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

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Draft

DEPARTMENT OF HUMAN SERVICES

MENTAL HEALTH DIVISION

# THREE-YEAR PLAN FOR SERVICES FOR PERSONS WITH MENTAL ILLNESS

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# GLOSSARY

Acute care hospital: A short-stay health care facility licensed by the state for the treatment of emergency, chronic or short-term illness, disease or other health problem.

Acute mental illness: A mental illness that is serious enough to require prompt intervention. (1987 Statute.)

Alcohol, Drug Abuse, Mental Health Block Grant (ADM): A block grant of federal funds to states. 25% of Minnesota's grant is dedicated to mental health programs for American Indians; 15% for planning and evaluation; 5% for administration; and the remaining 55% for special projects for children, elderly persons, homeless persons, and others.

Bipolar Affective Disorder: See Manic Depression.

Board and Lodging: A licensing category applying to all facilities which provide rooms and/or meals. These facilities are inspected for safety and sanitation standards, but not licensed to provide medical or health care. These facilities do not provide mental health programs, although some provide limited activity programs and assist their residents in using community resources. In a number of these facilities, especially in Minneapolis and St. Paul, a majority of residents have been hospitalized for mental illness.

Case Management: The Comprehensive Mental Health Act (Minnesota Statutes, section 245.462, subdivision 3), as amended in 1988, defines case management activities for persons with mental illness as "activities that are coordinated with the community support services program...and are designed to help people with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. Case management activities include developing an individual community support plan, referring the person to needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

An expanded definition was suggested in 1976 by the joint Commission on Accreditation of Hospitals:

> Case management services are activities aimed at linking the service system to a consumer and coordinating the various system components in order to achieve a successful outcome. The objective of case management is continuity of services...Case management is essentially a problem-solving function designed to ensure continuity of services and to

overcome systems rigidity, fragmented services, misutilization of certain facilities and inaccessibility.

Child and Adolescent Service System Program (CASSP). A technical assistance program for states, sponsored by NIMH, to develop systems of coordination for services for children with emotional disturbance.

Child With Severe Emotional Disturbance (SED). For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or
(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or
(3) the child has one of the following as determined by a mental health professional:
    (i) psychosis or a clinical depression; or
    (ii) risk of harming self or others as a result of an emotional disturbance; or
    (iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or
(4) the child, as a result of an emotional disturbance, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Community Mental Health Center (CMHC). A community based outpatient clinic specializing in outpatient, medical, community support, and other services for persons with mental illness.

Community Social Services Act (CSSA). Legislation passed in 1979 which shifted the responsibility for planning and implementing human service programs from the state level to the local level. CSSA is a block grant replacing a variety of categorical funds dedicated to specific health and social purposes. CSSA funds incorporate federal Title XX funds ($45 million annually) state dollars ($50 million annually) and county tax dollars ($200 million annually). An average of twenty percent of CSSA funds, approximately $60 million in F.Y. 1988, goes toward mental health services.

Community Support Services Program (CSP). Programs offering community support to persons with mental illness originally

encouraged by the National Institute of Mental Health. (In Minnesota Comprehensive Mental Health Act, Minnesota Statutes, section 245.462, subdivision 6.) a "Community support services program" means services, other than inpatient or residential treatment services, provided or coordinated by an identified program and staff under the clinical supervision of a mental health professional designed to help people with serious and persistent mental illness to function and remain in the community. A community support services program includes:

(1) client outreach,
(2) medication management
(3) assistance in independent living skills,
(4) development of employability and supportive work opportunities,
(5) crisis assistance,
(6) psychosocial rehabilitation,
(7) help in applying for government benefits, and
(8) the development, identification, and monitoring of living arrangements.

The community support services program must be coordinated with case management activities.

Continuum of Care. The availability to clients in a geographic area of a comprehensive array of preventive, emergency, diagnostic, treatment, and rehabilitative mental health services which offer varied amounts of support and care depending on the individual client's needs.

DHS. Minnesota Department of Human Services

DJT. Minnesota Department of Jobs and Training.

DRS. Division of Rehabilitation Services of the Minnesota Department of Jobs and Training.

Diagnostic Assessment. A written summary of the history, diagnostic, strengths, vulnerabilities, and general service needs of a person with mental illness using diagnostic, interview, and other relevant mental health techniques provided by a mental health professional. The diagnostic assessment is used in developing an individual treatment plan or individual community support plan.

Diagnostic and Statistical Manual of Mental Disorders - (DSM-MD). Along with the ICD-9-CM, a manual used to assist clinicians in the diagnosis of mental illness and emotional disturbance. Periodically revised by the American Psychiatric Association.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). A program for Medical Assistance eligible children. A mental health screen will be developed to assist in the early intervention of emotional disturbances.

Emotionally Disturbed (ED). An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the ICD-9-CM or the DSM-MD, and seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

General Assistance (GA). A state and county income program to low income persons who do not quality for any federal programs. Individual General Assistance recipients receive payments of $209 monthly.

General Assistance Medical Care (GAMC). Health coverage for low income persons not eligible for other health care programs; supported from state and county funds.

Health and Human Services. U.S. Department of Health and Human Services.

Health Maintenance Organization (HMO). An organization providing comprehensive health care to enrollees on a fixed and prepaid basis, without regard to the frequency or extent of services.

Human Resource Development (HRD). Refers to the education, hiring, and promotion of the numbers and kinds of mental health professionals determined to be needed in Minnesota's system.

Housing and Urban Development (HUD). Federal agency.

Individual Community Support Plan. A written plan developed by a case manager on the basis of a diagnostic assessment. The plan identifies specific services needed by a person with a serious and persistent mental illness to develop independence or improved functioning in daily living, health and medication management, social functioning, interpersonal relationships, financial management, housing, transportation, and employment.

Individual Treatment Plan. A written plan of intervention, treatment, and services for a person with mental illness that is developed by a service provider under the clinical supervision of a mental health professional on the basis of a diagnostic assessment. The plan identified goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individual responsibility for providing treatment to the person with mental illness.

Institutions for Mental Diseases (IMDs). Federally defined facilities which provide diagnosis, treatment or care to more than 16 persons who have mental illness. Persons between the ages of 22 and 64 who reside in IMDs do not quality for Medicaid coverage for services. IMDs include hospitals, nursing homes and Rule 36 facilities.

International Classification of Diseases (ICD-9-CM). See DSM-MD.

Medical Assistance. (Also known as Medicaid, MA or Title XIX). A matched federal, state, county program of medical insurance for persons receiving AFDC, SSI or meeting income eligibility guidelines.

Medicare. Federal health insurance for elderly and certain disabled persons (Title XVIII of the Social Security Act).

Mental Health Practitioner. By Minnesota Statute, a mental health practitioner is a person providing services to persons with mental illness who is qualified to provide services to persons with mental illness in at least one of the following ways:

(1) holds a bachelor's degree in one of the behavioral sciences or related fields from an accredited college or university and has at least 2,000 hours of supervised experience in the delivery of services to persons with mental illness;
(2) has at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness;
(3) is a graduate student in one of the behavioral sciences or related fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness;
(4) holds a master's or other graduate degree in one of the behavioral fields from an accredited college or university and has less than 4,000 hours post-master's experience in the treatment of mental illness.

Mental Health Professional. By Minnesota Statute, a mental health professional is a person qualified to provide clinical services in the treatment of mental illness in at least one of the following ways:

(1) in psychiatric nursing: a registered nurse with a master's degree in one of the behavioral sciences or related fields from an accredited college or university or its equivalent, who is licensed under Minnesota law (sections 148.171 to 148.285) with at least 4,000 hours of post-master's supervised experience in the delivery of clinical services in the treatment of mental illness;
(2) in clinical social work: a person licensed as an independent clinical social worker under Minnesota law (section 148B.21, subdivision 6) or a person with a master's degree in social work from an accredited college or university, with at least 4,000 hours of past master's supervised experience in the delivery of clinical services in the treatment of mental illness;

(3) in psychology: a psychologist licensed under Minnesota law (sections 148.88 to 148.98) who has stated to the board of psychology competencies in the diagnosis and treatment of menta illness;
(4) in psychiatry: a physician licensed under Minnesota law (Chapter 147) and certified by the American Board of Psychiatry and Neurology or eligible for board certification in psychiatry; or
(5) in allied fields: a person with a master's degree from an accredited college or university in one of the behavioral sciences or related fields, with at least 4,000 hours of post master's supervised experience in the delivery of clinical services in the treatment of mental illness.

Mental Health Division (MHD). Mental Health Division, Minnesota Department of Human Services.

Mental Illness. (As defined by the Minnesota Comprehensive Mental Health Act of 1987.) An organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work and recreation.

MN. State of Minnesota.

Mental Retardation. Significantly subaverage general intellectual functioning (an IQ of 70 or below) with onset before the age of 18. Mental retardation may result in deficits or impairments in adaptive behavior.

MHFA. Minnesota Housing Finance Agency.

M.S. Minnesota Statutes.

Minnesota Supplemental Aid (MSA). Payments to supplement SSI funds for low income elderly and disabled persons, supported from state and county funds. Ordinarily these payments go to facilities to support residents rather than to the residents themselves.

National Institute of Mental Health (NIMH). Federal agency.

Nursing Home. Facilities licensed to serve persons who require continuing nursing care as well as personal care and supervision. Nursing homes are licensed by the Minnesota Department of Health.

Pre-Admission Screening/Alternative Care Grants Program (PAS/ACG) and PAS/ARR, Alternative Resident Review. A program designed to prevent premature or unnecessary

institutionalization of elderly people by screening nursing home applicants to determine if nursing home placement is necessary or desirable. Also includes funds for alternative community care.

Psychosis (psychotic). A severe impairment of the individual in relating to reality, often evidence by delusions or hallucinations.

Regional treatment centers (RTCs). Formerly known as state hospitals, six of Minnesota's RTCs, at Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter and Willmar, serve persons with mental illness. The Minnesota Security Hospital at St. Peter has a capacity of 236 beds for patients judged mentally ill and dangerous.

Residential treatment facilities. See Rule 5 and Rule 36.

Request for Proposal (RFP). A document that is distributed by a funding agency to request proposals to receive such funds.

Refugee Immigration Assistance Division (RIAD). Refugee Immigration Assistance Division, Minnesota Department of Human Services.

Rule 5. Minnesota state licensing rule establishing the requirements of residential treatment facilities for children and youth who are emotionally disturbed and/or behaviorally disordered. Forty-one residential treatment facilities were licensed under Rule 5 in April 1987.

Rule 12. Minnesota funding mechanism which supports Rule 36 residential treatment facilities.

Rule 14. Minnesota funding mechanism which supports community programs for mentally ill people other than Rule 36 facilities.

Rule 29. Minnesota's voluntary certification of mental health clinics and centers for third party reimbursement. Facilities must have a multi-disciplinary staff, a staff of at least four persons, and regular service of a psychiatrist and psychologist.

Rule 36. First promulgated in 1974, Minnesota's Rule 36 sets licensing standards for programs in residential facilities for mentally ill adults. It ensures that, in addition to providing residents with room and board, facilities will offer appropriate programmatic services aimed at maximizing a resident's ability to function independently.

Section 8 Lower-Income Rental Program. A housing assistance program, administered by the U.S. Department of Housing and Urban Development, under which eligible families, handicapped and elderly persons pay no more than 30% of their income toward

rent. The Section 8 Existing Housing Program, administered by the local housing authority, gives eligible tenants "Section 8 Certificates" for rental subsidy. When the tenant finds a suitable apartment, the local housing authority contracts with the landlord to pay the rental subsidy. Under the Section 8 New Construction Program, now repealed, HUD agreed to subsidize rents on units occupied by eligible lower income persons for approved developers.

Serious and Persistent Mental Illness. (Under 1987 Minnesota Law) applies to persons who have a mental illness who meet at least one of the following criteria:

(1) the person has undergone two or more episodes of inpatient care for 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 patient's commitment has been stayed or continued.

Social Security Disability Income (SSDI). A federal social security program for persons with disabilities who have worked a certain time in the past. Monthly payments vary according to the length of time worked and the person's income level during employment. Persons quality if they have:

> Mental illness resulting in marked constriction of activities and interests, deterioration in personal habits or work-related situations, and seriously impaired ability to get along with other people.

SSDI recipients ordinarily qualify for either Medicare or Medicaid.

Supplemental Security Income (SSI). A federal program for persons with demonstrated disabilities which prevent productive work. SSI recipients usually qualify for Medical Assistance. Individual recipients currently receive payments of $369

monthly. SSI, in contract to SSDI, is for individuals who have not worked extensively before the onset of their disability.

Supported Employment. Supported employment helps persons with severe psychiatric disabilities maintain jobs in integrated employment settings by providing the needed job development, placement, training and support. Frequently job coaches are involved over the long term.

Title XIX. Medicaid.

Title XX. Federal Social Service funds passed through to county by state for use for low income persons and persons with handicaps.

* With thanks to the League of Women Voters of Minnesota for the development of the major portion of this section. From Mental Health System Monitoring Workbook, copyright League of Women Voters of Minnesota.

# CHAPTER I

# INTRODUCTION

The recent history of Minnesota's mental health system has been marked by critical evaluation from a number of independent bodies, and by major corrective action by the Minnesota Legislature. This history dates back to June of 1985, when Governor Rudy Perpich announced the formation of a Mental Health Commission to examine the state of Minnesota's system of services.

The Governor's Commission released its report, Mandate for Action, in early 1986, concluding that "the system of mental health services is, to a significant extent, divided, inconsistent, uncoordinated, undirected, unaccountable, and without a unified direction."

Mandate for Action was quickly followed by critical reports from the Minnesota Legislative Auditor's Office and the Washington, D.C. based Public Health Interest Research Group. The latter report ranked Minnesota's system 37th among the states, while the chief finding of the former was that significant numbers of persons were released from regional treatment centers without adequate discharge plans or follow-up care.

Finally, in the summer of 1986, ten statewide hearings were held with Governor Perpich and the Commissioner of Human Services to give the public an opportunity to express to the Governor and Commissioner their concerns about Minnesota's mental health system. All of the critical evaluation led the 1987 Legislature to pass the Comprehensive Mental Health Act, which created a system of services in all counties or regions of the state for persons with mental illness.

During the 1987 Legislative session, it was agreed that the needs of children and adolescents with emotional disturbance would be the focus of attention in the following (1988-89) biennium. As a result, the 1988 Legislature passed a mission statement which called for the Minnesota Department of Human Services (DHS) to submit a proposal for a statewide, comprehensive, coordinated system of mental health services for children. The remainder of 1988 was then spent planning for this system of care under the coordinated efforts of DHS, the Children's Subcommittee of the State Advisory Council on Mental Health (successor to the Governor's Commission mentioned above), and other state departments and agencies.

A major part of this effort were public hearings conducted by the Children's Subcommittee of the State Advisory Council. These hearings and a survey of county social services directors was followed by passage of the Comprehensive Children's Mental Health Act in the spring of 1989.

When the 1987 Legislature made permanent the Governor's Mental Health Commission by creating the State Advisory Council, it realigned its membership requirements to adhere to federal

Public Law 99-660. Since the appointment of members to the Council, it has worked with DHS and others to address such issues as the future role of regional treatment centers; the human resource development needs of Minnesota's mental health system; and plans for long-term and permanent housing for persons with mental illness, in addition to the needs of children and adolescents with emotional disturbance.

This report updates Minnesota's January 1989 Plan for Services for Persons with Mental Illness by including actions of the 1989 Legislature. This plan also identifies the major issues of the next one to three years and outlines the DHS' strategies for addressing them.

Overview - How the Planning Process Operates in Minnesota

To a significant degree, laws and budgets passed by the Minnesota Legislature and approved by the Governor serve as the DHSs true planning documents. While the Mental Health Division (MHD) of DHS continues to play a significant role in planning for and drafting mental health legislation, it is the Legislature and the Governor which determine the intent of legislation, the level of program funds, and the administrative and planning staff at the state level.

