Minnesota Department of Human Services
Mental Health Division

1990 Mental Health Report to the Legislature

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Executive Summary

I. EXECUTIVE SUMMARY

Particularly due to the passage of the Children's Comprehensive Mental Health Act but also because of other new activities, 1989 proved to be an extremely busy year for the Mental Health Division of the Minnesota Department of Human Services. Implementation of the Adult Comprehensive Act continued. In addition to children's services, projects serving older adults and compulsive gamblers and establishing a Human Resource Development project were added. Projects focusing upon refugees and rural Minnesotans were completed.

Also during 1989, Barbara Kaufman became the new Assistant Commissioner for Mental Health following the resignation in late 1988 of Allyson Ashley.

All in all, the Mental Health Division (MHD) and Department of Human Services (DHS) faced many challenges and changes in course. While the goal of a unified, accountable and comprehensive system of mental health services in Minnesota has not yet been reached, DHS pledges to continue its efforts to reach that goal.

Highlights of 1989 activities and recommendations that are discussed in this Report are presented below.

Chapter II - Mental Health Division Goals and Objectives

Using the statutory mission statements for the Adult and Children's Mental Health Acts as guides, the MHD developed a set of goals and objectives for the fiscal year. These range from the provision of leadership and the creation of a quality array of services, to the empowerment of adult and child consumers of services and the battling of stigma.

Throughout the year, these goals have been fundamental to the MHD's efforts.

Chapter III - Implementation of the Adult Comprehensive Mental Health Act

Implementation of the Act has been included in the development of quality case management and community support services within fiscal and regulatory constraints.

Two variables crucial to an individual's ability to live successfully in the community are employability and housing services. Regarding the former, the MHD renewed its interagency agreement with the Division of Rehabilitation Services of the Minnesota Department of Jobs and Training through 1991. The agreement entails shared activities ranging from joint program

and policy reviews to interagency coordination of budget requests.

In regard to housing, the MHD took part in several efforts to determine more effectively how to provide normalized living arrangements for persons with mental illness. These include:

1. implementation of federal Public Law 100-203, requiring the arrangement of alternative housing and services persons in nursing facilities who have a mental illness but are not in need of nursing facility level of care. In an effort to reach DHS' goal of making such arrangements for 300 persons by April 1992, the MHD has begun to provide technical assistance and funding to counties from a 1989 legislative appropriation. As part of its technical assistance package, the MHD is encouraging counties to be creative in their delivery of alternative services.

2. consideration of alternative ways of providing DHS Rule 36 services. The current Rule governs residential services provided to adults with mental illness. The MHD continued in 1989 to investigate the feasibility of separating the Rule 36 services components from its housing components, in an effort to allow consumers of services to live in more normalized surroundings. The MHD's 1989 efforts have also included investigations of the extent to which Medical Assistance reimbursement for services might expand with a change to Rule 36.

3. coordination of efforts with the Legislative Audit Commission for its December 1989 report "Community Residences for Adults with Mental Illness."

4. completion of a statutorily-required report with the Department of Health on methods of licensing and monitoring board and lodge facilities. This DHS-MDH report is not included here, but is referenced.

5. completion of initial recommendations by Adult and Children's Task Forces on Inpatient and Residential Treatment Services. These task forces have struggled with issues of screening adults and children for appropriateness of admission to such care, without adding yet another bureaucratic barrier to the availability of care.

6. continued efforts to address federal regulations declaring some residential facilities Institutions for Mental Diseases (IMDs). Persons living in facilities with more than 16 beds that provide mental health care are not eligible for Medical Assistance. While the 1989 Legislature approved expanded General Assistance Medical Care (GAMC) coverage for such persons, the MHD has attempted to downsize facilities to 16

beds or fewer to allow persons to once again become eligible for Medical Assistance.

