718,587
Medical Assistance	5,039,988	12,249,996	17,289,984
Gen. Assist. Med. Care	0	2,387,681	2,387,681
Sub-total	9,164,010	30,232,242	39,396,251
Case Management			
Rule 14	0	800,000	800,000
CSSA	456,770	1,727,230	2,184,000
Medical Assistance	1,523,017	3,298,983	4,822,000
Sub-total	1,979,787	5,826,213	7,806,000
Community Support Services, including			
Rule 14	0	6,200,000	6,200,000
CSSA	3,141,035	3,141,035	6,282,070
Gen. Assist. Med. Care	0	570,371	570,371
Medical Assistance	582,995	1,417,005	2,000,000
Sub-total	3,724,030	11,328,411	15,052,441
Residential Treatment			
Rule 12/36	0	11,644,000	11,644,000
Rule 36 - CSSA	0	2,600,000	2,600,000
Rule 36 - Gen. Assist.	0	3,500,000	3,500,000
Rule 36 - Minn. Supp. Aid	0	6,500,000	6,500,000
Rule 36 - Supp. Sec. Inc.	0	4,300,000	4,300,000
Rule 5 - CSSA - IVE	19,977,681	0	19,977,681
Sub-total	19,977,681	28,544,000	48,521,681
Acute Care Hospital			
CSSA	666,579	2,520,602	3,187,181
Medical Assistance	9,463,994	20,499,813	29,963,807
Gen. Assist. Med. Care	0	8,875,193	8,875,193
Sub-total	10,130,573	31,895,608	42,026,181
Regional Treatment Center			
RTC State $ - Co. Match	0	0	0
Medical Assistance	0	0	0
Other	0	0	0
Sub-total	3,236,303	77,081,429	80,317,732
Pre-petition and Other Screening			
CSSA	66,386	5,858,999	5,925,385
Medical Assistance	0	0	0
Sub-total	66,386	5,858,999	5,925,385

TABLE 7 (Continued)

Estimated DHS Funding for Mental Health Services - Calendar 1989

Service - Funding Source	CHILDREN	ADULTS	TOTAL
Special Projects			
Indian MH services	0	387,000	387,000
Homeless services - R14/Fed.	0	700,000	700,000
Housing support pilots	0	600,000	600,000
Public education	52,219	297,781	350,000
Training projects	0	330,000	330,000
Children's demos	666,667	0	666,667
Elderly demos	0	333,333	333,333
Other	0	80,000	80,000
Sub-total	718,885	2,728,115	3,447,000
Other MH services - CSSA	137,652	1,121,833	1,259,485
State Administration	99,000	891,000	990,000
Total DHS Funding	49,725,254	198,307,500	248,032,755
Percent	20.0%	80.0%	100.0%

needed, with a high county share. Since the actual cost of these services is so much less than the cost of institutionalization, it is doubtful that this factor will be sufficiently significant to influence counties to place non-MA/GAMC clients in the RTCs instead of the community.

F. County Share in Percentage Terms

Tables 8 and 9 describe local minimum match requirements for the major mental health funding programs in Minnesota. Table 8 was prepared in relation to F.Y. 1987 data, but is still essentially accurate for 1988. However, as described below and on Table 9, major changes are expected in 1989 and 1990 as a result of changes approved by the 1987 and 1988 Legislative Sessions.

As both tables indicate, there is considerable variation in minimum local match requirements for the different programs. The highest county match is for programs funded under CSSA: even with the inclusion of federal Title XX and Title IV-E, the average will be about 72% for county share of CSSA in 1990 (Table 9).

A significant service which has been funded mostly under CSSA is case management. The 1987 Legislature added a large amount of new state and federal dollars by adding coverage for case management under Medical Assistance (MA), effective January 1, 1989. The 1987 Legislature also expanded coverage for outpatient and day treatment services under General Assistance Medical Care (GAMC), effective July 1, 1988.

The 1988 Legislature approved the state takeover of income maintenance programs, effective January 1, 1990. This will totally eliminate the county share for MA, GAMC, GA and MSA (General Assistance and Minnesota Supplemental Aid pay for the room and board share of Rule 36 treatment.)

G. County Share in Dollar Terms

Table 10 provides an estimate of the actual total per day cost for placements in a community hospital acute psychiatric unit, an RTC inpatient unit, a community Rule 36, and an independent setting. As expected, the total cost for community or state operated inpatient placements is significantly higher than for noninpatient settings. But do the varying percentages in the funding system affect the county perception of cost of service? Tables 11, 12 and 13 attempt to answer this question by analyzing actual county costs for clients with different types of funding eligibility.