Prior to the legislative process, the input of the State Advisory Council, the Children's Subcommittee, advisory councils to special projects, county advisory councils, and other public bodies is used heavily. The timetable for planning for the 1989 legislative session, and implementation of its outcomes, is as follows:

| | |
|---|---|
| January 1988 | first county plans for 1988-89 for adult mental health services reviewed by MHD (result of 1987 Comprehensive Mental Health Act) |
| spring/summer 1988 | drafting of MHD/DHS budget for 1990-91 biennium begins (to be acted on by 1989 Legislature) |
| | drafting of first P.L. 99-660 Plan begins |
| | drafting of legislation for 1989 session begins |
| January 1989 | submission of first P.L. 99-660 Plan to NIMH |
| spring 1989 | Legislature reviews and approves budget and legislation for 1990-91 biennium (including Comprehensive |

| | |
|---|---|
| | Children's Mental Health Act; adjourns May 22 |
| August 1989 | second round of county plans for 1990-91 for adult mental health services due for MHD review and approval |
| | P.L. 99-660 Plan revisions continue (spring and summer 1989) |
| November 1989 | initial county plans for children's mental health services due (result of 1989 Comprehensive Children's Mental Health Act) |

As indicated in the timetable with the submission of county plans, Minnesota has a state-administered, county-operated system of service delivery. This often means that the budgetary, administrative, and political needs of two levels of government must be addressed in the development of new programs. The membership of the State Advisory Council and Children's Subcommittee reflect this arrangement with their inclusion of county commissioners and social services directors.

Typically, the need to address a given issue is identified by a variety of sources. A few of these are: 1) MHD regional staff, who have the responsibility of working with counties to ensure that services required by the Comprehensive Mental Health Act are available, accessible, and are of high quality; 2) county social services personnel, who must implement the programs required by the state; 3) mental health services providers; 4) members of the State Advisory Council, the Children's Subcommittee, and county advisory councils and children's coordinating councils; 5) advocacy organizations; and 6) federal programs and government.

These entities and the issues they identify are very much interrelated. For example, the budget and program needs of counties, as well as new issues identified in county plans, are used to develop responses that have applicability across the entire state. Similarly, the MHD and bodies such as the State Advisory Council identify new congressional, legislative, judicial, county, and local decisions requiring a response. Thus, while information presented in county plans, State Advisory Council studies, and other reports influence future directions, so also do counties and the state continue to implement past state and federal directives.

Because staff shortages are more often the rule than the exception at all levels of Minnesota's mental health system, identified needs generally are addressed by proposing new legislative and budgetary initiatives. Thus, as indicated

earlier, much of what the MHD and DHS plan for can be implemented only with the approval of the Legislature and the Governor, within the constraints of state and federal laws and regulations, and tailored to the needs identified by counties, providers, and consumers.

New legislation goes through countless drafts in an effort to respond to the concerns of all affected parties. Similarly, the MHD's budget request (appropriated on a biennial basis) is reviewed by DHS, the Department of Finance, the State Planning Agency, the State Advisory Council, and the Governor's Office before it is submitted to the Legislature with the rest of the Governor's legislative and budgetary initiatives.

Ultimately, the needs of persons with mental illness are balanced with the needs of many others seeking the assistance of the state. In the 1989 session, legislative leaders and the Governor determined public education and property tax relief to be major priorities overall. In the human services arena, new laws reflecting the Legislature's priorities were passed to create a system of services for children with emotional disturbance; and to plan for the future role and mission of Minnesota's regional treatment centers. Each of these initiatives represent progress in the implementation of a comprehensive system of care for adults with mental illness or children with emotional disturbance.

This plan reports on those legislative outcomes and discusses old and new issues confronting the development of a comprehensive, community-based system of mental health services. Coordinated efforts of the Mental Health Division, the Department of Human Services and other state departments, the Governor, the Legislature, counties, and the State and local Mental Health Advisory Councils are crucial for success. Ultimately, a degree of trust must continue to be developed in ensuring that all parties aim for the same goal. This plan can serve as one vehicle to continuing to build that trust.

# CHAPTER II

# MISSION, GOALS, AND OBJECTIVES OF MINNESOTA'S MENTAL HEALTH SYSTEM

As stated in Minnesota's January, 1989, mental health services plan, the 1987 and 1988 Legislatures established the mission of the Department of Human Services in implementing a comprehensive system of mental health services. For adults,

> The Commissioner shall create and ensure a unified, accountable, comprehensive adult mental health service system that:
>
> (1) recognizes the right of adults with mental illness to control their own lives as fully as possible;
> (2) promotes the independence and safety of adults with mental illness;
> (3) reduces chronicity of mental illness;
> (4) eliminates abuse of people with mental illness;
> (5) provides services designed to:
>  (i) increase the level of functioning of adults with mental illness or restore them to a previously held higher level of functioning;
>  (ii) stabilize adults with mental illness;
>  (iii) prevent the development and deepening of mental illness;
>  (iv) support and assist adults in resolving mental health problems that impede their functioning;
>  (v) promote higher and more satisfying levels of emotional functioning; and
>  (vi) promote sound mental health; and
> (6) provides a quality of service that is effective, efficient, appropriate, and consistent with contemporary professional standards in the field of mental health.

For children,

> The Commissioner of human services shall create and ensure a unified, accountable, comprehensive children's mental health service system that is consistent with the provision of public social services for children as specified in Section 256F.01 and that:
>
> (1) identifies children who are eligible for mental health services;
> (2) makes preventive services available to all children;
> (3) assures access to a continuum of services that:
>  (i) educate the community about the mental health needs of children;

(ii) address the unique physical, emotional, social, and educational needs of children;
(iii) are coordinated with the range of social and human services provided to children and their families by the departments of education, human services, health, and corrections;
(iv) are appropriate to the developmental needs of children; and
(v) are sensitive to cultural differences and special needs;

(4) includes early screening and prompt intervention to:
(i) identify and treat the mental health needs of children in the least restrictive setting appropriate to their needs; and
(ii) prevent further deterioration;

(5) provides mental health services to children and their families in the context in which the children live and go to school;

(6) addresses the unique problems of paying for mental health services for children, including:
(i) access to private insurance coverage; and
(ii) public funding;

(7) includes the child and the child's family in planning the child's program of mental health services, unless clinically inappropriate to the child's needs; and

(8) when necessary, assures a smooth transition from mental health services appropriate for a child to mental health services needed by a person who is at least 18 years of age.

The MHD utilized these mission statements in establishing its own goals and objectives, and in preparing drafts of this Plan. These goals and objectives are listed below.

Goal #1:

To provide leadership to the state's mental health system for children and adults.

Objectives:

1-A. To provide linkages and respond to requests for information, task force membership, etc., which expand knowledge, awareness and expertise in mental health issues.

1-B. To achieve positive and innovative change in the planning and delivery of local mental health services.

1-C. To enhance leadership of state and local advisory councils.

Goal #2:

To ensure statewide availability, accessibility, and provision of services for children and adults as required by the Comprehensive Mental Health Act.

Objectives:

2-A. To supervise counties in planning for and providing mental health services.

2-B. To provide effective management for Rule 12 and Rule 14 grants.

2-C. To assist counties in identifying persons in need of services, including those identified in the nursing home screening process.

2-D. To supervise local mental health authorities in arranging for the safe and orderly discharge of persons with mental illness who are found to be inappropriately residing in nursing facilities.

2-E. To assure client access to services through reasonable and equitable fee policies.

Goal #3:

To effectively plan for, manage and evaluate the state's mental health service system for children and adults, including human resource development.

Objectives:

3-A. To maximize the use of all available or develop new funding resources, including human resources, in the provision of mental health services.

3-B. To implement the new community mental health reporting system (CMHRS).

3-C. To maintain and manage the computer resources of the Division to maximize staff efficiency and effectiveness.

3-D. To implement effective methods to utilize available mental health data from MA/GAMC, RTCs, and other information systems.

3-E. To develop appropriate planning linkages with academic institutions, mental health service agencies, and other related agencies in order to encourage research into mental illness and effective treatment modalities, and

promote appropriate training of the state mental health work force.

3-F. To develop staff capacity to do work assignments effectively.

3-G. To maximize opportunities to plan service development systematically, based on client needs.

3-H. To implement statutory requirements for reporting children's residential treatment data.

3-I. To implement statutory requirements for annual report from the local children's coordinating councils.

3-J. To begin to develop a separate and distinct State Human Resource Development Plan to include into the agency's State Mental Health Services Plan.

3-K. To implement a minimum HRD data set which interfaces systematically with the organizational and client data sets.

Goals #4:

To assure that mental health services for children and adults meet standards of quality and when feasible, are based on relevant research findings and consistent with professional standards in the field of mental health.

Objectives:

4-A. To promote high standards of care to providers and counties.

4-B. To reassess rule development and revision plans and develop/revise rules accordingly.

4-C. To collaborate with Residential Program Management Division and Transition Team to enhance service quality in the regional treatment center system and to promote continuity with community based services.

4-D. To enhance Division's capacity to evaluate service provision.

4-E. To determine the best methods for assuring that out-of-home placements of adults and children are appropriate and necessary.

4-F. To develop new high quality services for children with emotional disturbance.

Goal #5:

To ensure the provision of services in the least restrictive environment which increases the level of functioning and safety of children and adults needs services.

Objectives:

5-A. To define an appropriate array of services for adults and children.

5-B. To promote community based services in the least restrictive environment when clinically appropriate to the clients needs.

5-C. To assess current rules to determine the degree to which these promote increasing individuals levels of functioning and safety.

Goal #6:

To assure the coordinated development of the mental health system for children and adults.

Objectives:

6-A. To develop state level inter- and intra-agency coordination for the development, implementation, and funding of mental health services.

6-B. To assure that mental health service development and implementation is coordinated at the local level.

6-C. To assure individual case level coordination among service providers and clients.

Goal #7:

To promote the development of a unified service delivery system for children and adults which incorporates the culturally, chronologically, and geographically diverse mental health needs of Minnesotans through integration into the mental health system and development of appropriate special programs.

Objectives:

7-A. To develop systems to identify underserved persons and populations or groups of persons in need of services.

7-B. To assure that services for persons and populations or groups of persons with diverse mental health needs are appropriately addressed by the system.

7-C. To maximize all existing and/or develop new funding resources to assure that the diverse mental health needs of Minnesotans are incorporated.

7-D. To target use of all available funding sources in providing services to diverse population groups.

Goal #8:

To empower adult and child consumers of mental health services and their families to participate in the development of the mental health service system and in development of their individual treatment plans.

Objectives:

8-A. To provide active outreach in order to elicit consumer input.

8-B. To assure involvement of families and consumers in the treatment process.

8-C. To promote the employment of consumers.

Goal #9:

To work actively on lessening the stigma of mental illness and emotional disturbance.

Objectives:

9-A. To develop an anti-stigma campaign RFP, contract, and program.

9-B. To integrate anti-stigma efforts throughout all activities of the Division.

9-C. To involve state and local mental health advisory councils, other advisory groups, and special grant projects in promoting anti-stigma efforts.

Background:

As indicated in Minnesota's January, 1989 State Plan, significant new legislation to meet the needs of children with emotional disturbance was introduced in the 1989 Legislature. That legislation was passed and has significantly increased the MHD's responsibilities. Because children's mental health represents a major new initiative, this chapter presents a more thorough analysis compared to others in the State Plan.

Since January, 1988, three major efforts have taken place to build a children's mental health system. The 1988 Legislature established a mission for children's mental health services which set the stage for 1989 legislative action. In 1989, the Comprehensive Children's Mental Health Act was passed, mandating a comprehensive and coordinated delivery system by 1992. In addition, the DHS funded eight demonstration projects which are modeled after the CASSP framework of interagency coordination and service delivery. These form the foundation for future departmental work in the children's mental health area.

The 1989 Comprehensive Children's Mental Health Act represents a commitment to the children of Minnesota to provide a comprehensive and coordinated system of care for their mental health needs. The Legislature appropriated $2.3 million over the 1990-91 biennium to begin the implementation of this initiative after a period of planning. Additional state funding will be required in the following biennium to complete the implementation of mandated services.

The passage of this legislation represents the effort of many persons. In conjunction with DHS the State Mental Health Advisory Council's Children's Subcommittee, collected information from parents, children, providers, advocates, county personnel, and others in a series of statewide hearings. In addition, DHS collected survey information from counties about their current systems of care for children and adolescents. The resulting legislation thus was able to address the concerns identified during this planning process.

The legislation was designed to accomplish three primary goals:

1. Mandate a comprehensive set of services throughout the state so that all children receive services based upon their individual level of need;
2. establish mechanisms at the state, local and individual case levels for coordination between agencies serving children with mental health needs; and
3. establish advisory councils at the state and county levels, assuring input from parents, providers, advocates, and others.

In the next section, gaps and issues identified during the planning process are presented. Features of the Comprehensive Children's Mental Health Act follow, and new legislative funding is discussed. Finally, goals and objectives for the children's mental health system over the next three years are described in Part III.

## PART I. GAPS AND PROBLEMS IDENTIFIED THROUGH THE PLANNING PROCESS

### By the Children's Subcommittee on Mental Health

Membership of the Children's Subcommittee of the State Mental Health Advisory Council, formed in September of 1988, is legislatively mandated to include a diverse group of persons who work with children's issues statewide. The group includes parents, providers, a former consumer of adolescent mental health services, county representatives, mental health professionals working in hospital and outpatient settings, a school social worker, representatives of advocacy organizations and representatives of culturally diverse programs. In addition, representatives from the Departments of Human Services, Corrections, Health, State Planning, and Education participate on the Subcommittee.

At its inception, the group established task forces which advised the DHS on all aspects of the proposed children's mental health legislation and funding. The Subcommittee estimated that $20 million in additional state funding would be necessary to provide needed services for children over the two-year state biennial period.

Subcommittee members continued to advise DHS and the bill's authors, Senator Linda Berglin and Representative Gloria Segal, (both are members of the State Mental Health Advisory Council), as well as other legislators to gain their support until the bill was passed.

The Children's Subcommittee also conducted seven public hearings on the needs of children and adolescents with emotional disturbance from December 1988 through February 1989. More than 325 persons attended the hearings with 75 providing testimony. Several common themes emerged from the hearings:

- In delivering services for emotionally disturbed children and adolescents, the needs of the entire family should be addressed, unless clinically inappropriate.

- Mental health services for children must be coordinated with other services they may receive: education, vocational development, juvenile corrections, and child protection services.

# CHAPTER III

# MENTAL HEALTH SERVICES FOR CHILDREN

- Available funding in both the private and public sectors is often the determining factor in the type of services children receive.

- Many counties outside the metropolitan area have limited local resources in terms of services, funding, and trained professionals.

- Paperwork, financial disincentives, and other barriers often postpone the access of a child to services until a crisis situation exists.

- Early intervention by professionals is needed.

In general, many people testified that the system needs were two-fold: first, to coordinate existing and new services; and second, to develop and provide additional mental health services specifically for children and adolescents.

(Minnesota State Advisory Council on Mental Health, "Report: Public Hearings on Children's Mental Health Issues", March 1989.)

By the DHS Study on the County Mental Health System of Care

As a part of its planning for the legislative proposal, the MHD surveyed counties on the mental health system of care for children and youth. Questionnaires were sent to the directors of all 87 county social service agencies; 78 questionnaires were returned for an 88% response rate. The survey questions addressed the following:

- the existing continuum of mental health services;
- service location;
- problems within these mental health services;
- types of services needed on an overall basis; and
- differences between services in the metropolitan region and other regions of the state.

Regarding the availability of services, the questionnaire asked the directors' opinions of the availability and need for various mental health services. Directors rated services according to whether they were:

- available and needed;
- available, more needed;
- not available but needed; and
- not available and not needed.

The following table summarizes the responses only for "available and needed" and "available, more needed" categories.

| Type of Service | Available/Needed # Counties | | Available/More Needed # Counties | |
|---|---|---|---|---|
| | Metro | Outstate | Metro | Outstat |
| Prevention | 1 | 28 | 5 | 37 |
| Early Identification/ Intervention | 0 | 37 | 6 | 30 |
| Assessment/Outpatient Treatment | 1 | 48 | 5 | 22 |
| Therapeutic Home-Based Services | 0 | 20 | 3 | 20 |
| Day Treatment | 3 | 19 | 3 | 17 |
| Day Treatment-Level 5 Special Education | 3 | 35 | 2 | 13 |
| Emergency Services | 5 | 60 | 1 | 11 |
| Service Coordination/ Case Management | 1 | 44 | 5 | 24 |
| Therapeutic Foster Care | 0 | 25 | 6 | 27 |
| Group Residential Treatment | 5 | 51 | 1 | 16 |
| Regional Treatment Centers | 5 | 51 | 1 | 16 |

The survey of county social service directors also provided information their perceived need for mental health services in their county. The following table identifies needed services ranked on a statewide basis.

| Type of Service | Number of Counties Expressing Need N = 78 | Percent of Counties Expressing Need |
|---|---|---|
| Therapeutic Foster Care | 50 | 64% |
| Therapeutic Home Based Services | 47 | 60% |
| Prevention | 46 | 59% |
| Day Treatment | 40 | 51% |
| Early Identification and Intervention | 39 | 50% |
| Case Management | 30 | 38% |
| Assessment and Outpatient | 27 | 35% |
| Residential Treatment | 19 | 24% |
| Regional Treatment Centers | 14 | 18% |
| Emergency Services | 12 | 15% |
| Inpatient Hospitalization | 12 | 15% |

NOTE: "Need" means a county director rating of "Available, More Needed" or "Not Available, but Needed".