The year also found the MHD focusing its efforts on a variety of special projects. Expanded federal Alcohol, Drug Abuse, and Mental Health (ADM) Block Grant funds allowed for additional services for Native Americans in Minnesota. Federal McKinney Act funds and state appropriations enabled ten projects serving homeless persons with mental illness to continue and focus their efforts. And while P.L. 100-203 (discussed above) affects more than just elderly persons, the MHD established mental health pilot projects around the state serving the unique needs of older adults. Finally, projects focusing upon refugees and persons in rural areas were terminated in 1989 as per the federal grants supporting the projects.

Finally, the MHD expended considerable effort in 1989 to ensure that counties had adult and children's mental health services plans that evidenced movement toward a more comprehensive mental health system.

Chapter IV - Implementation of the Children's Comprehensive Mental Health Act

The 1989 Legislature approved significant new legislation to create in each county an array of mental health services for children with emotional disturbance. $2.3 million and funding for one staff person were also appropriated for the biennium for the Act.

The array of services required by the 1989 Children's Act, and the date by which they must be in place, are:

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

Counties were required to submit initial plans for providing these services by November 15, 1989. Limited MHD staff made it extremely difficult to provide substantive technical assistance to counties in completing their plans. As of this writing, most counties have submitted children's plans and MHD staff continue

to work with counties on them. Part of this technical assistance includes information gained from the experience of eight children's pilot projects around the state.

Two other reports specifically required by statute are also included in this Chapter. These include a study of out-of-state placement of children and recommendations for serving them at Willmar Regional Treatment Center (RTC); and state-level interdepartmental coordination of programs and services for children with emotional disturbance.

CHILDREN'S OUT-OF-STATE PLACEMENT STUDY:

DHS and Willmar RTC staff surveyed counties which placed children out of state in 1989. Highlights of their findings are:

+ counties place children out of state for a variety of reasons. These include the need for an emergency placement when there are no vacancies in in-state programs; geographic proximity of programs to Minnesota's border counties; more intensive or less expensive services, or programs in which children are relatively easy to place; and established ties between county social services or juvenile court officials and personnel at out-of-state treatment programs.

Recommendations include:

1. Expansion of facility and staff resources at Willmar RTC to accommodate children now placed out of state. However, this option would appear to violate legislative intent as specified in Minnesota Statutes (1989) 253.018 as well as the priorities found in section 245.4873, subdivision 6.

2. Using staff and resources of Willmar RTC to develop state-operated community services in the Willmar area; or

3. Using the expertise of Willmar RTC to assist in developing an array of mobile, intensive services to serve children and their families in their home communities, across the state.

STATE-LEVEL INTERDEPARTMENTAL COORDINATION:

Commissioners' representatives of the state Departments of Human Services, Health, Education, State Planning, Corrections, and Commerce, along with a representative of the Minnesota District Judges Association have met quarterly since the end of the 1989 legislative session.

Their efforts focused upon the group's legislative charge. Highlights of recommendations include:

+ provision of training for multi-system service providers;

+ establishment across Departments of commonly defined eligibility criteria for programs;

+ studying of pooled funding to enhance access to resources and eliminate duplicative requirements;

+ state development of model interagency agreements to promote the provision of early identification and intervention services on the local level.

Chapter V - Reports of Task Forces on Inpatient and Residential Treatment Services for Children and Adults

This chapter separates its discussion and recommendations into sections on children and adults, respectively. The reports are required as part of statutes requiring counties to screen children and adults for admission to inpatient and residential treatment settings.

This Chapter reviews the variety of mechanisms currently in place which have as their purpose or effect the screening of persons before or soon after admission to residential and inpatient settings.

In summary, both the children's and adult task forces have found that these mechanisms (which range from pre-commitment screening for adults to prior authorization requirements of third-party payers) are generally fragmented and uncoordinated, and rarely are multidisciplinary in nature.

Highlights of recommendations from the Task Forces include:

1. any new screening mechanism should coordinate and make use of existing information and resources, rather than duplicate them;

2. at a minimum, the person and the person's family (when appropriate) should be involved in screening decisions, and appeal mechanisms should be clear to them;

3. Rule 5 (governing residential care for children), Rule 36 (governing residential care for adults), and other licensed programs should have common admission, continued stay, and discharge criteria;

4. screening process should be able to respond differentially to emergency and non-emergency situations; and

5. screening mechanisms must have as a primary focus the clinical needs of the child and adult.