Some clients have acute or severe needs which simply cannot be adequately served in noninpatient settings. The reason for Tables 10-13 is not to evaluate the cost effectiveness

Table 8

FY 87

MI Funding - Local Match Requirements

Funding Source	Legal Minimum	Estimated Percentages for FY 87			
		County Tax	State	Federal	Other
Supplemental Security Income	Federal pays 100% of federally established income maintenance standard for severely disabled persons. This funding source pays for 23% of all Rule 36 room and board costs.	--	--	100%	--
Medical Assistance	County pays 5% for eligible persons for certain services, e.g.: 1. hospitalization in community hospital 2. mental health center therapy 3. day treatment	5%	43%	52%	--
Regional Treatment Centers	County pays 10% unless other funding is available	8%	70%	10%	12%
General Assistance Medical Care (GAMC)	County pays 10% for GAMC eligible persons for certain services (similar to MA service list).	10%	90%	--	--
Minnesota Supplemental Aid	County pays 15% of MSA grant, which is a supplement to the SSI grant for eligible persons. MSA pays for 38% of all Rule 36 room and board costs.	15%	85%	--	--
Rule 14	State pays up to 90% of approved costs for community support services for adults with serious and persistent mental illness; county may use many sources for the other 10%	20%	78%	6%	4%
Rule 12	State pays 75% of approved Rule 36 program costs; county may use many sources for the other 25%	22%	75%	3%	--
General Assistance	County pays 25% for eligible persons. this funding source pays for 27% of all Rule 36 room and board costs.	25%	75%	--	--
CSSA	County must levy amount equal to state grant. These funds can used for any social service.	66%	18%	16%	--

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October 5, 1988

Table 9

C.Y 90

MI Funding - Local Match Requirements

Funding Source	Legal Minimum	Estimated Percentages for CY 90			
		County Tax	State	Federal	Other
Supplemental Security Income	Federal pays 100% of federally established income maintenance standard for severely disabled persons. This funding source pays for 23% of all Rule 36 room and board costs.	--	--	100%	--
Medical Assistance	County pays 0% for eligible persons for certain services, e.g.: 1. hospitalization in community hospital 2. mental health center therapy 3. day treatment 4. case management	0%	48%	52%	--
Regional Treatment Centers	County pays 10% unless other funding is available	8%	70%	10%	12%
General Assistance Medical Care (GAMC)	County pays 0% for GAMC eligible persons for certain services (similar to MA service list).	0%	100%	--	--
Minnesota Supplemental Aid	County pays 0% of MSA grant, which is a supplement to the SSI grant for eligible persons. MSA pays for 38% of all Rule 36 room and board costs.	0%	100%	--	--
Rule 14	State pays up to 90% of approved costs for community support services for adults with serious and persistent mental illness; county may use many sources for the other 10%	20%	70%	6%	4%
Rule 12	State pays 75% of approved Rule 36 program costs; county may use many sources for the other 25%	22%	75%	3%	--
General Assistance	County pays 0% for eligible persons. This funding source pays for 27% of all Rule 36 room and board costs.	0%	100%	--	--
CSSA	County must levy amount equal to state grant. These funds can used for any social service.	72%	15%	13%	--

JZ10-10:mw

October 10, 1988

of different settings but to address the concern that the funding system may encourage counties to make unnecessary use of inpatient programs. The charts indicate that there may be cause for concern for the almost complete lack of county cost in 1990 for MA/GAMC placements in community hospitals. However, in relation to RTC placements, the tables indicate that by 1990, current laws will eliminate any fiscal incentives for RTC placements vs. community residential or independent living.

H. Availability of Services

In 1985, Rule 14 funding for community support services (CSP) for persons with serious and persistent mental illness was limited to 45 counties. Even though the legal county share for Rule 14 is only 10%, many counties received no Rule 14 funds. Therefore, most CSP services were either non-existent or dependent on CSSA funding. The 1987 Legislature provided a major increase in Rule 14 funding to enable all 87 counties to receive at least $25,000 per county or one dollar per county population, whichever is larger. The first full year for the increased Rule 14 funding is F.Y. 1989.

During F.Y. 1989, the MHD is also initiating $500,000 worth of pilot projects for supportive housing services. This is a component of CSP services which has been particularly lacking and holds promise as an effective alternative to institutionalization.

The increase in Rule 14 funding and the increase in Medical Assistance funding for case management, together with the statutory maintenance of effort requirement, will have the effect of increasing the availability of community mental health services overall and the shifting of some CSSA funds from case management to outpatient and other required mental health services.

I. Recommendation Regarding Fiscal Incentives Issue

If Rule 14 community support appropriations can be increased to the level requested in the DHS budget proposal and if MA/GAMC utilization review procedures for community inpatient services continue to be strictly enforced, further legislative action relating to the fiscal incentives issue does not appear to be necessary.