Other key findings from the study include the following:

1. County directors indicated that both mental health and other support services for children and youth with severe emotional disturbances are in some cases totally unavailable or unavailable in sufficient quantities to meet the needs.

2. Many county directors indicated that they use residential mental health treatment facilities in locations which may be more than an hour's drive from the child's home community.

3. Barriers to mental health services exist in some counties in terms of:

   a) eligibility and admissions;
   b) affordability;
   c) lack of acceptance by parent/child;
   d) culture/language; and
   e) coordination problems.

## PART II -- STATE CHILDREN'S MENTAL HEALTH INITIATIVES

### A. Minnesota Comprehensive Children's Mental Health Act

The Minnesota Comprehensive Children's Mental Health Act was adapted for Minnesota's government structure from the CASSP model of the National Institute of Mental Health's Children's Program. The following is an overview of the Act.

OVERVIEW: Children's Comprehensive Mental Health Act

I. State Responsibilities:

A. Mission

The mission of the Department's efforts on behalf of children with emotional disturbance and their families is to ensure the creation of a unified, accountable, comprehensive children's mental health service system. Implementation of the service system must take place by January 1, 1992.

The Department will provide each county with information about the predictors and symptoms of children's emotional disturbances and information about groups identified as at risk of developing emotional disturbance to assist in planning for services. (M.S. 245.4872, subd. 2 and subd. 3.)

B. Services

Required services in each county and implementation dates include:

- Education and prevention.....Current*
- Emergency services.....Current
- Outpatient services.....Current
- Residential treatment services.....Current
- Acute care hospital inpatient services..Current
- Screening for inpatient and residential treatment.....Current
- Early identification and intervention... 1/1/91
- Professional home-based family treatment..... 1/1/91
- Case management services..... 7/1/91
- Family community support services..... 7/1/91
- Day treatment services..... 7/1/91
- Benefits assistance..... 7/1/91
- Therapeutic foster care..... 1/1/92

C. State Level Coordination:

The Department must convene quarterly meetings with the Commissioners, or designees of Commissioners, of the Departments of Human Services, Health, Education, Commerce, State Planning and Corrections and a representative of the Minnesota District Judges Association Juvenile Committee, in order to coordinate planning, funding and implementation of services.

No service shall be provided unless consent to the services is obtained. No information about the child/family shall be disclosed without informed written consent, unless required to do so by statute. Procedures must be established to ensure that the names and addresses of children receiving mental health services and their families are released only under very specific conditions (such as to service providers). A child or a child's family who requests services must be advised of services available and the right to appeal. (M.S. 245.4886.)

D. Continuation of Services:

Counties must continue to provide case management, community support services, and day treatment to children with serious and persistent mental illness as required by the Comprehensive Mental Health Act of 1987. By August 1, 1989, counties must notify providers of services to children

eligible for case management, day treatment, and community support services under the Comprehensive Mental Health Act of their obligation to refer children for services. (M.S. 245.487, subd. 5.)

E. Local Agency Coordination:

By January 1, 1990, the county must establish a local coordinating council at the county level, including representatives of mental health, social services, education, health, corrections, and vocational services (and an Indian reservation authority where a reservation exists within the county.) When possible, the council must also include a representative of juvenile court or the court responsible for juvenile issues and law enforcement. The members of the council must meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. The council must provide written interagency agreements and report annually to the Commissioner about unmet children's needs, service priorities, and the local system of care. (M.S. 245.4872, subd. 3 and M.S. 245.4875, subd. 6.)

F. Individual Case Coordination:

Coordination by the case manager is required with any other person responsible for planning, development, and delivery of social services, education, corrections, health or vocational services for the individual child. (M.S. 245.4872, subd. 4.)

The case manager must arrange for a diagnostic assessment, determine the child's eligibility for family community support services, develop an individual family community support plan, perform a functional assessment, and provide for service coordination for the child. (M.S. 245.4881.)

III. Services Eligibility:

Emotional disturbance is defined as an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory or behavior that:

1. is listed in specific code ranges of the International Classification of Diseases (ICD-9), current edition, or in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-MD), current edition; and

2. seriously limits a child's capacity to function in primary aspects of daily living, such as personal relations, living arrangements, work, school, and recreation (M.S. 245.4871, subd. 15.)

Eligibility for case management and family community support services requires that the child meet the definition of emotional disturbance and one of the following:

1. Admission within the last three years (this is included in an effort to provide follow-through coordination to children who have been removed from home) or is at risk of being admitted to inpatient or a residential treatment program for an emotional disturbance, or

2. Receipt of treatment for an emotional disturbance by a Minnesota resident through the interstate compact, or

3. A determination by a mental health professional that the child has:

   (i) psychosis or clinical depression; or

   (ii) risk of harming self or others as a result of an emotional disturbance; or

   (iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year, or

4. As a result of an emotional disturbance, significantly impaired home, school or community functioning of a child that has lasted at least one year, or, in the written opinion of a mental health professional presents substantial risk of lasting one year. (M.S. 245.4871, subd. 6.)

B. NEW MENTAL HEALTH FUNDING

Up to now, children with mental health needs have received services at the county level largely through the Community Social Services Act (CSSA). This block grant fund, consisting of federal, state, and county dollars, has supported a variety of services, although there is little data about the kinds and amounts of mental health services children receive under CSSA. In particular, residential treatment programs have been paid for by CSSA. Other mental health services have been provided to children through the MA system. But, because an array of services was not available in all areas of the state, DHS requested new state dollars to begin the balanced development of several services in areas of the state where they were needed.

The 1989 Legislature's appropriations for the 1990-91 biennium included $2.3 million in new funds for children's mental health services. The DHS will work with counties and the Children's Services and Health Care Management Division within DHS to begin to develop these services.

In addition, the Legislature appropriated funding for one staff position for children's mental health within DHS. The Department is developing mechanisms to serve children with severe emotional disturbance who are not currently eligible through its MA Program. The outcome of this project and a mandated study of current mental health funding to be completed over the next biennium will frame future funding requests. Additional funding will be necessary before the Comprehensive Children's Mental Health Act is totally implemented. Current DHS estimates are that the Legislature will need to appropriate $11 million in the next biennium to fund newly mandated children's mental health services.

C. MENTAL HEALTH PROJECTS SERVING CHILDREN AND ADOLESCENTS

In the current year, the DHS has undertaken a major new effort using block grant funds to establish pilot projects to serve severely emotionally disturbed children and adolescents. Projects were required to use the CASSP service delivery model developed by NIMH. This model has been most helpful in guiding the development of a children's mental health system. Below is a summary of the eight projects which are currently funded with the federal block grant dollars.

1. Carver County

The Youth Resource Program for Carver County promotes the availability and coordination of a full continuum of services by the many agencies serving children, adolescents and their families. The intent of the program is to increase local community based access to a full range of services by children who are presently underserved due to a variety of factors. This effort requires participation and cooperation by all agencies presently serving children and adolescents. It will result in a more unified and systematic delivery of multi-agency services through development and adherence to an Individual Community Support Plan.

Evaluation of the entire system of care will determine which services must be expanded or developed, with emphasis on reducing reliance on intensive out-of-county resources, such as residential treatment programs. Key components will be the process of early identification and increased access to less restrictive treatment options. During the first year, two local therapeutic foster homes will be recruited and

begin accepting children. The largest budget item is for a project coordinator. Small amounts will also be used to hire a therapeutic foster care consultant to get that program set up, and limited amounts for day treatment and in-home counseling.

2. Isanti County

The primary objective of this project will be to develop and implement comprehensive therapeutic/educational treatment plans for children with emotional disturbance served by the therapeutic day treatment program, a community based program to be established through interagency cooperation. Family involvement, through support group and therapeutic activities, is emphasized throughout as an integral part of each child's treatment plan. Treatment plans will be developed jointly by the Interagency Team, a multiagency group of educational, social service and mental health personnel.

The objectives of the project will be accomplished by the initiation and expansion of mental health services in the areas of education and prevention, outpatient services, day treatment, and professional family-based services. The program's budget shows a creative use of a number of local funding resources including special education funds, local school district funds, and county dollars.

3. Itasca County

The project will strengthen early intervention and service coordination activities for severely emotionally disturbed children and adolescents. Staff serving geographic areas of the county will provide information and resources to parents, become actively involved in suicide prevention activities, foster care training and crisis supervision of children in foster homes, and work on early identification of "at risk" children. The funds are used primarily to support regional service coordinators who will serve these functions.

4. Kandiyohi County

The project will bring together local community agencies to coordinate services for children. About half of the funds will be used to expand prevention and education and outpatient services including assessment. Lutheran Social Services will receive a contract to provide professional family based services.

5. McLeod County

The project will develop and expand services to children with emotional disturbance by hiring a care coordinator.

The coordination will assist in the identification of children in need, and provide necessary linkages between providers and the child's family to assure that needed services are provided and to provide parent education.

6. Mower County

The goal of the project is to implement a service coordination team under the leadership of a newly hired project manager. Funding will be used for the project manager position and subcontracts will be developed to provide consultation and training for foster care families, prevention and education activities, and foster home recruitment.

7. Olmsted County

For several years, Olmsted County has attempted to create community based care for children in need of out of home services. The county will become the lead agency in fostering the interagency collaboration needed to develop the comprehensive community based service system for children with severe emotional disturbance. A coordinator will be hired and funds will be used for an extended family home and emergency home.

8. Ramsey County

Funding will be focused on development of one specific professional family based enhancement to a school program. The project will serve level 5 (special education) students by providing intensive in-home mental health services to families and by offering intensive social skills for children and behavior management groups for parents in the school.

D. Children's Services Grant Application

The MHD has submitted a system development grant application to the Children's Services Division of NIMH. If funded, the MHD plans to institute an interagency planning process around the needs of homeless youth with mental illness, expand the involvement of parents and minorities in the implementation of the children's mental health system, and provide information and resources to inform the state and local legislative implementation process.

## III. OBJECTIVES AND TASKS

A. To provide linkages and respond to requests for information, task force membership, etc., which expand knowledge, awareness and expertise in mental health issues.

TASKS:

1. Participate in NASMHPD, CASSP, SMHRCY, and other national organizations as DHS representative -- ongoing.
2. Prepare for and attend advisory council meetings -- ongoing.
3. Develop relationships with advisory groups and professional organizations -- ongoing.
4. Review literature and present relevant research findings to staff and outside groups -- ongoing.
5. Maintain resource information on mental health programs and services from other states and throughout Minnesota -- ongoing.

B. To achieve positive and innovative change in the planning and delivery of local mental health services.

TASKS:

1. Provide staff support to SMHAC and Children's Subcommittee in developing recommendations -- ongoing.
2. Utilize SMHAC, consumers, and advocacy groups input in developing budget and statutory amendment proposals -- October, 1989; May and June, 1990.
3. Meet with mental health providers to ascertain provider needs and effective approaches to programmatic issues -- October, 1989; May, 1990.
4. Recommend "clean up" language changes for CMHA and Children's Comprehensive Mental Health Act consistent with research findings -- November, 1989.
5. Provide legislative analyses and fiscal notes as appropriate -- October, 1989 to April, 1990.
6. Participate in developing draft plan for funding mechanism for children's services - June 1, 1990.

C. To develop new high quality services for children with emotional disturbance.

TASKS:

1. With EPSDT, Minnesota Department of Health, and Minnesota Department of Education staff. determine appropriate mechanism for including mental health need identification in EPSDT and ECS (Early Childhood Screening) as part of Early Identification and Intervention Service -- January 1, 1990.

2. With EPSDT and Minnesota Department of Health staff, determine need for and appropriate method of providing training to EPSDT providers on use of mechanism -- January 1, 1990.
3. With Health Care Management and Children's Division staff, determine appropriate standards for Home-Based Services so that rulemaking can occur -- June, 1990.
4. With Children's Health Plan (CHP) staff, participate in study of mental health services inclusion in Children's Health Plan -- January, 1990.
5. With CHP staff, determine appropriate standards for and develop provider and informational bulletins on use of CHP for outpatient mental health services for eligible children -- June, 1990.
6. Collaborate with Children's Services Division in development of a white paper on rules governing children's services -- August 31, 1989.
7. With Children's Services Division, develop RFP for pilot program in therapeutic foster care, review grant applications, and award grants.
8. With Children's Services and Licensing Divisions, determine what licensure requirements and training are necessary to assure quality of therapeutic foster care so that rules can be promulgated -- June, 1990.
9. With Special Education and Children's Division, develop RFP for pilot program in family community support services -- June, 1990.
10. With Medical Assistance and Special Education, determine what standards and training are necessary to assure quality of family community support services so that rules can be promulgated -- June, 1990.
11. Provide staff support to the Children's Subcommittee of SMHAC to enable participation and involvement in Tasks 1-13 -- ongoing.
12. Issue bulletin on continuation of county children's demonstration grants from ADM funding -- July 15, 1989.
13. Review applications for county children's demonstration grant funding -- August 1-15, 1989.
14. Award grants for county children's demonstration projects -- August 15, 1989.
15. Determine whether to renew county demonstration evaluation contract at the University of Minnesota and if appropriate design ongoing evaluation/data collection mechanism for county demonstration projects -- March 1, 1990.
16. Issue continuation bulletin on county children's demonstration projects -- May 1, 1990.

17. Collect and analyze evaluation data on county children's demonstration projects -- May, 1990.
18. With Health Care Management Division, determine appropriate standards for case management for children so that rules can be promulgated -- June, 1990.

D. To assure that mental health services development and implementation is coordinated at the local level.

TASKS:

1. Identify training needs of local coordination councils -- February, 1990.
2. Provide workshop for local mental health advisory councils, including children's subcommittee -- February, 1990.

E. To assure individual case level coordination among service providers and clients.

TASKS:

1. Plan and schedule training for children's case managers -- June 1990.
2. Participate with Special Education and Developmental Disabilities Division in State Transition Interagency Committee process (responsible for issues pertaining to transitioning persons with disabilities from services to community living) -- ongoing.

F. To supervise counties in planning for and providing mental health services.

1. Develop Children's Mental Health Plan review process -- July, 1989.
2. Issue instructions for Children's Plan -- July, 1989.
3. Review county Children's Mental Health Plans -- November 15, 1989 to March 9, 1990.
4. Provide counties with children's information from CASSP and from other states on programs, treatment, modalities and research regarding service provision in the least restrictive environment appropriate to the clinical needs of the child -- ongoing.

G. To implement statutory requirements for reporting children's residential treatment data.

TASKS:

1. Compile data from facilities and hospitals on children's mental health placements -- October, 1989.

2. Incorporate data into state children's mental health planning -- November, 1989.
3. Recommend improvement in Juvenile Code reporting requirements based on data and planning -- November, 1989.

H. To implement statutory requirements for annual report from the local children's coordinating councils.

TASKS:

1. Develop a format for report and advise counties and councils -- December 1, 1989.
2. Assist local councils in obtaining the required data -- ongoing -- January, 1990.
3. Collect data and prepare report -- June, 1990.

I. To assist counties in identifying children in need of services.

TASK:

1. Provide counties with report on symptoms and predictors of emotional disturbance in children -- January 1, 1990.

J. To determine the best methods for assuring that out-of-home placements of children are appropriate and necessary.

TASKS:

1. Establish contract for preparation of analysis for joint adult and children's task forces on screening for inpatient and residential treatment services -- August 15, 1989.
2. Establish task forces -- August, 1989.
3. Develop task force recommendations and submit report to Legislature as required by statute -- August 1989 to February 15, 1990.
4. Advise/update SMHAC on progress of efforts; provide staff support for SMHAC participation if appropriate -- ongoing until February 15, 1990.
5. With Medical Director and Residential Program Management Division, determine appropriate services for children in the regional treatment center system -- June, 1990.