Chapter VI - Public/Academic Liaison Initiative

Though no appropriation was made for the Public/Academic Liaison Initiative (PALI), the MHD did receive in November 1989 a limited grant from the National Institute of Mental Health for Human Resource Development (HRD) capacity building. The HRD grant will allow for some activities called for in the Minnesota PALI legislation.

Because the HRD grant was received late in the year, initial efforts have focused upon the development of an advisory committee to the project and the initiation of ties to the state university system, Higher Education Coordinating Board, and professional societies and organizations.

While the HRD project will, over three years, focus on issues related to the supply, education, and training of mental health professionals, these efforts will create opportunities to coordinate specific research efforts with the University of Minnesota.

Chapter VII - Compulsive Gambling Treatment Program

The 1989 Legislature directed DHS to establish a Compulsive Gambling Treatment Program. This project was assigned to the MHD and a project director was hired in October.

The Program has developed an advisory committee and plans to focus its 1990 activities on the establishment of educational resources, a toll-free hotline, research efforts, and the dissemination of information about and establishment of treatment programs. Because only seven other states have similar programs, Minnesota will not have a large base experience from which to draw in its own efforts.

Chapter VIII - Commissioner's Consolidated Reporting Recommendations; Mental Health Information System Status Report

The MHD's ability to carry out its role and meet its responsibilities depends to a large extent on the quality of its information system. 1989 was a pilot year for the Mental Health Information System (MHIS), with 1990 targeted for full implementation of a system that will enable more detailed data to flow more efficiently from provider to state.

Progress on the MHIS has provided additional insights into the array of reporting requirements to which providers and counties are now subject. Because programs have been established and funded at different points in time, the MHD now administers Rule 12 (for Rule 36 programs), Rule 14 (community support programs), federal block grant, and special projects grants separately. The MHIS and other DHS efforts to update data systems should create opportunities to consolidate funding and reporting requirements. These activities will take DHS additional staff time to figure out.

II. DIVISION GOALS AND OBJECTIVES

The Minnesota Department of Human Services continues to strive toward the goal of a unified, accountable, and comprehensive system of mental health services. The 1989 activities of the Mental Health Division (MHD) are reported herein.

While much progress has been made in implementing the 1987 Comprehensive Mental Health Act for adults and 1989 Comprehensive Mental Health Act for Children, the goal of a unified, accountable, and comprehensive mental health system has not been met. This report and the coming activities of the Department of Human Services are designed to move the state closer to that goal.

The Adult Act and Children's Act was founded upon mission statements passed by the 1986 and 1988 Legislatures. For adults, the Department was directed to 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, DHS was directed to 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.

These mission statements were fundamental to the Mental Health Division (MHD) as it established its own goals and objectives for 1989. 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 the least restrictive, most appropriate services through reasonable and equitable fee policies and other mechanisms which account for an individual's inability to pay for services.

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 for planning 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 developing a separate and distinct State Human Resource Development (HRD) 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.

3-L. To assess progress toward meeting the MHD's goals, objectives and tasks.

Goal #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 the DHS Transition Team in enhancing 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 needing 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 that is clinically appropriate to the client's needs, using information from assessments of RTC patients to actively plan for their community services needs.

5-C. To assess current rules to determine the degree to which these promote increasing individual 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, including resources devoted to the RTCs, 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.

Chapter III

Implementation of the Adult Comprehensive Mental Health Act and Related Reports

III. IMPLEMENTATION OF THE ADULT COMPREHENSIVE MENTAL HEALTH ACT AND RELATED REPORTS

This section was written to comply with reports required by Minnesota Statutes 245.461.

As DHS has progressed in its implementation of the 1987 Comprehensive Mental Health Act, a variety of issues have come to light that are key to the successful establishment of a comprehensive coordinated system. Several of these issues are discussed in this section of the report.