TABLE 10

1987 TOTAL COST PER CLIENT PER DAY
(AGE 18 - 64)

	ACUTE CARE INP	RTC	RULE 36	INDEPENDENT
COMMUNITY HOSPITALS	410.86	.00	.00	.00
RTC	.00	126.55	.00	.00
CASE MANAGEMENT	3.29	3.29	3.29	3.29
LIVING ALLOWANCE	1.32	1.32	1.32	11.00
RULE 36 R&B	.00	.00	21.71	.00
RULE 36 PROGRAM	.00	.00	24.07	.00
DAY TREATMENT	.00	.00	10.45	10.45
OTHER CSP	.00	.00	4.75	4.75
OUTPATIENT MH	.00	.00	1.50	1.50
NON-MH MEDICAL SERVICES	.00	.00	3.90	3.90
TOTAL	415.47	131.16	70.99	34.89

ESTIMATED 1990 TOTAL COST
PER CLIENT PER DAY
(AGE 18 - 64)

	ACUTE CARE INPT	RTC	RULE 36	INDEPENDENT
COMMUNITY HOSPITALS	452.97	.00	.00	.00
RTC	.00	176.00	.00	.00
CASE MANAGEMENT	3.83	3.83	3.83	3.83
LIVING ALLOWANCE	1.31	1.31	1.31	11.66
RULE 36 R&B	.00	.00	23.61	.00
RULE 36 PROGRAM	.00	.00	32.18	.00
DAY TREATMENT	.00	.00	11.55	11.55
OTHER CSP	.00	.00	5.25	5.25
OUTPATIENT MH	.00	.00	1.75	1.75
NON-MH MEDICAL SERVICES	.00	.00	4.32	4.32
TOTAL	458.11	181.14	83.80	38.36

The above costs are established averages and will vary from client to client depending on the specific facilites/services utilized.

12/29/88

TABLE 11

1987 PER CLIENT PER DAY COUNTY SHARE
CLIENTS ON MA/SSI/MSA

	ACUTE CARE INPT	RTC	RULE 36	INDEPENDENT	FUNDING SOURCE
COMMUNITY HOSPITALS	18.90	.00	.00	.00	MA
RTC	.00	12.66	.00	.00	RTC
CASE MANAGEMENT	2.17	2.17	2.17	2.17	CSSA
LIVING ALLOWANCE	.00	.00	.00	.00	SSI
RULE 36 R&B	.00	.00	1.53	.00	SSI/MSA
RULE 36 PROGRAM	.00	.00	6.02	.00	R12/CSSA
DAY TREATMENT	.00	.00	.48	.48	MA
OTHER CSP	.00	.00	.95	.95	R14/CSSA
OUTPATIENT MH	.00	.00	.07	.07	MA
NON-MH MEDICAL SERVICES	.00	.00	.18	.18	MA
TOTAL	21.07	14.83	11.40	3.85	

ESTIMATED 1990 PER CLIENT PER DAY
COUNTY SHARE CLIENTS ON MA/SSI/MSA

	ACUTE CARE INPT	RTC	RULE 36	INDEPENDENT	STATE FUNDING SOURCE
COMMUNITY HOSPITALS	.00	.00	.00	.00	MA
RTC	.00	17.60	.00	.00	RTC
CASE MANAGEMENT	.00	.00	.00	.00	MA
LIVING ALLOWANCE	.00	.00	.00	.00	SSI
RULE 36 R&B	.00	.00	.00	.00	SSI/MSA
RULE 36 PROGRAM	.00	.00	8.05	.00	R12/CSSA
DAY TREATMENT	.00	.00	.00	.00	MA
OTHER CSP	.00	.00	1.00	1.00	R14/CSSA
OUTPATIENT MH	.00	.00	.00	.00	MA
NON-MH MEDICAL SERVICES	.00	.00	.00	.00	MA
TOTAL	.00	17.60	9.05	1.00	

The above costs are established averages and will vary from client to client depending on the specific facilites/services utilized.

12/29/88

TABLE 12

1987 PER CLIENT PER DAY COUNTY SHARE
CLIENTS ON GA/GAMC

	ACUTE CARE INPT	RTC	RULE 36	INDEPENDENT	FUNDING SOURCE
COMMUNITY HOSPITALS	41.09	.00	.00	.00	GAMC
RTC	.00	12.66	.00	.00	RTC
CASE MANAGEMENT	2.17	2.17	2.17	2.17	CSSA
LIVING ALLOWANCE	.33	.33	.33	2.75	GA
RULE 36 R&B	.00	.00	5.43	.00	GA
RULE 36 PROGRAM	.00	.00	6.02	.00	R12/CSSA/GA
DAY TREATMENT	.00	.00	1.05	1.05	R14/CSSA
OTHER CSP	.00	.00	.95	.95	R14/CSSA
OUTPATIENT MH	.00	.00	.99	.99	CSSA
NON-MH MEDICAL SERVICES	.00	.00	.39	.39	GAMC
TOTAL	43.59	15.16	17.32	8.30	

ESTIMATED 1990 PER CLIENT PER DAY
COUNTY SHARE CLIENTS ON GA/GAMC

	ACUTE CARE INPT	RTC	RULE 36	INDEPENDENT	STATE FUNDING SOURCE
COMMUNITY HOSPITALS	.00	.00	.00	.00	GAMC
RTC	.00	17.60	.00	.00	RTC
CASE MANAGEMENT	2.76	2.76	2.76	2.76	CSSA
LIVING ALLOWANCE	.00	.00	.00	.00	GA
RULE 36 R&B	.00	.00	.00	.00	GA
RULE 36 PROGRAM	.00	.00	8.05	.00	R12/CSSA
DAY TREATMENT	.00	.00	.00	.00	GAMC
OTHER CSP	.00	.00	1.00	1.00	R14/CSSA
OUTPATIENT MH	.00	.00	.00	.00	GAMC
NON-MH MEDICAL SERVICES	.00	.00	.00	.00	GAMC
TOTAL	2.76	20.36	11.80	3.76	

The above costs are established averages and will vary from client to client depending on the specific facilites/services utilized.