Provisions of the 1987 Comprehensive Mental Health Act were described in Minnesota's January 1989 State Plan. As implementation has proceeded, a number of key issues have been either newly identified or have been confirmed as ongoing aspects of Minnesota's system requiring attention.

This Chapter provides an overview of these issues and gives plans on the part of DHS to address them. It is not intended to be a presentation of all of the activities of the MHD to implement the Comprehensive Mental Health Act, but rather to give focused attention to key systemic issues. A primary goal of the MHD continues to be to ensure that statewide availability, accessibility, and provision of services for children and adults, including multicultural services, as required by the 1987 and 1989 Comprehensive Mental Health Acts.

1. Case Management Services for Persons with Mental Illness:

Background:

Case management services are defined in the Comprehensive Mental Health Act as services designed to help adults with serious and persistent mental illness gain access to needed medical, social, educational, vocational, and other necessary services as they relate to the persons's mental health needs. According to statute, case management services are to be coordinated with community support programs, which are also mandated to be available in each of the 87 counties in Minnesota.

The primary goal and responsibility of the case manager is to develop an individual community support plan which is based both on a diagnostic and a functional assessment. The case manager then refers the person to needed mental health and other services identified in this plan, and provides the coordination and ongoing monitoring and evaluation of these services. DHS views case management as a cornerstone to the overall delivery of a comprehensive mental health system for persons with mental illness in Minnesota.

The underlying philosophy of case management in Minnesota is based on the idea that adults with serious and persistent mental illness:

(1) are often involved with more than one service provider;
(2) have difficulty managing multiple systems, e.g., mental health, financial, social services, education; and
(3) are unable to access necessary mental health services.

Case management is one of the services required by the Comprehensive Mental Health Act to ensure the provision of services in the least restrictive environment which

increases the level of functioning and safety of children and adults needing services.

The delivery of case management has been defined in Rule 74 (the DHS body of regulations governing its provision) to ensure that each adult with serious and persistent mental illness will be offered the services of a case manager with primary responsibility for assisting that person in accessing the kinds of services necessary to enhance that person's life. The responsibility for providing the service rests with the county or local agency. The rule requires the first source of payment to be Medical Assistance (MA) for eligible persons, and targets this assistance toward persons with the most serious illnesses to help ensure that they are a priority for receiving such services. However, counties are required to make case management available to all persons with mental illness, and may use CSSA (Community Social Services Act) dollars and Rule 14 funding for non-MA eligible persons.

Another component of Minnesota's philosophy is that the case manager should work with persons in an ongoing manner over the long term so that the case manager will continue to follow up and be a constant presence in that persons life, whether or not that client:

- is involved in one or many services;
- is successful or unsuccessful in a variety of programs; or
- is hospitalized,

A third component is that case management needs to be provided in the client's own environment. This means that the responsibility to access case management should be the case manager's.

An amendment to the 1987 Comprehensive Mental Health Act added a provision to permit refugees to receive case management services from other refugees who may not yet meet the minimum professional requirements of a case manager. The amendment includes a sunset provision to allow existing refugee case managers additional time to meet the minimum requirements.

Current Issues:

1. Implementation: The implementation of case management services began January 1, 1989, and thus is in its initial stages. It is anticipated that, over time, the MHD will continue to identify specific problems that will need to be addressed.

Initially, counties resisted providing case management. This resistance was partly due to the development of case management as an independent mental health service and not as a traditional social service function of the county. Counties have needed to restructure and reorganize internal administrative processes to accommodate the provision of case management as defined in Rule 74. In many cases, these adjustments have led the county to become a vendor of services in much the same way as other mental health providers in the overall system.

2. Reimbursement rate: There continues to be concern that the MA reimbursement rate for case management is not adequate to cover the true cost of providing the service. This appears to be more of an issue in the metropolitan area than in greater Minnesota. Metro counties have tended to use county social workers and service providers as case managers. Often the experienced social worker earns significantly more than the reimbursement rate allows. Many metro area social workers have master's degrees with several years experience, while Rule 74 requires case managers only to have a bachelor's degree and one year of experience.

3. Functions of the case manager: Finally, there are concerns that Rule 74 limits the function of the case manager. Rule 74 clearly defined the role and responsibilities of case managers and further requires that they not provide mental health and other services to clients they are case managing. This is to comply with federal MA regulations, and, from a programmatic perspective, ensures that the case manager continues to work with the client beyond a time-limited treatment period.

Plans for the next year include:

A. Continued education regarding Rule 74, with clarification that it is not only an MA reimbursement rule, but is also based on sound mental health principles to best meet the needs of persons with serious and persistent mental illness.

While technical assistance was provided to all counties as part of the implementation of Rule 74, additional assistance will be given to case management providers in developing the internal structure and organization necessary to accommodate the implementation of Rule 74.

B. Joint monitoring by the Mental Health and Medical Assistance Reimbursement Divisions of DHS to ensure that counties are maximizing the availability of MA as

a funding source, yet not using the MA reimbursement rate as the sole funding source.

C. Development of a case management implementation committee. The function of the implementation committee is to identify issues and concerns, suggest solutions, and otherwise advise the MHD on the implementation of case management services in Minnesota. It includes representatives from the Minnesota Association of County Social Services Directors, the State Mental Health Advisory Council and the Children's Subcommittee, the Minnesota Association of Community Mental Health Center Directors, the Mental Health Association of Minnesota, the Alliance for the Mentally Ill, and consumer and case manager representatives.

2. Community Support Services for Persons with Mental Illness:

The MHD continues to provide technical assistance to counties to develop or continue community support programs (CSPs) as needed. A highlight of this past year's technical assistance effort was a statewide, three-day conference attended by 300 CSP workers, county social service administrators, local advisory council members, and others. Norma Schleppegrell, Chair of the State Mental Health Advisory Council, and Howie the Harp, consumer organizer from Oakland, California, provided keynote presentations. The Department of Human Services' Medical Director, Thomas Malueg, also gave a presentation on linkages between regional treatment centers (RTCs) and community support programs (CSPs). Limited scholarship funding allowed two persons from each Minnesota county to attend without charge.

The conference's success was indicated by plans to replicate it annually, with the second conference scheduled for May, 1990.

In addition to the provision of technical assistance by the MHD, the Governor submitted to the 1989 Legislature a request to expand funding for CSPs so that each county would receive a minimum of $50,000 or $1.80 per capita in state funding. However, the Legislature approved only enough funding for $40,000 or $1.65 per capita, so full implementation of CSPs in all counties may be somewhat delayed. This issue will need to be revisited in upcoming legislative sessions.

In fact, a special session of the Minnesota Legislature in September, 1989, may take up the issue of state take-over of some county funded social services costs. The MHD is investigating the possibility of securing additional funding for CSPs as part of that process.

3. Employability Services for Persons with Mental Illness:

Background:

Employability services are increasingly being viewed as top priorities in the development of a community based system for persons with mental illness. Indeed, along with housing, employability was considered most important in a recent survey of consumer members of local mental health advisory councils.

Through an interagency agreement created in 1987, the MHD has been coordinating efforts with the Division of Rehabilitation Services (DRS), part of the Minnesota Department of Jobs and Training to establish employability and work-related opportunities in all areas of the state. These services are designed to be a part of CSP services in all 87 counties and include:

a. functional and situational employability assessments to determine the person's employability needs, strengths, and goals;

b. habilitative services designed to prepare the person for employment in the community; and

c. ongoing supportive services (not time limited) to enable the person to manage his or her mental health in the work setting and to stabilize and maintain employment.

Current Issues:

Employability services have for some time been inadequate to meet the need in Minnesota. The historical mission of DRS has been to serve persons with physical and developmental disabilities; only recently was there a recognition of the job-related needs of persons with mental illness. In addition, while DRS provides services such as job training and placement, work evaluations, and so forth, the CSP program role is to assist persons with mental illness to improve their employability through activities such as medications management or assistance in developing social interaction skills through employment or volunteer work.

Although funding for employability services historically has been inadequate, many counties have created their own programs by using Rule 14 (the source of funds for CSP services) and other funds. With the passage of the Comprehensive Mental Health Act, all counties were required to provide employability services as part of a full array of CSP services. Counties which had been using their entire Rule 14 allocation to finance employability services were

now faced with the need to provide all CSP services rather than just one component. At the same time, other counties which had not previously used Rule 14 funds for employability services now were required to do so. The availability and quality of such services has been uneven as a result.

In response, DRS continues to have as a top priority the development of services for persons with mental illness. The 1987 DRS/MHD Interagency Agreement clarified responsibilities and workplans.

Tasks:

1. Meet with DRS on employability issues 6 times a year -- ongoing.
2. Develop workplan with DRS -- December 31, 1989.
3. Renew DHS/DRS interagency agreement -- December 1989.
4. Participate in monthly internal DHS supported employment meetings and State Supported Employment Advisory Council meetings -- ongoing.
5. Participate in review process for DRS-MI grants -- ongoing.

4. Institutions for Mental Diseases (IMD's):

Background:

As a result of federal legislation and the Health Care Financing Administration regulation which reclassified services provided to persons with mental illness in residential treatment programs, a number of facilities were declared IMDs on January 1, 1989. The effect of this declaration was to make the residents of these facilities ineligible for all MA funded services.

The 1989 Legislature precluded the possibility of mass discharges from residential facilities by expanding eligibility guidelines for GAMC to include persons who would have been eligible for MA if they hadn't been living in these facilities. The Legislature also:

1. expanded the types of services under GAMC to more nearly equate to those under MA, including reimbursement for case management services;

2. let expire a temporary provision which had reimbursed mental health providers less under GAMC than under MA. The effect of this provision could have been to discourage mental health providers from serving persons receiving GAMC; and

3. raised the room and board reimbursement rate for residential treatment providers to the level allowed under the state's MSA program.

In the next year, the MHD will be working with providers to downsize facilities, where feasible, to 16 or fewer beds to fall under the bed capacity set by federal law. Five facilities have downsized to 16 or fewer beds to date.

A number of reports and studies on the housing and residential treatment needs of persons with mental illness were required by the 1989 Legislature. As the MHD prepares or participates in the development of these studies, additional plans will be developed. The MHD continues to discuss the long term implications of the IMD regulations on the funding and structure of Minnesota's mental health system.

For more information, see the following sections on housing issues, the Nursing Home Reform Act, and revisions to DHS Rule 36.

Tasks:

1. With Long Term Care Division staff, undertake the IMD study required under M.S. 245.463, subd. 3, including data collection, projected fiscal impact of maximizing availability of MA for persons with mental illness residing in IMDs -- January, 1990.
2. Develop a plan to identify the long term fiscal impact of downsizing facilities to avoid IMD determination and to study mental health funding as required by M.S. 245.463 -- April, 1990.
3. Assist facilities identified as IMDs or potential IMDs in downsizing, obtaining JCAHO accreditation, etc., to permit residents to regain/retain MA eligibility -- June, 1990.
4. Advise/update and provide staff support to State Mental Health Advisory Council on progress of these efforts -- ongoing.

5. <u>Housing Services for Persons with Mental Illness</u>:

<u>Background</u>:

Housing for persons with mental illness continues to be identified as a primary need of persons in need of a community based system of services. It was identified as the greatest need among non-mental health services in a recent survey of consumer members of local mental health advisory councils.

In addition to continuation of efforts to serve homeless persons with mental illness (See Chapter V) and revisions to DHS Rule 36, the MHD plans to continue for a second year several housing support pilot projects. This second year funding was made possible with the appropriation of $500,000 from the 1989 Legislature. These pilot projects will result in the collection of information and experiential data for a base of information on what services work well in Minnesota to help persons maintain their living situation. Tasks related to this effort are listed below.

The 1989 Legislature also established in law a mission statement on housing upon which the MHD's implementation plans will be based.

> "The Commissioner shall ensure that the housing services provided as part of a comprehensive mental health service system:
>
> (1) allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;
>
> (2) allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and
>
> (3) provide necessary support regardless of where persons with mental illness choose to live."

Finally, a representative of the Minnesota Housing Finance Agency (MHFA) has joined the State Advisory Council at the same time as coordination of efforts continue between the MHD and relevant staff persons at Minnesota HFA. These developments are in addition to an appropriation by the 1989 Legislature to the MHFA to provide additional housing subsidies and loans for persons with mental illness.

Other efforts include MHD participation in the development and review of HUD 202 applications with the Minnesota Office of Housing and Urban Development. HUD 202 applications include the rehabilitation of old, and development of new, buildings for persons with mental illness.

TASKS:

1. Assess value of housing support projects and their continuation -- December, 1989.
2. Issue continuation bulletin for F.Y. 91 Housing Support Services if appropriate -- January 1, 1990.
3. Review applications for Housing Support Services, if appropriate -- May-June 1990.

4. Award grants/contracts for Housing Support Services, if appropriate -- June 30, 1990.
5. Collect and analyze evaluation data on Housing Support Services for use in F.Y. 91 grant reviews and for preparation of 92-93 budget, if appropriate -- May 1, 1990.
6. Meet with Interagency Task Force on Homelessness -- ongoing.
7. Coordinate with HUD and HFA regarding housing issues of persons with mental illness -- ongoing.
8. With Department of Health and DHS Divisions, participate in the development of Supportive Living Residences emergency rule and report to the Legislature as required by 1989 Session Laws, Chapter 282, Section 213 -- January, 1990.

6. OBRA -- The Federal Nursing Home Reform Act:

Background:

The MHD is implementing the Federal Nursing Home Reform Act (P.L. 100-203) by adapting the previously existing nursing home preadmission screening program of DHS and by utilizing the Quality Assurance and Review program of the Minnesota Department of Health.

In 1979, the Minnesota Legislature decided to develop a program which would help prevent the premature or unnecessary institutionalization of elderly people, by screening all applicants to nursing homes to determine if nursing home placement is necessary or desirable. In 1980, the Minnesota Legislature established a pre-admission screening program for nursing home applicants in two counties as a pilot project. The pilot project proved to be successful and, in the 1981 Legislative Session, the program was funded for statewide implementation. In addition, the program was expanded to include funds for alternative care grants for case management, adult day care, homemaker services, home health aide services, foster care services, personal care services and respite services.

The Pre-Admission Screening Program is perceived as a valuable, systematic approach to assess the need for and the provision of long-term care services. Therefore, the MHD determined that the most effective method by which to implement P.L. 100-203 would be to build upon the existing Pre-Admission Screening Program.

Prior to the enactment of P.L. 100-203, the MHD was awarded an NIMH grant for a demonstration of community based services for older adults with serious and persistent mental illness. (See Chapter V, section on Mental Health Services

for Older Adults.) Objectives of the project included enhancing the mental health portion of the pre-admission screening process and improving community based services for older adults regardless of their place of residence. The Pre-Admission/Alternative Care Grant rule now requires that a Pre-Admission Screening team that has reason to believe a person being screened has been diagnosed or may be diagnosed as mentally ill to refer the person for services. These services include screening, development of an individual service plan and case management services under the Comprehensive Mental Health Act. Also, the Pre-Admission Screening instrument has been revised to include an enhanced mental health screen.

Each county will be required to develop and submit a plan which must describe how they will implement OBRA. This supplement will require the following information:

1) identification of person(s) responsible for implementation of P.L. 100-203;
2) development of policies and procedures for handling referrals from the pre-admission screening team and from the ARR process, making arrangements for diagnostic assessments, determining whether nursing facility services are appropriate, and arranging for safe and orderly discharges as required; and
3) development of systems to monitor implementation and track persons identified in the Pre-Admission Screening/Annual Residence Review (PASARR) process.

Residents will be encouraged to participate in determining appropriate alternative placements and mental health services. In addition, Minnesota Statutes, Section 245.467, Subdivision 1, mandates that the required services be provided under conditions which protect the rights and dignity of the individuals being served; be provided in the most appropriate, least restrictive setting available to the local mental health authority; and be based on individual clinical needs, cultural and ethnic needs, and other special needs of individuals beings served.

Although Minnesota does not anticipate that a large number of persons with mental illness will need discharge from nursing facilities in order to comply with P.L. 100-203, one must be mindful of the fact that the mental health system is in transition and that by April 1, 1990, local mental health authorities will have had less than two years to develop services mandated by the Comprehensive Mental Health Act.