1. CASE MANAGEMENT SERVICES FOR PERSONS WITH MENTAL ILLNESS

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

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

- are often involved with more than one service provider;
- have difficulty managing multiple systems, e.g., mental health, financial, social services, education; and
- 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 adults needing services.

The primary goal and responsibility of the case manager is to develop an individual community support plan which is based on diagnostic and functional assessments. The case manager then refers the person to needed mental health and other services identified in this plan, providing the coordination, 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 responsibility for providing the service rests with the county or local agency.

Rule 74 governs the provision of case management services. 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 serious and persistent mental illness, and may use CSSA (Community Social Services Act) dollars and Rule 14 funding for non-MA eligible persons.

The case manager is expected to work with persons in an ongoing manner over the long-term so that the case manager will be a positive constant presence in the person's life, whether or not he or she:

- is involved in one or many services;

- is successful or unsuccessful in a variety of programs; or
- is hospitalized.

The case manager is expected to be provided in the individual's own environment. A strong outreach component is essential to successful case management.

Case management requirements are specified in statute. A 1989 amendment 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.

Implementation of case management services began January 1, 1989. In the past year, some counties have experienced difficulties providing case management, partly due to the development of case management as an independent mental health service and not as a traditional social service offered by 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 permitted the county to become a vendor of services in much the same way as other mental health providers in the overall system.

In addition, concerns that the MA reimbursement rate for case management is not adequate to cover the true cost of providing the service have also risen, especially in the metropolitan area. Metro counties have tended to use experienced social workers and service providers as case managers who often earn 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.

Preliminary analyses of MA reimbursements for case management have also indicated that case managers may not receive sufficient reimbursement for travel time, a critical factor if the service is to be delivered in settings other than offices.

Counties have also expressed difficulties in funding case management when fewer than 50% of their clients are MA eligible.

Finally, Rule 74 clearly defines the role and responsibilities of case managers and further requires that they not provide mental health and other services to clients for whom they are providing case management services. This regulation ensures that the case manager continues to work with the client beyond a time-limited treatment period.

Each of these issues will be examined in the next year to determine what changes, if any, should be made in Minnesota's case management system.

2. COMMUNITY SUPPORT SERVICES FOR PERSONS WITH MENTAL ILLNESS

In 1989 the MHD's regional consultants provided technical assistance to counties to develop or continue community support programs (CSPs) as needed. This technical assistance was ongoing, and to the extent possible, tailored to needs identified by counties in their mental health plans.

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, discussed linkages between regional treatment centers (RTCs) and community support programs (CSPs). MDH Special Projects staff (older adults, Indians, homeless persons, rural services) led roundtable discussion and/or moderated panels regarding CSP services for special populations. Scholarship funding allowed A CSP worker and a county representative from each Minnesota county to attend without charge. The 1990 conference is scheduled for May.

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, compared to last year's minimum of $25,000 per county or $1.00 per capita. The Legislature approved enough funding for $40,000 or $1.65 per capita, so implementation of CSPs in all counties will proceed in 1990 but at a slightly lower level than needed. This issue will need to be revisited in upcoming legislative sessions.

3. EMPLOYABILITY SERVICES FOR PERSONS WITH MENTAL ILLNESS

Employability services are increasingly viewed as top priorities in the development of a community based system for persons with mental illness. With housing, employability was considered most important in a 1989 survey of consumer members of local mental health advisory councils.

Employability services have for some time been inadequate to meet the needs of persons with mental illness in Minnesota. Historically the mission of the Division of Rehabilitation Services (DRS), Minnesota Department of Jobs and Training, 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.

While DRS provides services such as job training and placement, work evaluations, the CSP programs assist persons with mental illness to improve their employability through activities such as medication 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 money allocated for community support 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 using their entire Rule 14 allocation to finance employability services were faced with the need to provide all CSP services, rather than just one component. At the same time, other counties which had <u>not</u> previously used Rule 14 funds for employability services were required to do so. As a result, the availability and quality of such services have been uneven.