12/29/88

TABLE 13

1987 TOTAL COUNTY SHARE
FOR THE "WORKING POOR"
INDIVIDUALS NOT ON PUBLIC ASSISTANCE

	ACUTE CARE INPT	RTC	RULE 36	INDEPENDENT	FUNDING SOURCE
COMMUNITY HOSPITALS	VARIED	.00	.00	.00	VARIED
RTC	.00	12.66	.00	.00	RTC
CASE MANAGEMENT	2.17	2.17	2.17	2.17	CSSA
LIVING ALLOWANCE	.00	.00	.00	.00	CLIENT
RULE 36 R&B	.00	.00	.00	.00	CLIENT
RULE 36 PROGRAM	.00	.00	6.02	.00	R12/CSSA
DAY TREATMENT	.00	.00	2.09	2.09	R14/CSSA
OTHER CSP	.00	.00	.95	.95	R14/CSSA
OUTPATIENT MH	.00	.00	.99	.99	CSSA
NON-MH MEDICAL SERVICES	.00	.00	.00	.00	CLIENT
TOTAL	VARIED	14.83	12.22	6.20	

PROJECTED 1990 TOTAL COUNTY SHARE
FOR THE "WORKING POOR"
INDIVIDUALS NOT ON PUBLIC ASSISTANCE

	ACUTE CARE INPT	RTC	RULE 36	INDEPENDENT	STATE FUNDING SOURCE
COMMUNITY HOSPITALS	VARIED	.00	.00	.00	VARIED
RTC	.00	17.60	.00	.00	RTC
CASE MANAGEMENT	2.76	2.76	2.76	2.76	CSSA
LIVING ALLOWANCE	.00	.00	.00	.00	CLIENT
RULE 36 R&B	.00	.00	.00	.00	CLIENT
RULE 36 PROGRAM	.00	.00	8.05	.00	R12/CSSA
DAY TREATMENT	.00	.00	2.31	2.31	R14/CSSA
OTHER CSP	.00	.00	1.05	1.05	R14/CSSA
OUTPATIENT MH	.00	.00	1.26	1.26	CSSA
NON-MH MEDICAL SERVICES	.00	.00	.00	.00	CLIENT
TOTAL	VARIED	20.36	15.43	7.38	

The above costs are established averages and will vary from client to client depending on the specific facilites/services utilized.

12/29/88

J. Non-DHS Funds for Mental Health Services

Section B described DHS efforts to assist clients in obtaining SSI and SSDI. In addition, DHS works at the local, state and federal levels to ensure funding for mental health services from other sources. However, data regarding non-DHS funds for mental health services has been difficult to obtain and, when available, the data is often not comparable to other data. A very rough estimate is that non-DHS funds for mental health services (including insurance and private pay) may, on a statewide basis, be as much as the $248,000,000 projected for 1989 for DHS funding.

Minnesota has mandated mental health outpatient and inpatient insurance benefits since 1975. In 1989, it is estimated that insurance and health maintenance organizations will pay $54 million for mental health inpatient and approximately $18 million for outpatient services. These estimates are based on limited data obtained in 1984, adjusted for inflation.

In 1987 the MHD introduced legislation to improve insurance coverage by mandating that private health insurers and HMOs increase the number of outpatient visits to be covered from 10 to 40 if the final 30 were approved prior to commencement of treatment. However, since the passage of that legislation, experience has shown that some private payers continue to deny coverage for more than 10 outpatient visits, essentially disagreeing with the provider's diagnosis or recommended treatment plan. As discussed in the section on identified needs, legislation may be introduced in 1989 to more clearly articulate those treatment circumstances in which coverage for additional services may not be denied.

Veterans Administration hospitals in Minnesota spent $12 million in federal funds on inpatient and $6.4 million on outpatient mental health services for veterans with mental illness in 1987.

The Minnesota Department of Jobs and Training (DJT), Division of Rehabilitation Services, paid about $6.6 million in state and federal funds in 1987 for vocational services for persons with mental illness.

The Minnesota Department of Education reports that school districts spent about $36,000,000 in state, federal and local funds in 1987 for special services for emotionally disturbed children.