In fact, case management, probably the most crucial component in ensuring a safe and orderly discharge for persons with mental illness, will have been operational for only a little over a year. (Moving all 300 persons by April

1, 1990, has budget implications of up to $5,000,000 per year and sufficient state funding cannot be obtained to relocate and provide or arrange for the provision of appropriate mental health services for all 300 persons by that time). Therefore, in order not to overburden a development mental health system, the MHD requested an extension to June 30, 1992, which HCFA approved.

The 1989 Legislature approved additional funding to support alternative services (primarily Community Support Services and Residential Treatment Services, including relocation to appropriate Institutions for Mental Diseases) required to relocate a portion of the 300 persons each year between April 1, 1989, and June 30, 1992.

Based on Quality Assurance and Review (QAR) data from the Department of Health from September, 1988, 586 persons were in nursing facilities who were not of advanced age and who were identified as having a diagnosis of mental illness, excluding Alzheimer's disease or related disorder, and who were additionally identified as not having a terminal condition or severe illness. It is expected that after assessing each individual, about 300 persons currently residing in nursing facilities may need to be discharged in a safe and orderly manner.

In January, 1989, county nursing home Pre-Admission Screening teams began implementing the Pre-Admission Screening process required by P.L. 100-203 and, in April, 1989, the Health Department Quality Assurance and Review teams began implementing the Annual Resident Review process required by P.L. 100-203, as described in the state's Alternative Disposition Plan.

All 87 Minnesota counties have begun to develop a system of locally available and affordable mental health services. Although all of the services should be available for an individual who must be discharged from a nursing facility, current funding is limited, as counties had developed their initial plans based on the needs of persons who were then residing in non-institutional settings. Many local authorities were unable to anticipate the need for additional services for this population.

Objective:

A. To supervise local mental health authorities in arranging for the safe and orderly discharge of persons with mental illness who are found to be inappropriately residing in nursing facilities.

Tasks:

1. Identify county contacts -- July 1, 1989.

2. Develop and implement data collection system to monitor implementation of OBRA/PASARR process.
3. Issue bulletin/RFP regarding state alternative placement funds -- August 15, 1989.
4. Provide technical assistance on OBRA to counties and providers -- September 1989.
5. Report to HCFA -- August 1989, February 1990.
6. Receive applications for alternative placement funds -- October 1, 1989.
7. Prepare LAC report for state OBRA funds transfers, if appropriate -- November 1, 1989.
8. Establish alternative placement monitoring system -- June 1989.
9. Assist counties in their use of PASARR process for determining appropriateness of mental health placements -- ongoing.
10. Provide monitoring and technical assistance for alternative placements -- ongoing.
11. Issue bulletin for F.Y. 91 funds -- January, 1990.
12. Review applications for F.Y. 91 -- May 1, 1990.
13. Award F.Y. 91 grants -- June 30, 1990.
14. Make ARR referrals to counties -- ongoing.

B. Schedule:

January 1, 1990 to March 30, 1990:

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

April 1, 1990 to march 30, 1991:

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

April 1, 1991 to June 30, 1992:

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

7. Rule 36 -- Revision of Rule 36 and Reconfiguration of Licensed Residential Programs for Adults with Mental Illness:

Background:

Rule 36 is the body of DHS regulations that govern the provision of rehabilitation services in residential treatment settings for adults with mental illness. Most

facilities governed by Rule 36 are based in the community, although Minnesota's regional treatment centers also hold Rule 36 licenses. The rule is being revised for the first time since 1982. The rule revision process is expected to take 18 to 24 months.

Prior to the development of a first draft of the rule, three focus group meetings were held, two involving consumers of mental health services, and one with providers of residential treatment services.

The purpose of the consumer focus group was to gather input on each individual's first hand experience in residential based rehabilitation services under the existing rule. Topics discussed included issues such as client rights, family involvement, health and safety, and quality of care.

The provider focus group was convened to gain input on a variety of technical concerns regarding the delivery of services. These include program evaluation, treatment planing, core services in a residential rehabilitation program, and service models.

The input from these focus groups was used in combination with reviews of recent research findings and program models in other states to complete an initial draft of the rule.

Next, an advisory committee was formed in May 1989. Membership includes consumers, family members, advocacy groups, providers, county social service agencies, and regional treatment centers. Throughout the process, the advisory committee will review and provide input relating to drafts of the rule as they are developed.

Tasks have been assigned to subcommittees of the advisory committee on issues relating to rehabilitation services in a residential setting, including health and safety standards, crisis services, adult foster care program and licensing, and the provision of rehabilitation services within and in coordination with regional treatment centers. The subcommittees will meet throughout the rule writing process, as needed, to provide information in the development of future drafts of the rule.

Current Issues:

Rule 36 will need to address a number of issues, many of which were identified in the information gathering process described earlier. These issues include:

(1) Client Empowerment:

Assuring through the rule that those who are receiving the services are allowed to make choices on their own

behalf, and that their individual freedom and independence is promoted within programs;

(2) Regulatory Consistency:

The rule will be updated to correspond with the requirements and standards existing in the Comprehensive Mental Health Act and current statutes, rules, and regulations.

(3) Quality Assurance:

The rule will require all mental health services to be based upon current research and accepted contemporary professional practices. It also will require services to be available to persons of all ages and ethnicities.

(4) Expansion of the Array of Services:

The treatment needs of individuals who have a mental illness are often better met through services other than those that are provided by a traditional halfway house. For this reason, the scope of Rule 36 will be expanded to include additional types of residential based rehabilitation programs and services.

(5) Facility Size:

The rule will address the reduction and/or limitation of the size of current residential treatment programs. Currently, many facilities in Minnesota have more than 16 beds. This not only increases the likelihood of such facilities becoming "mini-institutions", but residents of such facilities are ineligible for Medical Assistance under the recent MA/IMD interpretation. In an effort to create environments which are more conducive to effective treatment and community integration, DHS will phase out some of its larger programs and limit the development of larger new Rule 36 programs.

Tasks:

1. Complete Rules 12/26 revision including appropriate sections on crisis/respite residential services -- April, 1990.
2. Advise/update SMHAC and Children's Subcommittee on progress in rule development -- ongoing.
3. Work with the Legislative Audit Commission in providing information for Rule 36 audit -- ongoing until October, 1989.

4. Review Legislative Audit Commission's Draft Rule 36 Audit Report -- October, 1989.

8. State Health Facility System:

Background:

Eighteen months ago the Commissioner of Human Services brought together representatives of 34 separate interest groups to begin negotiating a plan for the future direction of the state regional treatment centers. Membership included representatives of mental health consumer, family, provider organizations, communities, and representatives of employees working in the regional treatment centers. A consensus proposal was reached in March, 1989, and brought to the 1989 Legislature for action.

The proposal restated the role of the RTCs and a modified plan was approved. Because inpatient psychiatric care is one component in the array of mental health services available statewide, RTCs will continue to provide such services to residents of their service areas. Inpatient active psychiatric treatment will continue at Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter and Willmar. Expansion of these facilities will occur in conjunction with the Comprehensive Mental Health Act.

Specifically:

- By January 31, 1990, a proposal to recapitalize three state psychiatric facilities will be developed.

- By January 1, 1990, a plan to establish 35 auxiliary Minnesota Security Hospital beds will be developed.

- Beginning July 1, 1991, a system of state-operated, community based programs for persons with mental illness may be established.

Responsibility for implementation will be vested in a transition team of persons experienced in mental health delivery systems. The transition team will be responsible for the coordination of implementation efforts throughout DHS and the state. The team will work with employees of individual RTCs, unions, county agencies, and communities to see that progress is made.

A DHS policy board will provide guidance and direction to the transition team. The policy board is composed of the Deputy Commissioner, the State Medical Director and DHS' Assistant Commissioners, including the Assistant Commissioner for Mental Health.

The 1989 legislation requires the need for psychiatric services to be based on individual assessments of persons in the RTCs. Under the leadership of the State Medical Director, a clinical survey of patients was initiated in June, 1989. The results of this clinical survey, to be available in the fall of 1989, will become the cornerstone of a major effort to redesign treatment programs within RTCs for persons with major mental illness.

The implications of this data for the purpose of planning outpatient programs are also clear. The data will indicate in which programs patients could best be treated, and how many patients are suitable for community care. The need for continuity of care between hospital and community will become more evident.

Target dates for this statewide patient survey are:

- June, 1989.....Survey data collection.
- October, 1989.....Data analysis and development of patient and facility profiles.
- December, 1989.....Final report of survey and recommendations for program planning.

Purpose:

Currently there are six RTCs providing inpatient treatment to people with mental illness. The centers provide active psychiatric treatment designed to:

- Stabilize the individual and the symptoms which required hospital admission;
- restore individual functioning to a level permitting return to the community;
- strengthen family and community support; and
- facilitate discharge, after care and follow up as patients return to the community.

The primary mission of the RTCs is to provide quality services and appropriate individualized treatment in accordance with contemporary professional standards. This will require higher staff to patient ratios, employment of well-qualified staff, continued training of staff and upgraded physical facilities.

Services Offered:

Psychiatric services currently offered by the RTCs may be classified broadly as follows:

A. Inpatient hospital psychiatric services, including:

1. Crisis stabilization and emergency services;

2. Acute inpatient care of a duration shorter than 30 days, actively focused, designed to address the sudden onset of mental illness or an acute episode of mental illness, and to return the individual to community living as quickly as possible;

3. Intense psychiatric treatment, generally of longer than 30 days duration, actively focused, for persons with major mental illness whose acute symptoms are not promptly resolved and who require highly structured treatment, programs and supervision and for whom a community placement is not clinically appropriate.

B. Other psychiatric services, including:

1. Continued care for persons until their symptoms have been stabilized, at which time transition to an appropriate community placement will be planned in conjunction with the county;

2. Short-term services to discharged patients to facilitate their transition back to the community;

3. Services for persons committed by the court;

4. Professional and consultative services as appropriate and as may be arranged through shared service agreements.

Funding was included in the legislation to plan for a modern psychiatric facility to serve the heavily populated metropolitan area. Funding was also allocated to plan for the upgrading of three of the regional psychiatric treatment facilities.

Objective:

To collaborate with the Residential Program Management Division and Transition Team to enhance service quality in the RTC system and to promote continuity with community-based services.

Tasks:

1. Work with RTC transition team to provide input for decisions about RTC-MI program development, including planning for MI-state operated community services (SOCS) and secure facility use and development -- ongoing.

2. With Medical Director and Residential Management Program Division, determine what services for children are appropriate in the RTC system -- June, 1989.
3. Participate in analysis of RTC assessment data -- October-December, 1989.
4. Participate in final report on RTC client needs -- January, 1990.
5. Participate with Medical Director in consideration of criteria development for admission and continued stay in RTCs -- June 1, 1990.
6. Incorporate retraining programs for RTC staff into overall statewide Human Resource Development (HRD) program -- June, 1990.
7. Provide staff support to SMHAC's legislative mandate to be involved in RTC issue resolution, including assessment -- January, 1990.
8. Begin process for determining appropriate regulatory mechanism for RTC programs -- June, 1990.
9. Participate with Residential Program Management Division regarding nursing home bed placements planning for RTCs (M.S. 251.012), Subd. 1 and 2) -- June, 1990.
10. Develop a plan for assessing mental health needs in south east Minnesota -- January 1, 1990.
11. With Medical Director and Residential Program Management Division, plan for establishment of 35 security beds at Brainerd RTC -- January 1, 1990.

## 9. INFORMATION SYSTEMS

Background:

Agencies of the state of Minnesota did not have an integrated mental health information system prior to 1989. Mental health data were collected through a combination of methods: annual aggregate reports from state-funded community support (Rule 14) or adult community residential treatment (Rule 12) programs; fiscal year summaries of counties' use of RTCs; fiscal year summaries of the use of MA-reimbursed mental health services; and calendar year aggregate reports of mental health service use from county social service information systems.

There were several problems with this makeshift "system", including:

1. data were not compatible across data sources;
2. the aggregate nature of much of the data limited the number of useful analyses;
3. data from the county social services system was out of date and questionable in its reliability and validity, due mainly to definitional problems;

4. very little information on non-grant reimbursed mental health services provided by mental health centers could be linked to a specific provider; and
5. without client-specific information across the different systems, an accurate, unduplicated count of clients and service use was impossible.

Partly out of response to the problems caused by the lack of an integrated mental health information system, the 1987 Legislature mandated the establishment of a "Mental Illness Information Management System" by January 1, 1990. To meet that requirement, the MHD is implementing a management information system (MIS) throughout 1989, which will provide a more complete picture of all publicly funded mental health services.

The MIS is composed of two major subsystems. The first is a recently implemented system of data transfer from the data systems of local service providers to the state agency. A core set of data on publicly funded services and clients are transferred through various electronic and paper media. This subsystem is called the Community Mental Health Reporting System (CMHRS).

The second subsystem is a set of reports and special studies designed to meet information requirements that the CMHRS is unable to meet. It typically addresses issues that are too specific and nonroutine for the CMHRS. This second system is particularly important in producing information about client and service outcomes in state grant programs.

Further development of the MIS is planned in three areas:

1. increasing the performance of the system;
2. expanding the capabilities of the database subsystem; and
3. developing decision-support procedures that will enable the use of data-based information in decision-making.

Current Issues:

Performance

The adequacy, credibility, and efficiency of the MIS will be formally assessed each year. The purpose of each assessment will be to quantify the extent to which previously identified performance criteria are being met and to identify new criteria. The assessments will also specify changes to be made in the system.

1. Adequacy will be measured in terms of the number of information requirements the system is able to meet.

Some of these requirements have been identified in the legal and regulatory mandates of DHS, and in the Division's workplan; others will arise more spontaneously from management, policy makers, service providers, and the public in the course of conducting business. Currently, the system is not capable, in its content, of meeting all known requirements. Adequacy will increase as the capabilities of the system are expanded (see below).

2. In past years, users of state level information have increasingly questioned its quality. Information credibility, based on the validity, reliability, and accuracy of measurement (data), and on the integrity of data processing techniques is now a primary concern of the MHD. Assessment of performance will look at all of these aspects of the system, with special attention to computation of data error rates for the purpose of identifying where better data definition and more training is needed.

3. Implementation of the new database subsystem had as one of its main objectives the replacement of labor intensive statistical reports from service providers with more efficient methods. Database to database transfers coupled with more focused studies using statistical samples would be less intrusive, more productive, and less costly in the long run. Assessments of the MIS will determine the extent to which this replacement has occurred.

Capabilities

The database subsystem now includes only nine data elements: program, provider, client ID, sex, race, date of birth, severity of mental illness, service received, and amount of service. These elements are capable of meeting core requirements relating to the concerns of external (e.g., funding) sources, such as accountability, availability, and descriptions of service utilization. However, they are not able to meet many of the questions of management -- planning, control, program development, or program evaluation.

Expansion of the system's capabilities must begin with its content. Grant funding being sought from the federal government will be used to examine which data elements from a set of national data standards will be most useful and cost-effective to implement in Minnesota. The products of this grant will include specification of the changes needed in local systems to capture, store, transmit, and use additional data.

Decision Support

To fulfill its potential, the MIS must include decision-support procedures for integrating the information it produces into decision making processes. These procedures will be developed during the second and third years of the plan period, preceded by an analysis of the decision structure within the MHD during the first year. They will consist of computer programs, spreadsheets, and other software suitable for use by management personnel. Their flexibility will allow decision makers to test alternative decisions against outcomes predicted from the database. Once in place, the ways in which these procedures are used, and by whom, will be continually monitored.

Some initial planned uses for the service data include:

1. Comparison of actual service utilization with county mental health plan projections.
2. Monitoring availability and accessibility of services in each county.
3. Comparison of per capita utilization rates across counties to identify extreme variants.

Objective:

A. To implement the new community mental health reporting system (CMHRS).

   Tasks:

   1. Collect, store, and process data reported through the CMHRS -- ongoing.
   2. Identify incomplete and inaccurate data records, obtain corrected records from counties, and update the database -- ongoing.
   3. Provide technical support -- ongoing.
   4. Manage performance of Division's work items in the CSIS contract -- ongoing.
   5. Meet with Division staff and staff of reporting agencies to identify changes to be made in the CMHRS system to improve its quality and efficiency -- July 1989.
   6. Revise CMHRS system specifications and documentation, and distribute these to reporting agencies -- October 1989.
   7. Provide input and assistance to technical staff regarding the development of children's data reporting -- ongoing.