Through an interagency agreement signed in 1987, the MHD and DRS have coordinated efforts to establish employability and work-related opportunities in all areas of the state. These services, designed to be a part of CSP services, in all 87 counties, 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.

In 1989, the MHD, DRS, and the DHS Division for Persons with Developmental Disabilities conducted employability training programs in 10 sites around the state. Over 600 persons attended the sessions, which provided technical assistance on employability services as well as information on funding sources. A training manual was compiled from the sessions.

DRS and the MHD renewed their interagency agreement through December 31, 1991. The workplan of the two agencies includes:

- joint planning and participation on state and local advisory committees;
- joint development, review, and support for biennial budget requests;
- joint legislative initiatives and demonstration projects;
- joint site visits and technical assistance efforts;
- joint policy, fiscal and data analysis; and
- exchanges of Request for Proposals and reciprocal grant and program reviews.

4. OBRA - FEDERAL NURSING HOME REPORT ACT

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

Objectives for DHS' efforts to implement P.L. 100-203 include screening all applicants to nursing facilities and conducting diagnostic assessments of persons identified as possibly having a mental illness by county pre-admission screening teams. An individual who has or may have mental illness is referred to the local mental health authority (county) to arrange for a mental health diagnostic assessment. (This assessment must be conducted by an independent mental health professional.)

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

ARR's are conducted by the Minnesota Department of Health Quality Assurance and Review (QAR) teams. The QAR teams identify residents who may have a mental illness, determine need for nursing facility care and refer for active mental health treatment (inpatient hospitalization) if needed.

By April 1, 1990, arranging for the safe and orderly discharge of all persons who are inappropriately residing in a nursing facility. The law permits states to submit an Alternative Disposition Plan (ADP) to the federal Health Care Financing Administration (HCFA) to request additional to arrange for safe and orderly discharge of individuals determined to be inappropriately residing in a nursing facility. HCFA approved Minnesota's ADP, relocating and arranging for the provision of appropriate community based or residential services to such persons, according to the following schedule:

- <u>January 1, 1990 to March 30, 1990</u>: 50 persons

- April 1, 1990 to March 30, 1991: 100 addition persons (total: 150 persons)

- April 1, 1991 to June 30, 1992: 150 additional persons (total: 300 persons)

The Minnesota Department of Health Quality Assurance and Review Section refers residents who have or may have mental illness and who do not need nursing facility care to the Mental Health Division (MHD) for further review. MHD staff then notify the county contact to ensure that thorough mental health diagnostic and functional assessments are completed and individual alternative disposition plans are developed, implemented and monitored.

Progress and achievements during 1989 include:

-- All counties have identified their OBRA contact and approximately 60% of counties have submitted local OBRA implementation policies and procedures for MHD approval. All these counties have received technical assistance from the MHD for their policies. In addition, all counties who have submitted policies and procedures have been notified of current nursing facility residents who may have a mental illness and do not appear to need nursing facility care. Counties who have not submitted policies and procedures have been provided with additional written technical assistance to help them develop local policies and procedures.

-- Counties have received Requests for Proposal (RFP) information to request state funding for developing, implementing and monitoring individual alternative disposition plans for persons who have mental illness and who have been inappropriately admitted to nursing facilities.

-- The MHD obtained approval from the Legislative Audit Commission for 2.25 FTE positions within the MHD to plan, organize, implement and evaluate the mental health PASARR activities mandated by P.L. 100-203, and to ensure that the activities are coordinated with the mandates of the Minnesota Comprehensive Mental Health Act.

-- MHD staff have conducted local technical assistance meetings for Minnesota Department of Health Quality Assurance and Review (QAR) teams, local mental health authority staff, PAS staff, RTC staff, nursing facility staff and other local health and human service providers.

-- As of November 30, 1989, QAR teams had conducted ARRs in about 65% of Minnesota's Medicaid certified nursing facilities. Of the 162 persons identified as having a mental illness and not needing nursing facility care or active treatment for mental

illness, 15 are no longer residing in the facilities. An additional 35 persons will need individual alternative disposition plans developed and implemented by April 1, 1990.