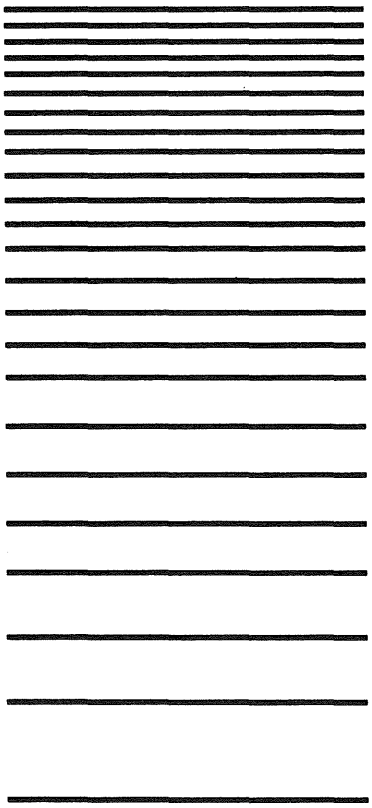
No specific data is available from the Department of Housing and Urban Development (HUD) or from local housing agencies, but DHS does work with housing agencies at all levels. The MHD will hire a full-time mental health housing specialist in 1989 to improve coordination with housing agencies and facilitate more and better housing for persons with serious and persistent mental illness.

The MHD has also worked closely with private funding sources. Since 1981, the McKnight Foundation has contributed almost $8.5 million for mental health programs in Minnesota.

The McKnight mental health program provided a major impetus for the initiation of community support programs and other services for persons with serious and persistent mental illness throughout Minnesota. Additional significant support has come from United Way organizations. In 1988, the United Way of Minneapolis alone allocated over $700,000 for programs serving persons with serious and persistent mental illness.

XIII.

Human Resource Development



XIII. HUMAN RESOURCE DEVELOPMENT ISSUES

Efforts are just getting underway within the MHD to address the human resource development (HRD) needs of Minnesota's mental health system. While information on the number of professionals practicing in the state is available, little information as yet exists regarding a variety of equally important issues, such as:

- the geographic (rural and urban) and programmatic distribution of professionals;
- the number of professionals "needed" in the state;
- the current and projected capacity of state educational institutions to educate and train mental health professionals;
- the quality of both education received and services rendered;
- income and professional esteem issues.

The Education, Prevention, and Research Committee of the State Advisory Council on Mental Health has undertaken a series of hearings of the four core mental health professions (psychiatry, psychology, social work, and nursing) to gain their input on HRD issues. The MHD will build on the information received at these hearings to plan for submission of a HRD capacity building grant proposal to NIMH. Pending the awarding of the grant, the following activities would then be undertaken:

The MHD will prepare and submit to NIMH a proposal for a two year capacity building grant, at the completion of which time the following must be accomplished:

1. Design and establishment of structures, processes and supportive resources essential to identifying state mental health resource development priorities; including designation of a mechanism and staff to perform and take responsibility for agency HRD responsibilities.

2. Systematic assessment of essential mental health human resource development needs, including development of a design and commitment and the implementation of the minimum manpower data set which interfaces systematically with the organizational and client data sets.

3. Development of appropriate planning linkages with relevant mental health service agencies, other related agencies, and institutions of higher learning.

4. Development of a separate and distinct state human resource development plan and inclusion of that plan into the state mental health service plan.

XIV.

Public Participation in the Development of the Plan

XIV. PUBLIC PARTICIPATION IN THE DEVELOPMENT OF THE PLAN

As stated in the opening chapter of the Plan, the State Advisory Council on Mental Health is the designated mental health planning council for the State of Minnesota. The Council was formed in September 1987 with the charge of advising the Governor, Legislature, and state agencies about mental health policies and programs within the state. In the fifteen months since its formation, the Council has reviewed a number of issues and presented its recommendations to the appropriate bodies.

Though the Council has been active, it has reviewed the issues contained in the Plan separate from a formal planning process. The addition of a staff person for the Council in July 1988 enhanced its capacity to address issues. However, the Plan's comprehensive scope delayed an opportunity for the Council to conduct a review until late November 1988.

Despite the short timeline for review of the Plan (before its January 1989 submission), Council members were provided with opportunities to briefly comment at its December 1988 and January 1989 meetings. Starting in February 1989, the Council will undertake an assessment of a separate chapter of the Plan at each of its monthly meetings. It is hoped that this will provide the opportunity to give the Plan the attention it warrants.

Also in November 1988, over 375 copies of the draft of the Plan were distributed to members of the public, key legislators, local advisory council chairpersons, other state agency heads, advocacy groups, and provider representatives. Over forty comments were received, which were distributed to affected staff persons within the MHD for consideration for revisions to the Plan.

Finally, multiple copies were distributed to the Alliance for the Mentally Ill of Minnesota and the Mental Health Association of Minnesota to enable a more participatory review process by those organizations. A meeting was also held with the Board of Directors of the Mental Health Association to solicit comments. Additional meetings will be requested of both groups and other interested organizations in preparation for the September 1989 submission of a revised Plan.