B. To maintain and manage the computer resources of the Division to maximize staff efficiency and effectiveness.

Tasks:

1. Maintain operational effectiveness of hardware and software -- monthly.
2. Review and revise policies and standard procedures for use of computer resources -- June 1990.
3. Install the hardware and software to implement the network -- July 1989.
4. Obtain training for network administration and operation -- August 1989.
5. Train appropriate division staff to perform E-Mail, file transfer, and peripherals utilization -- September 1989.

C. To implement effective methods to utilize available mental health data from MA/GAMC, RTCs, and other information systems.

Tasks:

1. Test programming and storage requirements for MA/GAMC Extract System -- June 1989.
2. Implement system for storing extracted data -- July 1989.
3. Incorporate MA/GAMC data into state and local reports -- November 1989.
4. Participate in the development of the RTC information system and arrange for appropriate linkages -- ongoing.

# CHAPTER V

# SPECIAL INITIATIVES

## MULTICULTURAL MENTAL HEALTH PROGRAMS

The Mental Health Division recognizes the need to develop programs and human resources to meet multicultural mental health needs in the state. Although the growth of minority populations in Minnesota may not be as substantial as previously thought, (Minneapolis Star/Tribune, July 7, 1989) the experiences with the Asian refugee community (through the NIMH grant) and with Indian communities (through ADM block grant funds) have shown that planning, organizing and delivering services to multicultural communities requires the combined efforts of the Multicultural Program Advisor and the MHD's regional consultants.

The overall goal for the MHD is to utilize special projects as appropriate to promote the development of a unified service delivery system for children and adults which incorporates the culturally, chronologically, and geographically diverse mental health needs of Minnesotans through integration into the mental health system and development of appropriate special programs.

The following sections are updates on the MHD's efforts to meet the needs of diverse populations. Plans for the next year are listed at the end of the Chapter.

Mental Health Services for American Indians

Background:

Agencies that provide culturally relevant services for the American Indian population are limited in number. However, under the Comprehensive Mental Health Act all counties must provide for an array of mental health services to all persons living in a county. The new federal legislation included increased funding for Indian mental health services, setting aside 25% of Minnesota's federal mental health block grant allocation for Indian mental health services. The Minnesota Comprehensive Mental Health Act also created an opportunity for the Indian population to access additional mental health services previously inaccessible due to lack of coordination and gaps in services.

An ideal system would be one which recognizes and accepts cultural differences in mental health services delivery, allows the client to make choices, and provides flexibility the clients and their families. Therefore, in counties where there is a significant multicultural population, the MHD will continue to work with local mental health authorities to develop appropriate services to reach multicultural persons at risk of mental illness.

At the state level, the Minnesota Indian Mental Health Advisory Council, comprised of representatives from the eleven reservations and urban Indian communities of Minneapolis, St. Paul, and Duluth, meets quarterly and provides information to the staff of the MHD on issues, concerns, and needs in their communities. Updates are provided on their mental health programs as well. These meetings also create opportunities to provide mutual support among programs as some are in isolated areas of the state.

The service system problems for the American Indian population in Minnesota are due to cultural differences, inadequate funding, and fragmentation between substance abuse and mental health programs. Results in inefficient and ineffective programs, and a lack of coordination between Indian mental health programs and the local mental health system.

Increased federal block grant funds made it possible to create new and expanded mental health programs in 1988. Two urban programs were funded in addition to the eight programs which had previously been funded.

Indian Health Board, located at 1315 East 24th Street, South Minneapolis, provides comprehensive mental health services for children, adolescents, adults and families. Mental Health services include: outreach and intervention, independent living skills training, a drop-in center program and case management services.

Upper Midwest American Indian Center, located in north Minneapolis, is a multi-service agency and provides the following services: child welfare, employment, housing and education assistance. Through the federal block grant funds, the program has employed a mental health worker to assist American Indians living in north Minneapolis to access mental health services in their area.

The following eight Minnesota reservations continue to receive federal block grant funds to help provide mental health services and have contracts or arrange for provision of services:

1. Fond Du Lac, Cloquet, which includes the Duluth area, provides individual, couple, family, and group counseling and psychiatric and psychological evaluations through a contract with the Human Development Center in Duluth.

2. Bois Forte, located in the most northern part of the state in St. Louis and Koochiching Counties and also serves the Vermilion and Deer Creek communities, provides education and prevention, crisis assistance, outpatient treatment services, outreach and supportive services. The Range Mental Health Center, located in Virginia, Minnesota, provides the five required services.

3. Grand Portage, located in Cook County, provides information and education case management, independent living skills training, client outreach, and consultation. Clinical supervision is provided by Cook County Mental Health Services in Grand Marais, Minnesota, which is 35 miles south of Grand Portage.

4. Leech Lake, located 14 miles east of Bemidji, provides case management, client outreach, crisis assistance, medication management, education and prevention, and advocacy. (The reservation extends into five counties: Cass, Itasca, Beltrami, Hubbard and Crow Wing.) The Upper Mississippi Mental Health Center (Bemidji) provides coordination.

5. Mille Lacs, located in the four north central counties of Aitkin, Mille Lacs, Pine and Kanabec provides outpatient counseling, consultation, education, and coordinating services with the three counties of Aitkin, Mille Lacs and Pine. The two local mental health centers are Northland Mental Health Center, Grand Rapids, and Five County Mental Health Center, Braham. Regional treatment centers located in Brainerd and Moose Lake are also available.

6. Lower Sioux Community, at Morton in Redwood and Renville Counties, provides outreach services and information and referral to West Central Community Services Center (Willmar) and to the Rural Rainbow Project at Marshall, Minnesota.

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

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

The following two Minnesota Reservations provide mental health services, but do not receive federal block grant funds:

1. White Earth, located in the northwestern part of the state in Mahnomen, Clearwater, and Becker Counties, includes the Indian communities of White Earth, Pine Point/Ponsford, Naytahwaush, Rice Lake, Calloway, Elbow Lake and Ebro. The mental health services are provided through Indian Health Services and include family therapy, marriage counseling and child/adolescent behavioral evaluation. Fergus Falls Regional Treatment Center is used for extended mental health treatment.

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

One Minnesota reservation, Red Lake, is a "closed" reservation and is not subject to state law. Therefore, the reservation does not have a contract with the state for providing mental health services using federal block grant funds. The reservation, located in northwestern Minnesota, includes four reservation communities: Red Lake, Redby, Ponemak and Little Rock. The reservation provides a comprehensive health care program for their enrolled members.

## Mental Health Services for Refugees

Background:

Minnesota ranks fourth among the states for refugees resettled within their borders, with an estimated refugee population of 37,862. The state continues to accept new refugees, with 1,174 new arrivals during the first half of F.Y. 1989, and has historically been an area of net gain due to secondary migration of refugees as well. Because of these factors, refugees are a prominent special needs group within the mental health services system.

In an effort to address those needs, Minnesota became one of twelve states to participate in the Refugee Assistance Program-Mental Health (RAP-MH) program funded by the federal Office of Refugee Resettlement and administered by the National Institute of Mental Health. The Minnesota RAP-MH program has been housed within the MHD as the "Refugee Mental Health Program" (RMHP). After a no-cost extension of the RAP-MH grant monies, the RHMP will end on August 31, 1989.

During its existence the RMHP has:

1. identified the mental health needs of refugees;
2. ascertained gaps in service provision;
3. identified system changes needed to improve refugee access to mental health services;
4. identified and design model programs;
5. identified resources in the state;
6. coordinated and provide training to mainstream and bicultural staff;
7. provided a mechanism for networking and resource development; and
8. made recommendations about service provision to refugees.

Several changes over the past year, both legislative and administrative, should improve the quality and availability of mental health services for refugees.

Legislative changes include:

a. appropriation of funds for refugee and immigrant social adjustment/mental health programs;
b. appropriation of funds to reimburse the cost of language interpreters in MA-reimburseable health care situations; and
c. a sunset waiver (effective until 6/30/91) allowing bilingual refugee mental health case managers to operate under supervision while working toward credentials required for case managers.

Administrative changes include:

a. a grant with the Mental Health Association of Minnesota (D/ART - Depression/Awareness, Recognition and Treatment) and the Zumbro Valley Mental Health Center to translate educational materials into refugee languages and provide training for bilingual personnel in their effective use;
b. a requirement that counties with refugee populations exceeding 100 identify and plan to overcome obstacles to refugee access to their local services; and
c. the creation of an ex-officio seat for the Chair of the Refugee Mental Health Advisory Council on the State Mental Health Advisory Council to provide a voice for refugee concerns in the Council's work.

Current Issues:

Current issues facing the MHD regarding provision of services to refugees fall within two main categories. First, work remains for improving the accessibility and effectiveness of mental health services for refugees. Second, the termination of the RMHP presents challenges to the MHD to ensure continued input on its work from those knowledgeable and interested in refugee mental health issues.

These issues for improving services for refugees include:

1. Interpreters and western professionals with training in cultural sensitivity remain unavailable at many mainstream mental health services locations such as RTCs, residential facilities, and community mental health centers. This is particularly true outside of the Minneapolis/St. Paul metro area.

2. Current arrangements with counties allow them to enter into agreements with neighboring areas for the provision of services. Since the technical ability to work with refugees remains localized in Hennepin, Ramsey, and Olmsted Counties, these arrangements result in refugees going great distances for treatment, if indeed the assessment that treatment is needed ever occurs. Combined with the issues raised above, this results in an over-reliance on acute and emergency care, as well as refugees who must seek help outside of their own communities.

3. Federal funding for refugee assistance has been declining steadily on a per capita basis over the past ten years. While Minnesota has endeavored to make up some of the difference, there is simply less money with which to work.

Issues of continued input on refugee mental health concerns include:

a. With the termination of the RMHP, the MHD will lose its focal point for refugee mental health concerns. Consequently, it will need to develop a method for preserving the expertise and knowledge gained through the course of the project as well as maintain a channel for gaining input on refugee needs and on strategies for meeting those needs.

b. Because of the highly decentralized, county-based service system in Minnesota, there is a need for refugee input at the county level as well as at the state level.

## Services for Homeless Persons with a Mental Illness

### Background:

The state of Minnesota has probably had homeless people since the days of its discovery; however, the number of homeless people has varied through the years. In the early 1900's there was an increase in the number of homeless individuals when a large number of immigrants came to the state and housing was in short supply. Once the number of housing units grew and jobs were found, the number of homeless individuals declined. Again, the number of homeless individuals increased drastically during the Depression. Many people were not able to afford housing because of a loss of jobs and savings. The government and community responded to provide a larger continuum of a welfare system and social services and eventually met the needs of many of these people.

In 1981, the number of homeless individuals again rose with federal cuts in social services, a rise in unemployment and the continued erosion of affordable housing. The cut in social services compounded the problem of addressing a lack of effective community mental health services. A shortage of affordable housing and difficulties in referring skeptical clients to mental health professionals when street workers finally gain their trust continue to be major issues. The most notable current problem is the number of migrant workers who arrive in Minnesota during the spring and summer to work on farms in the Red River Valley.

Since 1985, the Minnesota Department of Jobs and Training (DJT) maintained a quarterly one-night count of the number of homeless people sheltered in the state. Transitional housing units, battered woman's shelters, community action vouchered beds, public and private shelter beds and runaway children's beds are counted. On the night of the first shelter count there were 1,165 sheltered people and a capacity to shelter 1,165 people. On August 24, 1988, when the last quarterly recording was completed, shelter capacity was exceeded. There were 2,922 people sheltered in a system with a capacity to shelter only 2,320 people.

### Minnesota's Mental Health Grant:

When funding became available to offer professional mental health outreach to persons who were homeless, Minnesota used the DJT statistics to target the areas of need. Based on the identified needs, seven counties have received funding from the MHD to hire personnel and develop programs for persons who are homeless or at risk of being homeless and who have or are at risk of having a serious and persistent mental illness. The project staff are required to have experience in mental health and the program must be available to homeless people during

their times of need rather than the times that may be most convenient for the county to offer them.

The 1987 Legislature appropriated $350,000 for the biennium to deliver mental health services to homeless individuals, especially homeless persons in Minnesota's largest metropolitan counties (Hennepin, Ramsey, and St. Louis). The money was held while Congress debated the McKinney Act and the match that would be required. On November 30, 1987, the state of Minnesota applied for Public Law 100-77, Title V of the Public Health Service Act, Part C Community Mental Health Services for Homeless Individuals.

Minnesota was notified of its award on January 5, 1988. The award period was from October 1, 1987 through September 30, 1989 and required a contribution equal to not less than $1 for each $3 of federal funds provided in the grant.

On January 8, 1988, the MHD informed six counties that federal and state funds were available to provide community mental health services to homeless persons with mental illness. These six areas were chosen from the DJT surveys over the previous two years. The counties and their community areas were:

| | | |
|---|---|---|
| Blue Earth County | - | Mankato |
| Clay/Wilkin Counties | - | Moorhead/Breckenridge |
| Hennepin County | - | Minneapolis |
| Polk County | - | Crookston |
| Ramsey County | - | St. Paul |
| St. Louis County | - | Duluth |

Each of the counties accepted local responsibility for providing mental health services to homeless persons and submitted a proposal for funding. Wilkin County decided to support Clay County's involvement, rather than develop a separate proposal.

In February, 1988, Minnesota received a special notice that Congress had approved additional funds for the fiscal year ($176,083). The total amount of federal funds for Minnesota then totalled $572,273.

Proposals were received in March and April of 1988. A state review team comprised of a representative of the Alliance for the Mentally Ill, the Mental Health Association of Minnesota, the Minnesota Coalition for the Homeless, the Mental Health Law Project and several staff from the DHS met on April 28, 1988, to review the proposals. The team approved all proposals based on certain provisions being fulfilled.

The amount of funds granted amounted to the total federal and state funds, less $79,450 for training and administration. Shortly after all grants were approved, it was determined that a portion of the state funds ($350,000) needed to be spent before

June 30, 1988, or would be lost. The state funds had been divided between the years of the biennium; $150,000 for 1987 and $200,000 for 1988 (If the $150,000 could not be spent before June 30, 1988, it could not be spent in the next fiscal year).

It was impossible for most counties to begin as soon as was needed to expend the 1987 allotments. With additional funding by the federal government, it became possible to have all the projects receive the full amount originally proposed. After allotting the additional dollars to the six counties, $59,276 remained.

A second request for proposals was sent in August, 1988 to two counties/areas:

| | | |
|---|---|---|
| Anoka | - | suburban Anoka County |
| St. Louis | - | Northern St. Louis County |

These two areas were selected because the DJT surveys had lumped suburbs and rural areas together and found that they contained a large number of homeless individuals. Because the small amount of funds made it impossible to accomplish anything significant in rural or suburban Minnesota as a whole, the MHD choose to fund a small area in rural and suburban Minnesota to illustrate the potential of programs in these areas.

Proposals were reviewed and both counties were granted funds to provide services to homeless persons who were mentally ill. These projects were to begin September 1, 1988.

Activities of the projects over the past year have included:

1. a first meeting of the six county projects in Duluth on May 13,1988. The purpose of the meeting was to begin to network together and meet with the Minnesota Homeless Coalition, which was having its annual meeting in Duluth at the same time;

2. a second meeting/training in Alexandria, Minnesota on August 18-19, 1988. The purpose of this meeting was to inform mental health professional staff about homelessness in Minnesota;

3. a third meeting in Crookston on October 13, 1988. The purpose was to share updates, first quarter reports and learn about the host project.

Quarterly meetings have been scheduled throughout 1989 and take administrators and, in some cases, staff to different project areas each meeting. These have included:

1. a Second Quarter meeting and training on January 26-27, 1989 in Minneapolis, Quarterly reports were presented, training

on multi-cultural and crisis issues was given, and case histories were given;

2. a Third Quarter meeting was held in Mankato on April 14, 1989. Project funding was examined for F.Y. 1990 and issues were raised for the Fourth Quarter meeting.

The following is a brief synopsis of each program and how it aims to meet requirements of the federal grant:

A. Anoka County. The county contracts with Rise, Incorporated to provide outreach and supportive housing services to homeless individuals. Rise has hired one and a half FTE outreach/service workers. Anoka County was selected because it represents a suburban area of the state, which accounted for 5.2% of all sheltered homeless individuals in Minnesota in 1987.

B. Blue Earth. In May, 1987, Blue Earth sheltered 2.6% of the homeless individuals in Minnesota. The county operates the project itself through its Community Support staff. One outreach worker has been hired to walk the streets and visit shelters and drop-in centers.