5. HOUSING AND THE AVAILABILITY OF MEDICAL ASSISTANCE

NOTE: This section was written to comply with Minnesota Laws 1989 Chapter 282, Article 4, Section 63.

The development of a comprehensive community-based system of care for adults with mental illness requires an array of choices of places for people to live. Some of these residences must be facilities where acute or rehabilitative treatment occurs; others must be homes where people live on a relatively permanent basis and where they may or may not receive needed services. These housing alternatives fall into three basic categories:

-- Settings for acute treatment. These include acute psychiatric hospitals and regional treatment centers.

-- Settings for 24-hour rehabilitation services. These include "Rule 36" facilities, crisis beds, adult foster homes, and transitional shelters.

-- Settings where people live. Rehabilitation and maintenance services may take place on the premises or the residents may receive their services elsewhere. These include supported housing, supervised apartments, independent living, and "Residential Care Facilities" (formerly board and lodging facilities).

For each of these residential settings, the following questions must be answered:

- Does the facility itself need regulation? If so, by what agency?
- Is there a program or service "attached" to the facility? If so, does it need regulation and by what agency?
- What are the characteristics of persons who need this type of living arrangement? Are they "placed" and, if so, by whom or what agency?
- What source(s) of funds are available to pay for (1) the basic housing costs? and (2) the program or service costs?

An equally important question that applies to all types of residential settings is how do adults with a mental illness most effectively use this array of settings?

While some types of service may be offered only in a particular type of setting, ideally people should not be required to move every time they need a different service.

The next section provides additional discussion of these issues,

including the availability of MA funding, within the context of proposed revisions to DHS rules governing residential services to adults with mental illness.

6. REPORT ON THE STATUS OF RESIDENTIAL RULEMAKING

Minnesota Statutes (1989), section 245.095, subdivision 2(7), require the Department of Human Services to report to the Legislature on the status of rulemaking with regard to programs and services to address the residential treatment and support needs of persons with mental illness. Included in the factors on which the rulemaking is to be based are the following:

> ...additional types of program and services, including but not limited to supportive small group residential care, semi-independent and apartment living services and crisis and respite services...;
>
> ...review...[of Rule 36 programs]...including but not limited to programs meeting needs for intensive treatment, crisis and respite care, and rehabilitation and training;
>
> ...provide in rule a definition of the term "treatment"...;
>
> ...adjust funding mechanisms by rule as needed to reflect the requirements established by rule for services being provided;
>
> ...review and recommend staff educational requirements and staff training as needed;
>
> ... review and make changes in rules relating to residential care and service programs for persons with mental illness...

BACKGROUND

In 1989, the MHD began the process of revising Minnesota Rules, parts 9520.0500 to 9520.0690 (Rule 36), governing provision of residential treatment services to adults with mental illness. This rule has not been revised since 1981, well before the passage of the Comprehensive Mental Health Act in 1987. Thus, its enforcement by the DHS Licensing Division has created disparities with current law and philosophy. An advisory committee of community members and mental health service providers was established to assist in this process.

Pending development of departmental recommendations on the establishment of a mental health consolidated fund, revision of Minnesota Rules, parts 9520.0500 to 9520.0690 (Rule 12), the funding rule for residential treatment services, has not been undertaken. If authority to develop a consolidated fund is to be sought, Rule 12 is unlikely to be revised. Otherwise, revision will be planned to coincide with the SFY 1992 funding cycle.