A copy of the original solicitation of comments letter is attached, along with a recommended review form, as Appendix H.

STATE OF MINNESOTA
Department of Human Services **Interoffice Memo**

March 13, 1989

TO: Acting Assistant Commissioner Tom Malueg
Norma Schleppegrell
Barbara Kaufman
Jerri Sudderth
All Mental Health Division Staff
Members, State Advisory Council on Mental Health
Members, Subcommittee on Children's Mental Health

FROM: Jim Auron (7-4164) JA
P.L. 99-660 Plan Coordinator

RE: Federal Response to Minnesota's Three-Year Plan for Services for Persons with Mental Illness

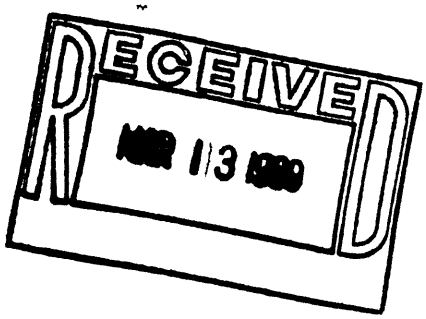
Attached is the response by the National Institute of Mental Health (NIMH) to Minnesota's Three-Year Plan for Services for Persons with Mental Illness. The Plan is required by P.L. 99-660; federal disapproval of Plans submitted after September 30, 1989 could result in reductions to Minnesota's Alcohol, Drug Abuse, and Mental Health Services Block Grant. Minnesota's grant is expected to be approximately $1.2 million in FY 1990.

There are two documents. The first outlines common themes and major issues found to pervade most state's plans. The second provides comments specific to Minnesota's Plan. Recommendations appear on pp. 4-6 of the second document.

I will be in Washington next Monday and Tuesday, March 20 and 21, for a conference on the Plan. Additional detail on the attached comments is to be provided, as is technical assistance for addressing the NIMH recommendations. Strategies for producing the September 30, 1989 submission of the Plan will then need to be devised.

Please contact me with any questions or comments you may have, or with any issues you would like discussed at the conference next Monday and Tuesday.

Summary: Review of P.L. 99-660 State Plan - Minnesota



Contact: Sandra S. Gardebring, Commissioner, Minnesota Department of Human Services

Title: Department of Human Services, Mental Health Division, Three-Year Plan for Services for Persons with Mental Illness

NIMH Review Date: February 17, 1989

Summary of Major Issues: The Minnesota Plan reflects activities, since 1985, at the grass roots, State and local human service agency, and State legislative levels to "create and ensure a unified, accountable, comprehensive system of mental health services." This effort reflects, in various ways, the goals and objectives of P.L. 99-660. Studies undertaken by the Governor's Mental Health Commission, the Legislative Auditor's Office and a national consumer research group identified many problems and gaps in the system which were incorporated into legislation and subsequent statewide hearings. As a result, the State's Commissioner of Human Services was charged with development of a comprehensive service system which required all 87 counties to make an array of services available (most by July 1988); State and local mental health advisory councils were to be created to advise and monitor, each with representation of consumers, families, advocates, etc. A mission statement for children was introduced in the 1988 Legislative Session and will be submitted for the 1989 Legislature.

The P.L. 99-660 Plan is designed to build upon these past accomplishments and reportedly was circulated widely to a variety of individuals and organizations for comment. The document contains a statutory definition of mental illness upon which planning for services is based, current and planned management information systems, and the current and envisioned system of care. Goals and objectives/outcomes are set for different target populations/service systems, with specification of funding mechanism for some services. Several special populations are covered -- the homeless mentally ill, Native Americans, refugees, rural residents, seniors and children and adolescents. Services to protect client

rights, strategies, for inter/intradepartment coordination, funding for services and human resource development are discussed in some detail.

Strengths and Weaknesses: The Plan is considered basically sound and is strengthened by the listing of expected outcomes. The plan for children's services, while not complete in all details, is excellent in that it reflects a strategy for obtaining needed resources to implement the system and has a strong family orientation with involvement of the child and family in the services. The Plan seems strong in inter/intradepartmental coordination. The discussion of service principles reflects a humane, caring tone and the mission statement (pages 10-11) is excellent in the sense that it focuses on desired outcomes. The housing plan is also comprehensive and should provide additional funds for residential treatment and supportive housing. Definitions of the populations seem adequate (in general).

The descriptions of current and ideal system components, however, contains too few details and the priority for serving the long-term mentally ill is not clear. The definition of severely emotionally disturbed children and adolescents for case management purposes (page 53, [c]) seems inappropriate for this population (the definition of SED, pages 53-54, I-IV, seems more appropriate). Also unclear are: how County plans relate to the State Plan; why implementation of screening prior to hospitalization cannot be implemented until 1991; the rationale for the definition of the adult target populations; how a comprehensive plan is to be developed for providing appropriate services to the homeless mentally ill; and other areas included in the recommendations below.