C. Clay County. This county has contracted with Lakeland Mental Health Center's Community Support Program. Lakeland has hired two case managers to work with providers of services and shelter to homeless persons in Moorhead. The county was chosen based on the May 1987 shelter statistics that indicate Moorhead had 2.4% of sheltered homeless persons in Minnesota.

D. Hennepin County. 46.4% of the 1987 Minnesota homeless population are sheltered in Hennepin County. The county has hired seven staff in its Community Services Unit as assessment and psychological workers. Four of the staff work with the Homeless Primary Health staff to assess homeless people in shelters, drop-in centers and other locations in the county. The other three staff are a psychiatrist, a psychiatric nurse and a social worker. They work with persons who have mental health problems, train staff at the shelters and drop-in centers, and have shelter and drop-in "office hours" to see those people who wish to talk to someone about their mental health problems.

E. Polk County. The Northwest Mental Health Center has taken the lead to coordinate a project with Polk County Social Services and Care and Share, Inc., a nonprofit program for homeless individuals. Two specialist have been hired to work with Care and Share staff to provide mental health care to those who come to the center and to others in the community. Crookston accounted for 6.4% of the homeless sheltered in 1987, this was the fourth largest number of homeless people sheltered.

F. Ramsey County. In 1987, St. Paul sheltered 23.3% of homeless individuals, which was half the number sheltered in Minneapolis. Ramsey County Human Services has contracted with a private mental health provider, South Metro Regional Treatment Center (SMRTC). SMRTC has hired four case managers to work with the providers of services to homeless persons. They use a pager system that allows the providers to access them at anytime.

G. St. Louis County. St. Louis County has contracted with the Human Development Center. Duluth has a network of providers of services to homeless persons with whom mental health personnel work. When an additional $176,000 became available, St. Louis County was also chosen to demonstrate a rural model of providing services to persons who are homeless and have mental illness. The northern St. Louis County Community Support Program hired a half-time person to travel the back roads of the county in search of homeless persons staying in county and state parks, abandoned buildings and wayside rest. (Minnesota's rural areas had sheltered 6.7% of persons who were homeless in the state.)

Current Issues:

The DHS is one of five departments that make up the Interagency Task Force on Homelessness, which has prepared the State's 1989 Comprehensive Homeless Assistance Plan. The representative of DHS is the program advisor for mental health services to persons who are mentally ill.

For 1989 five issues are being addressed:

- homeless veterans;
- homeless youth;
- data privacy;
- social detoxification; and
- discharge planning.

These issues were also identified by the 16 staff in the demonstration projects.

In addition, research is needed to determine how many persons who are homeless have a serious and persistent mental illness. Persons who are homeless undoubtedly suffer mental stress; but it is unclear whether they have serious and persistent mental illness.

Rural Mental Health Services

Background:

Minnesota has been 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. The project was designed specifically to be time-limited; it will terminate in 1989. Additionally, the project is geographically limited; it only serves the southwest portion of the state.

Over the course of this decade adverse agricultural economic conditions combined with severe drought have served to increase stress reactions among farm families. Drought conditions throughout the state continue to have a variety effect on the farm economy. In general, economic conditions are better than in 1988, but a large central portion of the state remains without adequate rainfall. In virtually all portions of the state, moisture levels are low to barely adequate, with groundwater levels depleted everywhere. A recent survey of farm wives in the Southwest areas indicated that family stress levels are as high as they have ever been in the extreme west central portion of the state, but have eased elsewhere. Those with crops to sell have found a strong market, owing to drought-induced reduction of overall supply. FmHA foreclosures have eased for the time being throughout most of the southwest portion of the state.

The Demonstration Project has accomplished tasks in a number of program areas. Predictably, there has been much less progress in the larger, more intractable problems facing rural communities.

Examples of innovative service delivery are listed below:

1. Attempts to facilitate clergy involvement in rural community support has yielded good participation in a grant-sponsored "caring week". Local clergy were given materials and sermon ideas on stewardship and community support.

2. Grant staff have initiated adolescent peer counseling programs in a number of high schools, thanks to combined efforts by the Department of Human Services and contributions from a state foundation.

3. School folders and folios with community mental health information will be distributed at local high schools. Students have participated in the artwork and content of the folios.

4. Peer helping networks are being supported through training and organizational help by demonstration staff.

5. A teleconference which will disseminate innovations through the project is planned for August, 1989.

6. Regular newspaper columns emphasizing rural mental health have been well received, according to a recent survey by the grant administrator at the MHD.

Examples of interagency relations include:

1. The Interagency Committee for the grant has helped cement working relationships among its members, DHS, the Minnesota Department of Agriculture, and the Minnesota Extension Service. The three state agencies have begun exchanging information and resources, including expertise on projects.

2. The 26-member state advisory committee (composed of representatives from agencies ranging from the Minnesota Bankers Association to Lutheran Social Services) for the grant is completing formulation of recommendations for distribution to appropriate bodies. These recommendations are listed below.

3. Local linkages are numerous and varied, occurring pragmatically as programs are devised by the local interagency task forces.

Current Issues:

Issues affecting rural areas and the demonstration project have not changed since the January 1989 plan. The issues and solutions mentioned below have been generated and continue to be addressed by the Rural State Advisory Committee.

1. Shortage of Professional Personnel

   There is a severe shortage of mental health service providers in rural areas. According to national data, less than 7% of child psychiatrists work in communities of 50,000 or less. According to another recent national study of 952 counties with less than 100 persons per square mile, 75% had no registered psychologist. The reasons for this dearth of professionals are obvious: professionals prefer urban settings and are often forced by financial choices to seek communities with larger populations. Additionally, there is a failure of professional training programs to direct their students toward rural populations.

2. Lack of Coordination

   Programs for rural residents at risk for environmentally induced stress lack a coordinated approach. They are scattered unevenly throughout the state and are often uncoordinated with the goals of the mental health provider

housing them. Many other programs are run by lay people without adequate credentials or supervision, simply because no alternative exists.

Outreach programs set up for farm families and individuals must be connected with a wide range of resources and referral sources. What is needed is more information on programs and innovative alternatives.

## Mental Health Services for Older Adults

Background:

According to 1985 population estimates, 489,646 Minnesotans are 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 home 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 elderly persons living in the community have received no diagnostic assessment or treatment;
4. about 3% of elderly 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 Disease (33,048 to 55,081 Minnesotans);
6. 65% of elderly persons may have depression, or 318,270 Minnesotans, according to estimates by Roybal (1984); 16% of all suicides in 1978 occurred among persons over age 65.

Because of these and other factors, the MHD has initiated a project targeting CSP services at older adults. The project includes a rural demonstration in St. Louis County, a sparsely populated, large county in northeastern Minnesota. (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 population of 210,000 (19% are 60 years 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. The primary economic activity of the county has revolved around the iron ore mining.

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 MHD 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 completion 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 array 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 MHD 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 DHS and also with the State Departments of Health and Veterans Affairs and the federal Veterans Administration. The State Project Director is also involved in implementing the Comprehensive Mental Health Act; analyzing statewide data on mental health needs and services to older adults; assuring that the mental health needs of older adults are addressed in local mental health proposals and therefore in the redesign of the mental health system in Minnesota; and providing technical assistance to local mental health authorities and providers.

The county 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 (in St. Louis County) 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.

In addition to the NIMH funded project, the MHD funded eight additional projects in 1988 with the federal ADM Block Grant. Each project demonstrates a different model or approach to providing mental health services for older adults. A description of the project models follows:

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

1. Lead Agency: Dakota County Community Mental Health Center

   Other Agency(ies): Community Health Services of Dakota County

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

2.* Lead Agency: Community Health Nursing (Olmsted County)

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

   Focus: To address training and coordination issues in a "resource (manpower) rich" area (addresses provider barriers).

3.* Lead Agency: Hiawatha Valley Mental Health Center and Winona County 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: Polk County Social Services Board

Other Agency(ies): Northwestern 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: Carver 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 utilize services available.

(This project did not reapply for funding for the 1990 state fiscal year. The county Human Service Department is incorporating the activities into the overall programs.)

6.* Lead Agency: Morrison 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: Carlton 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: Pyramid Community Mental Health Center

Other Agency(ies): Senior Services Division of Hennepin 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.

Compulsive Gambling

Background:

The 1989 Legislature directed DHS to establish a program for the treatment of compulsive gamblers. The program may include the establishment of a statewide toll-free number, resource library, public education programs, regional in-service training programs and conferences for health care professionals, educators, treatment providers, employee assistance programs, and criminal justice representatives; and the establishment of certification standards for programs and service providers. The program may also include inpatient and outpatient treatment and rehabilitation services and research studies. The research studies must include baseline and prevalence studies for adolescents and adults to identify those at the highest risk. $300,000 in fiscal year 1990 and $300,000 in fiscal year 1991 was appropriated to implement the compulsive gambling treatment program.

The program is being developed in the Special Projects Unit of the MHD. The plan for state F.Y. 1990 is as follows:

1. Staffing: Prepare job description and negotiate job classification by August 1, 1989. Have the position filled by early September 1989.

2. Advisory Task Force: Organize a regional based task force during October/December 1989.

3. Research (incidence, and prevalence for adults and adolescents): Prepare an RFP during October 1989; publish RFP by November and plan to begin conducting the research project by January 1990.

4. In-Service Training for Community Treatment Personnel: Prepare RFP during December 1989/January 1990, with plan to begin conducting the training sessions during February and March of 1990. Efforts made to enter into a contract with the Minnesota Council on Compulsive Gambling for this service.

5. Public Education and Information: Prepare an RFP during February/March 1990 and plan for the contract to be effective by April 1990.

6. Toll-Free Telephone Line: In place by April 1990.

7. Community Treatment Grants: If time and funds allow, make one or two grants for period beginning April 1, 1990.

The overall goal for the MHD is to utilize special projects as appropriate to promote the development of a unified service delivery system for children and adults which incorporates the culturally, chronologically, and geographically diverse mental health needs of Minnesotans through integration into the mental health system and development of appropriate special programs.

OBJECTIVES AND TASKS FOR MHD SPECIAL PROJECTS:

A. To develop systems to identify underserved persons and populations or groups of persons in need of services.

Tasks:

1. Provide technical assistance to counties and providers on meeting diverse needs -- ongoing.
2. Develop/continue grant programs for older adults, persons who are homeless, Indian communities and other groups identified as having special needs -- ongoing.
3. Conduct quarterly meetings of persons working with Homelessness/MI projects -- July, 1989, October, 1989, January, 1990 and May, 1990.
4. Establish Compulsive Gambling Task Force -- October-December 1989.
5. Develop and publish RFP for Compulsive Gambling Incidence and Prevalence Study -- November, 1989.
6. Receive and review proposals for Compulsive Gambling Incidence and Prevalence Study -- November, 1989.
7. Award grant for Compulsive Gambling Incidence and Prevalence Study -- November, 1989.
8. Develop contract for public education campaign on compulsive gambling -- April, 1990.
9. Provide staff support and attendance at SMHAC and Children's Subcommittee regional hearings -- ongoing.
10. Review county plans to assure they address cultural, age, and geographically diverse mental health needs of each county -- August, 1989; November, 1989.
11. Collect appropriate data on service utilization and unmet needs -- ongoing.

B. To assure that services for persons and populations or groups of persons with diverse mental health needs are appropriately addressed by the system.

Tasks:

1. Conduct site visits at special projects:
   a. Homelessness
      Moorhead - July, 1989
      Duluth - August 1989
      Ramsey County - August 1989
      Crookston - August 1989
      Hennepin County- October 1989
      Hibbing - October 1989
      Anoka County - January 1990
      Mankato - February 1990
   b. Rural Crisis -- July, 1989 (with external evaluators).
   c. Indian Communities:
      Mille Lacs, Leech Lake, Net Lake, Grand Portage -- July-October 1989.
      Upper Midwest Indian Center, Minneapolis Indian Health Board -- October, 1989 - January, 1990.
      Shakopee, Upper Sioux Community, Lower Sioux Community -- January - April 1990.
   d. Older Adults:
      NIMH: August, December, 1989
      ADM: July, 1989, January, 1990
2. Review reports from special projects -- quarterly and annually.
3. Prepare and distribute final report on Refugee Mental Health Project -- August, 1989.
4. Prepare and distribute final report on Rural Crisis Project -- August, 1989.
5. Prepare and distribute final report on Older Adult Project -- December, 1989.
6. Amend regional consultant quarterly meetings, coordinate site visits with regional consultants, attend and assist in Mental Health Division conferences -- ongoing.
7. Present special population/special project issues to SMHAC -- ongoing.
8. Prepare for, attend and follow up special population/special project advisory groups:
   a. Indian communities -- July, October, 1989 and January, April 1990.
   b. Compulsive Gambling -- October/November, 1989.
   c. HRD -- January, 1990.
9. Hire new staff for special projects:
   a. Compulsive Gambling -- September, 1989.
   b. Human Resource Development -- November, 1989.
   c. Older Adults -- July, 1989.
10. Plan and conduct statewide conferences to address diverse needs:
   a. Older Adults -- October, 1989.
   b. Indian Community -- May-June 1990.

11. Prepare and distribute Homelessness Newsletter -- September, 1989; December, 1989; March, 1990.
12. Develop/update homelessness slide presentation -- September, 1989.
13. Conduct rural project teleconference in Marshall -- August, 1989.
14. Present materials at national rural mental health and rural social work meetings -- July, 1989; August, 1989.
15. Complete contract and begin provider training regarding compulsive gambling -- February, 1990.
16. Establish compulsive gambling hotline -- April 1990.
17. Hold meetings with at least 3 special populations advocates on state plan -- ongoing.

C. To maximize all existing and/or develop new funding resources to assure that the diverse mental health needs of Minnesotans are incorporated.

Tasks:

1. Obtain input to RFPs, grant and plan reviews from specialized needs consumers through Division mailings -- ongoing.
2. Assess carry over funds (from S.F.Y. 89) for Homelessness and Mental Illness projects and distribute to projects -- September, 1989.
3. Prepare and distribute F.Y. 91 RFPs:
   a. Homelessness -- September, 1989.
   b. Older Adults -- January, 1990.
   c. Indian Communities -- January, 1990.
4. Review proposals from F.Y. 91 RFPs:
   a. Homelessness -- April, 1990.
   b. Older Adults -- April, 1990.
   c. Indian Communities -- July-August, 1989.
5. Prepare and distribute grant awards:
   a. Homelessness -- June, 1990.
   b. Older Adults -- June, 1990.
   c. Indian Communities -- September, 1989.
6. Develop position description for Compulsive Gambling Program Director -- August 1, 1989.
7. Hire Compulsive Gambling Program Director -- September, 1989.
8. Assess possibility of extending NIMH Older Adult Grant and request extension, if appropriate -- September 1989.

D. To target the use of all available funding sources in providing services to diverse population groups.

Tasks:

1. Include needs of diverse populations as part of all RFPs, grant applications, and plans -- ongoing.

2. Seek funding as appropriate from special grants to fund services -- ongoing.
3. With Departments of Commerce and Health, identify issues for future study regarding availability of insurance coverage for mental health services -- June, 1990.

E. To develop state level inter- and intra-agency coordination for the development, implementation, and funding of mental health services for diverse population groups.

Tasks:

1. Develop policy statement for Housing Task Force -- October, 1989.
2. Assist in preparing CHAP (Comprehensive Homelessness Assistance Plan) for 1990 -- January 1, 1990.
3. Develop discharge planning paper with Interagency Homelessness Task Force -- September 15, 1989.
4. Continue coordination with Minnesota Extension Services and Minnesota Department of Agriculture regarding rural mental health issues -- ongoing.
5. Participate in Governor's HIV Issue Team -- August, 1989, November, 1989, February, 1990, May, 1990.
6. Continue coordination of multicultural mental health issues with Chemical Dependency and Children's Divisions -- ongoing.
7. Explore including MHD representative on Interagency Board on Quality Assurance (Long Term Care) -- November, 1989.
8. Establish state level intra-agency library on homelessness, including mental health issues -- July 15, 1989.
9. Prepare agreement with RIAD for supervising administration of mental health/social adjustment funds -- July, 1989.

Anti-Stigma Educational Efforts

The MHD continues to promote an overall goal of lessening the stigma of emotional disturbance and mental illness. In the past year, the Minnesota Department of Health developed and implemented, through a contract with DHS, a self-esteem and wellness program targeted at young children. The program was developed in conjunction with the MHD and the State Mental Health Advisory Council

The MHD recently initiated a new undertaking: developing and implementing an anti-stigma public education campaign using special projects funds appropriated by the Legislature. The campaign will focus on either of two subjects: 1) battling negative images of persons with mental illness; or 2) addressing the stigma of obtaining mental health services.