Legislative Provisions: Comments on compliance to P.L. 99-660 in the Minnesota Plan are presented below.

1. The State Plan shall provide for the establishment and implementation of an organized and comprehensive community-based system of care for severely mentally ill individuals.
   Comments: The Plan contains basically sound descriptions of the current and an ideal community-based system of care, although the children's plan needs strengthening and there are too few details on serving the long-term mentally ill. Ways in which County plans relate to the State Plan and Planning Council, as well as involvement of other relevant State agencies, are particularly lacking. A system for tracking populations and services needs to be described.

2. The State Plan shall contain quantitative targets to be achieved in the implementation of such a system, including numbers of severely mentally ill individuals residing in the areas to be served under such

a system.

Comments: Goals and objectives/outcomes are set for different target populations and service systems. Specific details on implementation are lacking and goals/objectives are not related to service gaps.

3. The State Plan shall address how severely mentally ill persons will gain access to treatment, prevention, and rehabilitation services at the community level.

   Comments: The Plan provided too few details on services to help people gain access to services (e.g., client identification, outreach, referral).

4. The State Plan shall address how rehabilitation services, employment services, housing services, medical and dental care, and other support services will be provided to severely mentally ill persons to enable them to function outside of inpatient institutions to the maximum extent of their capabilities.

   Comments: The Plan did not provide a clear description of the involvement of other key agencies in the planning of rehabilitation, housing and Medicaid.

5. The State Plan shall provide for activities to reduce the rate of hospitalization of severely mentally ill individuals.

   Comments: The data provided indicate a significant reduction in hospitalization rates for clients using community services. A tracking system is in place. If current service development continues, it appears the State will continue to reduce hospital utilization rates.

6. Case management services shall be designed for each severely mentally ill individual in the State who receives substantial amounts of public funds or services, and these services will be phased in over the period of fiscal year 1989 through fiscal year 1992.

   Comments: There was little information on the philosophy, approaches and services provided through case management, the functions/roles of case managers, or ways of identifying clients.

7. The State Plan shall provide for the establishment and implementation of a program of outreach to, and services for, severely mentally ill individuals who are homeless.

   Comments: Using McKinney, HUD, and State funds, it appears that the

State is providing appropriate services for the homeless mentally ill population. However, there is no detail on how many are being served and where the gaps are. They do indicate that they will be working with other State agencies to develop a comprehensive plan for serving this population.

8. In developing the State Plan, the State shall consult with representatives of employees of State institutions and public and private nursing homes who care for severely mentally ill individuals. Comments: This was not clearly addressed in the Plan.

Recommendations: A number of recommendations were made for strengthening the Minnesota Plan:

- Clarify how the local County plans relate to the State Plan and to the State Planning Council.
- Provide a clear description on the involvement of other key agencies in the planning process (e.g., housing, vocational rehabilitation, Medicaid).
- Provide a clear description of the process for consulting with representatives of employees of State hospitals and nursing homes.
- Clarify the priority on serving the long-term mentally ill.
- Provide a clearer, more detailed description of the planning for and implementation of components of the envisioned system of care, including:
  - Emergency services for the long-term mentally ill
  - Crisis stabilization services (and consider including services more comprehensive than a toll-free number and 30 minute consultation)
  - Health and dental care
  - Peer supports and family supports
  - Services to help people gain access (client identification,

outreach, case management, referral)

- Residential (especially planning for defined levels of residential care)

- Case management (including more details on the philosophy/approaches to case management, location and organization, authority and responsibility, approaches for different populations).

- Service accountability mechanisms

- Provide a more detailed description of planning/services for several special populations:

  - Racially/culturally relevant services for minorities (other than refugees and Native Americans)

  - Seniors (address, especially, planning in regard to State agencies with overlapping responsibilities for the elderly)

  - Homeless mentally ill (include more information on the numbers, locations and needs of this population)

  - Children/adolescents (consider a less adult-oriented definition for case management)

- Consider strategies for using the existing data management systems to collect and analyze client data in terms of successful community living outcomes.

- Include an explanation as to why screening prior to hospitalization cannot be implemented until 1991 and delineate the incentives for diverting people from unnecessary inpatient care.

- Attention to/consideration of resource issues in moving toward a community-based system (i.e., the fact that the largest dollar increases go to State hospitals).

- A more detailed focus on developing formalized linkages between inpatient programs and community programs.

- Articulate the role of the State-supported higher education in human resource development for mental health programming and provide more details on such issues as required number and distribution of professionals.

- Include more details on how goals and objectives will be implemented, including financial and human resource needs, legislative/policy/regulatory issues, timeliness, responsibilities, etc., and how the goals/objectives relate to gaps in services.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse and
Mental Health Administration
Rockville, MD 20857

TO: State Mental Health Program Directors

FROM: Director, DESSL, NIMH

SUBJECT: Critique of Initial State Plans Required by the State Mental Health Plan Act (Title V of P.L. 99-660)

You will find attached a critique of your State Mental Health Plan.

The status of each initial State P.L. 99-660 plan has been reviewed to identify strengths and weaknesses, and provide recommendations that should be helpful in enhancing both the planning process and plan content and in ensuring compliance with the requirements of the planning legislation. This should help in the preparation of your September 30, 1989, submission. It is following this upcoming review that plan approval determinations will be made. A disapproval at that time would result in a reduction of your State's Alcohol, Drug Abuse, and Mental Health Services Block Grant funds in fiscal year 1990.

A number of major issues were identified in the plan reviews as being characteristic of the majority of State Plans. While each of these issues does not apply to every State Plan, we thought it important to identify these cross-cutting concerns as areas that merit additional attention in the next plan submissions.

- Most States identified goals and objectives but failed to identify specific action steps necessary for their implementation. Priority setting processes are clearly needed to assure realistic incremental implementation.

- Most plans were very weak when identifying funding strategies and resources to support new or modified services.

- Most plans did not address the many workforce issues (e.g., availability of appropriate staff and/or need for training, etc.) inherent in reaching goals.

- Most plans did not identify how States planned from the local level up through the State level.

- The meaningful involvement of consumers and families at various points in the planning process was not well described.

- Many plans did not document inter-agency planning with other relevant State agencies (e.g., medicaid, social services, housing, vocational rehabilitation, public health).

- The membership and role of the planning council was often not described. (A copy of the new planning council membership requirements as established in Section 2035 of P.L. 100-690 in November 1988 are attached.

- The development of a definition and strategy for meeting the case management requirement of P.L. 99-660 was not thoroughly developed.

The specific recommendations at the end of your plan critique are intended to assist you in the update of your plans by September 30, 1989.

You will have additional opportunities to discuss plan issues at the National Planning Technical Assistance Conference on March 20-21, 1989. We look forward to interacting with State representatives at that time. Meanwhile, if you have questions about the critique of your plan, please contact Mr. Maury Lieberman at (301) 443-4257.

James W. Stockdill

James W. Stockdill

Attachments

cc: State Planner

SEC. 2035. REQUIREMENT OF ESTABLISHMENT OF MENTAL HEALTH SERVICES PLANNING COUNCIL.

(a) IN GENERAL.—Section 1916(f) of the Public Health Service Act (42 U.S.C. 300x-4(f)) is amended to read as follows:

"(f)(1) The State agrees to establish and maintain a State mental health planning council in accordance with this subsection.

"(2) The duties of the Council will be—

"(A) to serve as an advocate for chronically mentally ill individuals, severely emotionally disturbed children and youth, and other individuals with mental illnesses or emotional problems; and

"(B) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

"(3) The Council will be composed of residents of the State, including representatives of—

"(i) the principal State agencies with respect to—

"(I) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and

"(II) the development of the plan submitted pursuant to title XIX of the Social Security Act;

"(ii) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

"(iii) chronically mentally ill individuals who are receiving (or have received) mental health services; and

"(iv) the families of such individuals.

"(4) Not less than 50 percent of the members of the Council will be individuals who are not State employees or providers of mental health services.

"(5) The Council may assist the State in the preparation of the description of intended expenditures required in section 1925.".

(b) CONFORMING AMENDMENT.—Section 1916 of the Public Health Service Act (42 U.S.C. 300x-4) is amended—

(1) by striking subsection (e); and

(2) by redesignating subsections (f) through (h) as subsections (e) through (g), respectively.

SEC. 2041. STATE COMPREHENSIVE MENTAL HEALTH SERVICE PLAN.

(a) ADMINISTRATIVE EXPENSES.—Section 1925(d) of the Public Health Service Act, as redesignated by section 2038, is amended to read as follows: 42 USC 300x

"(d) The amount referred to in subsections (a), (b), and (c) with respect to a State is the total amount that the State is permitted to expend for administrative expenses under section 1915(d) for fiscal year 1986 from amounts paid to the State under subpart 1 for such fiscal year. If in the judgment of the Secretary the State is making a good faith effort to comply with this subpart, the Secretary may assess the State a penalty that is less than the maximum penalty, but in no event shall the penalty be less than 2 percent of the amount the State is permitted to expend for administrative expenses.".

(b) REPORT.—Not later than September 30, 1990, the Comptroller General of the United States shall prepare and submit to the Committee on Energy and Commerce of the House of Representatives and the Committee on Labor and Human Resources of the Senate, a report that— 42 USC 300x note.

(1) evaluates the status of the implementation of section 1925 of the Public Health Service Act (as redesignated by section 2038) requiring State Mental Health Services Plans; and

(2) includes an assessment of—

(A) the number of States that have submitted such plans;

(B) the number of States that have implemented the plans submitted by such States;

(C) the efficacy of the plans that have been implemented in achieving effective, organized community-based systems of care for seriously mentally ill individuals; and

(D) recommendations on additional legislation that is necessary to facilitate the achievement of the goals of this title.