The MHD's objectives and tasks toward actively lessening stigma are:

Objectives:

A. To develop an anti-stigma campaign RFP, contract, and program.

Tasks:

1. Develop an anti-stigma RFP by July 1, 1989.
2. Finalize contract for anti-stigma campaign -- August 31, 1989.
3. Negotiate continuation of depression education contract -- July, 1989.
4. Consult with appropriate SMHAC subcommittee on priorities, target populations, etc. -- March, 1990.
5. Consult with consumer and family organizations on methods of addressing stigma -- March, 1990.

B. To integrate anti-stigma efforts throughout all activities of the Division.

Task:

1. With assistance of DHS Public Information Officer, develop Division policy regarding stigmatizing jargon and appropriate terminology -- November, 1989.

C. To involve state and local mental health advisory councils, other advisory groups, and special grant projects in promoting anti-stigma efforts.

Task:

1. Require mailings of contractors to state and local advisory councils -- August, 1989.

The MHD also has as a goal the empowerment of adult and child consumers of mental health services and their families to participate in the development of the mental health service system, and in the development of their individual treatment plans.

This goal has brought about renewed dedication on the part of the MHD to work on behalf of consumers and families. Objectives and tasks toward this end include:

Objectives:

A. To provide active outreach in order to elicit consumer input.

Tasks:

1. Develop a consumers-only mailing list -- September, 1989.
2. Regularly survey consumer members of local advisory councils and other consumer organizations on division policies, programs, etc. -- ongoing.
3. Identify classes of consumers not currently involved in creation of the mental health system and provision of services -- December, 1989.
4. Plan methods of including classes of consumers not currently involved in mental health system planning and development -- January, 1990.
5. Include consumers and family members in rulemaking process -- ongoing.
6. Encourage consumer skill development through participation in workshops, conferences, and training -- ongoing.
7. Assess the possibility for reimbursement of transportation costs to enable consumers to participate in DHS processes -- January, 1990.
8. Hold meetings with at least 4 consumer/family organizations on the state plan -- July, 1989.
9. Meet individually with consumer members of SMHAC and subcommittees, regarding state plan -- ongoing.
10. Distribute anonymous needs assessment survey to consumer members of local mental health advisory council members -- March, 1990.

B. To assure involvement of families and consumers in the treatment process.

Tasks:

1. Arrange for Monitoring Division to assess, monitor sample ITPs of individual clients for statewide system impact for family and consumer involvement -- August, 1989.
2. Review county plans and grant applications for methods of assuring such involvement -- August/November 1989.

C. To promote the employment of consumers.

Tasks:

1. Include consumers in solicitations for hiring -- ongoing.

2. Encourage consumer hiring as criterion in RFP/grant process, as appropriate -- ongoing.
3. Include employment themes into anti-stigma campaigns -- July, 1989.
4. Explore coordination with academic institutions and technical institutes to train additional vocational rehabilitation specialist -- March, 1990.
5. With Department of Employee Relations, Personnel Division, and Department Medical Director, develop DHS policy to encourage employment of persons with mental illness and coordinate with HRD effort -- April 1990.

# CHAPTER VI

# HUMAN RESOURCE DEVELOPMENT

HUMAN RESOURCE DEVELOPMENT

Background:

Although DHS has recognized the significance of mental health human resource development (HRD), it has not been a high priority until recently as the role of the RTCs and the personnel employed changes, and the third year of implementation of the 1987 Comprehensive Mental Health Act begins. DHS has not had a systematic mental health HRD plan, nor have there been formal liaisons with academic institutions. Furthermore, the data which has been collected on the mental health work force, other than on the Department's employees in the RTCs has been incidental and therefore, of minimal benefit for planning purposes.

Minnesota is at a critical point in developing and shaping the mental health system to meet the needs of persons with mental illness appropriately, especially those with serious and persistent mental illness. To assure that the system will address future as well as currently identified needs and to recognize that mental health HRD efforts involve several program divisions with the Department, the Assistant Commissioner responsible for Personnel and Staff Development recently established a HRD work group representing the Mental Health, Developmental Disabilities, Chemical Dependency, Residential Programs, Licensing, Personnel and Staff Development Division to address human resources issues. This work group has been replaced by the RTC Transition Team, which includes the DHS Medical Director, and whose purpose is to guide changes made in the role and function of the RTCs.

Current Issues:

The RTCs are located throughout the state, with only one being in the Minneapolis/St. Paul metropolitan area. The distance to the other RTCs ranges from 73 to 190 miles. In addition, Minnesota is largely a rural state. Approximately 50% of the population is scattered throughout 95% of the geographic area, either in small agricultural communities and the surrounding farms or in heavily forested areas with small communities and scattered, often isolated home sites. These present challenges for the creation of a systematic, coordinated and comprehensive mental health HRD program.

The 1987 Comprehensive Mental Health Act created a framework for a unified, statewide system of comprehensive community based mental health services. After two years of effort to implement the law, during which time the Department also participated in lengthy negotiations with a broad range of interest groups regarding the future role of the RTCs, the state's renewed commitment to mental health services is evident. There still is much work to be done and DHS recognizes the relationship of a

strong human resource development capacity to the system's service delivery goals.

The HRD capacity needed in order to continue to make progress in improving the delivery of mental health services in the state is not yet available. For example, Minnesota has not been able to fully participate in the activities of the Midwest Consortium for Leadership Development because of a lack of a focal point for mental health HRD. Also, NIMH commented in the review of Minnesota's first P.L. 99-660 State Plan that the state needs to articulate the role of state supported higher education in human resource development for mental health programming, and provide more details on such issues as the required number and distribution of professionals. Furthermore, DHS needs to include more details on how goals and objectives will be implemented, including financial and human resource needs. To improve planning and to participate fully in activities such as the Midwest Consortium for Leadership Development, DHS must build its mental health HRD capacity. In view of both the continuing implementation of the Comprehensive Mental Health Act and the anticipated changes in the role of the RTCs, the time is ripe for developing this capacity.

Objectives:

A. To develop appropriate planning linkages with academic institutions, mental health service agencies, and other related agencies in order to encourage research into mental illness and effective treatment modalities, and promote appropriate training of the state mental health work force.

   Tasks:

   1. Assess relationships of the Department with colleges and universities in the state for the purpose of establishing productive linages -- December, 1989.
   2. Plan mechanisms for improving coordination which will enhance mental health human resource development throughout the system -- January, 1990.
   3. Review policies regarding the roles, responsibilities and coordination in relationship to the Department's overall strategic and operational plans to support staff development, recruitment, retention and distribution/redistribution so as to continue to improve the delivery of mental health services in the state in the most cost-effective manner -- May, 1990.
   4. Plan cooperative linkages between the Department and academic institutions -- February, 1990.
   5. Assess the nature of internship opportunities for students in public sector mental health for the purpose of supporting and enhancing those internships -- May, 1990.

6. Analyze existing situation to identify and describe current mental health resource development strengths and limitations, barriers, and constraints -- January, 1990.
7. Identify and encourage methods to expand collaboration between public sector mental health systems and the Department -- June, 1990.
8. Develop linkages with organizations responsible for licensure, certification and reimbursement policies and processes affecting the deployment and utilization of the mental health system's work force -- June, 1990.
9. Participate in National HRD Assembly -- October, 1990.
10. Participate in DHS Institutional Review Board -- monthly.
11. Participate in the development of PALI report (M.S. 245.4861) -- June 15, 1990.
12. Develop a Draft Mental Health Human Resource Development Plan to be included in the Three-Year Plan -- June 1990.
13. Advise appropriate SMHAC subcommittees on progress -- ongoing.

B. Begin to develop a separate and distinct State Human Resource Development Plan to include into the agency's State Mental Health Services Plan.

Tasks:

1. Assimilate minority concerns, children's issues, rural service issues and consumer input into the draft State Human Resource Development Plan -- June, 1990.
2. Identify human resource development issues and priorities -- January, 1990.
3. Develop a draft Human Resource Development mission statement including goals and objectives consistent with statutory requirements -- June, 1990.
4. Assess current problems facing the Department and incorporate into the plan -- June, 1990.
   a. Client-based service outcomes.
   b. Changing role of hospital personnel.
   c. Client needs link to staff skills.
   d. Training support for staff who want to change roles.
   e. Quality assurance and training linkages.
5. Enhance opportunities for involvement of the academic community in planning -- June, 1990.
6. Develop and improve training for mental health administrators at state and county levels through full participation in the Midwest Consortium for Leadership Development -- April, 1990.
7. Explore the feasibility of joint appointments and joint recruitment with academic and service institutions -- June, 1990.

C. Implement a minimum HRD data set which interfaces systematically with the organizational and client data sets.

Tasks:

1. Analyze existing documents to determine what elements of the minimum HRD data set are not implemented, in order to assure a data and information system that describes the current work force -- February, 1990.

2. Assess how the HRD data set can be interfaced systematically with organizational and client data sets to help determine the short and long term needs and begin appropriate planning -- February, 1990.
3. Prepare a report of specific kinds of work force data to be collected -- May, 1990.
4. Prepare a plan for developing a data system to meet human resource development needs -- June, 1990.

# CHAPTER VII

# MENTAL HEALTH FUNDING

1989 Legislative Action

The Minnesota Legislature concluded its 1989 Session on May 22, 1989, with a number of significant decisions regarding funding of mental health services. These decisions were partly due to issues identified in Minnesota's Three-Year Plan for Services to Persons with Mental Illness and partly due to public comments regarding the Three-Year Plan.

A major theme evident throughout the 1989 Legislature's funding decisions was a priority for adults with serious and persistent mental illness and for children with severe emotional disturbance. 1989 amendments to the 1987 Comprehensive Mental Health Act for adults, and the 1989 Children's Mental Health Act, spell out this priority for the entire statewide mental health system. Although Minnesota uses slightly different terminology, the 1989 funding decisions concentrate almost all new state mental health funds on the group of persons which NIMH has referred to as "the long-term mentally ill."

These decisions include:

- New state funding of $2.3 million for the initial phases of a comprehensive children's mental health system. Mandated service improvement and development which is expected to cost the state $16.6 million per year after 1992. See Chapter III for a more complete discussion of the state's plans for implementing the children's legislation.

- New state funding of $3.1 million over the next two years for continued expansion of community support programs for adults with serious and persistent mental illness.

- New state funding of $6.8 million to provide case management, residential and medical services for persons with mental illness who have lost their Medical Assistance (MA) eligibility due to their residence in facilities which have been determined to be Institutions for Mental Diseases (IMD's). See Chapter IV for a more complete discussion of the state's plans for addressing the IMD issue.

- New state funding of approximately $3.0 million for community alternatives for persons with mental illness who will be required to move out of nursing homes due to federal requirements (OBRA-87). See Chapter IV for a more complete discussion of the state's plans for addressing this issue.

- New legislation and state funding of $600,000 to establish a program for treatment of compulsive gambling.

- A policy commitment and initial funding to plan for the development of small state-operated community facilities for persons with mental illness as an alternative to continued long-term residence in state institutions.

In addition to the appropriations decisions, the 1989 Legislature requested DHS to conduct a number of studies related to the funding system for all mental health services and to recommend improvements to the 1990 and 1991 Legislatures.

- DHS must recommend measures by February 15, 1990 to improve the efficiency of the state's mental health funding mechanisms, and to standardize and consolidate fiscal and program reporting. Concerns have been expressed that mental health funding and fiscal reporting is too fragmented, and that the different funding mechanisms need to be more streamlined and standardized.

- DHS must, by January 31, 1991, complete a review of all mental health funds and recommend any needed changes. This request arose from the planing process for the future role of the RTCs, and related particularly to concerns about the current separation of RTC and community mental health funds.

- DHS and the Department of Health must develop a joint report for the 1991 Legislature for increasing the number of small community-based residential programs and support services for persons with mental illness. In addition, DHS is required to adjust funding mechanisms to reflect the requirements of different levels of residential treatment and support services.

- DHS must report to the 1990 Legislature regarding improved screening mechanisms for residential and inpatient services, including an evaluation of the placement impact of different financial reimbursement rules for different types of placements.

- DHS and the Department of Health must develop a joint report for the 1990 Legislature regarding the existing use of board and lodging facilities throughout the state and recommendations regarding regulation and funding It is estimated that over 1,000 persons with mental illness reside in board and lodging facilities which are neither licensed nor adequately staffed to serve persons with mental illness.

Funding for State Administration

State level expenses for planning, evaluation and administration of mental health services are expected to remain at the 1988

level for the next two years. While the 1989 Legislature provided a small increase in state funding for planning and administration, federal funding (especially through the mental health portion of the ADM block grant) has declined. Continuation of the $82,000 three-year planing grant is critical to continued effective planning for the major changes now underway in Minnesota's mental health system.

Additional Graphics Describing Current Funding

This update includes the following graphics, which were developed for the 1989 Legislature to illustrate computer spreadsheets which were included in the January 1989 Three-Year Plan:

1. 1989 Estimated DHS Funding for Mental Health Services:

   This pie chart describes the proportion of DHS funding which goes for each of the major types of mental health services. "Regional treatment centers" means state-operated inpatient services. "Residential treatment" means privately operated community residential treatment which is licensed to serve persons with mental illness.

2. Federal, State and County Shares of Funding for Selected Mental Health Services:

   This chart shows that the largest share of state funding goes for RTC state-operated inpatient services.

3. Federal, State and County Funding Sources: Mental Health Services for Children and Adults.

   This chart shows that counties are the primary funding source for mental health services for children.

4. Expenditures Department of Human Services Mental Health:

   This chart describes the increasing community mental health state funding administered by the Mental Health Division of the Department of Human Services. For 1990-1991, the Governor requested an increase of $9,858,000. The Legislature approved $9,145,000 (not including the IMD package).

These graphics proved to be helpful in obtaining legislative approval for new community mental health service mandates and the associated funding.

Summary: Fiscal Projections for 1990-1991

County agencies are preparing county mental health plans and budgets for 1990 and 1991 to reflect the 1989 Legislature's new

service mandates and new state funding. Counties have significant flexibility in deciding how much local and other funding to add to the state funds. Similar county budgets (prepared in 1988 for 1989) were the key source for the 1989 comprehensive fiscal projections in the January 1989 Three-Year Plan.

This year, the 1990-91 county mental health plans for adults are due to the state by August, 1989. The 1990-91 plans for children are due by November, 1989. Additional time is provided this year only for the children's plan to reflect the major new children's legislation enacted in May, 1989. Both the children's and the adult plan are expected to be reviewed by the state, revised as necessary, and finalized by December 31, 1989.

Thus, comprehensive fiscal projections for 1990-91 were not available for inclusion in this report. However, complete data should be available for the 1990 update of the three-year plan.

Objectives:

A. To maximize the use of all available or develop new funding resources, including human resources in the provision of mental health services.

Tasks:

1. Assure that rules are developed or revised so that MA funding is not precluded in the future -- ongoing.
2. With Health Care Management and Long Term Care Divisions, maximize the availability of MA through TEFRA 134 (CHCO) option for children at risk of institutionalization as a result of severe emotional disturbance -- June, 1989.
3. Update children's bill fiscal note -- May 1, 1990.
4. Maintain division files and record keeping procedures to ensure accountability for program and fiscal audits -- ongoing.
5. Participate in the development of a unified format for fiscal and program reporting by counties as required by M.S. 245.482, subd. 2 -- January, 1990.
6. Prepare annual legislative report on fiscal data obtained from counties -- February 15, 1990.
7. With Departments of Commerce and Health, identify issues for future study regarding availability of insurance coverage for mental health services -- June, 1990.
8. Provide legislative analyses and fiscal notes as appropriate -- October, 1989 to April, 1990.
9. Participate in developing draft plan for funding mechanism for children's services -- June 1, 1990.
10. Review and plan for special projects' need for ongoing funding, including public education, housing support services, and homeless services -- June 1, 1990.

B. To assure client access to services through reasonable and equitable fee policies.

Tasks:

1. Develop unified procedures to review and approve county mental health fee policies in coordination with CSSA procedures -- September 1, 1989.
2. Publish bulletin to counties and providers on fee policies -- September 15, 1989.
3. Implement fee policy review as part of county plan review -- November 15, 1989.