A number of issues to be addressed in the Rule 36 revision were identified:

-- restructuring to assure appropriate service provision while also addressing the need and desire of mental health service consumers to live as independently as possible, in accordance with the Housing Mission Statement passed by the 1989 Legislature (Minnesota Statutes, section 245.461, subdivision 4);

-- determining the appropriate licensing requirements for specialized facilities, including those providing short-term crisis or respite care and those facilities which are part of regional treatment centers already accredited by the Joint Commission on Healthcare Organizations and certified by the Health Care Financing Agency. Currently, this range of facilities and functions is covered by the same state regulatory requirements, with variances being given for some requirements in order to facilitate appropriate service provision;

-- downsizing of many currently-licensed Rule 36 facilities to assure the availability of federal financial participation in Medical Assistance funding, as well as meeting the legislative intent of the Housing Mission Statement. Each decision around downsizing to avoid the federal determination of an Institution for Mental Diseases (IMDs) has major financial implications for both facility owners and operators and for the state; and

-- assuring appropriate lengths of stay so that those individuals requiring residential treatment are able to obtain that treatment while they are also encouraged to live more independently with appropriate community supports.

1989 ACTIVITIES

An initial draft of the proposed rule was circulated and numerous advisory committee meetings were held during the summer of 1989. During this period, departmental decisions were made to attempt separation of treatment/program components and costs from those associated with housing, to assure that as much flexibility as possible be given to facilitate individual consumer choice and treatment needs. The goal is the development of a rehabilitative service model which could be offered in multiple sites, depending on individual need. Such sites might include licensed adult foster care homes, board and lodging facilities, or even the individual's own home if such an option were economical. This philosophical underpinning and a subsequent separation of programming and housing also could conceivably make some services currently offered in Rule 36 facilities Medical Assistance reimbursable, thus providing an approximate 50% federal match for those expenditures.

Activities to revise the rule were interrupted during the period of August 1989 to March 1990, as all available staff resources were diverted to the review of county biennial children's and adult's mental health plans. This delay has coincided with the release of a report by the Legislative Auditor ("Community Residences for Adults with Mental Illness"), and thus affords an opportunity to incorporate some of the LAC's findings into the revision.

Two other studies currently underway also have impact on Rule 36 revision: the report on Inpatient and Residential Screening for Adults (elsewhere in this document) and a report on Board and Lodging Facilities with Supportive Services. The latter report is being submitted to the Legislature by both DHS and the Department of Health in a separate document.

Regarding the former, the Screening Task Force has recommended inclusion of both admission and continued stay criteria in the rule revisions. However, the group has not yet completed its work and other recommendations may be forthcoming. Implications from the Board and Lodging Study are expected to address some of the same issues as those mentioned above, including separation of programming from board and lodging services as well as screening and assessment of residents prior to entry into negotiated rate facilities.

Work on revision of Rule 36 is expected to resume shortly, with promulgation expected in mid-1991. It should be noted that, as DHS moves toward development of State Operated Community Services for persons with mental illness, as directed by the 1989 Legislature in the Regional Treatment Center Act, other related issues will be raised. These include funding mechanisms for supervised apartments which will not create undesired facility-based programs. Development of resources to stimulate both housing availability and appropriate levels of service in the local community, to support individuals who previously were served only with more institutional levels of treatment, are critical to the success of this effort.

A number of recommendations from the LAC report have been added to the Division's workplan for the next year. Some relate directly to revision of Rule 36; others address case management and supported housing issues raised by the LAC. These include: evaluation of case management services and constraints imposed by Rule 74 requirements; development of training mechanisms for case managers on numerous issues (medication monitoring, discharge planning, individual treatment planning); evaluation of supportive housing grants; and seeking additional funding for Rule 14 grants to counties.

Chapter IV

Implementation of the Comprehensive Children's Mental Health Act and Related Reports

IV. IMPLEMENTATION OF THE COMPREHENSIVE CHILDREN'S MENTAL HEALTH ACT AND RELATED REPORTS

This section was written to comply with reports required by Minnesota Statutes 245.487 (Implementation of Comprehensive Children's Mental Health Act; Early Identification and Intervention Recommendations), Chapter 282, Article 1, Section 2, Subdivision 8 (Plan for Willmar Regional Treatment Center Use for Children in Out-of-state Placement), and 245.4873 (State Level Coordination).

1. IMPLEMENTATION OF THE MINNESOTA COMPREHENSIVE CHILDREN'S MENTAL HEALTH ACT

NOTE: This section was written to comply with reports required by M.S. 245.487.

Background:

Significant new legislation to meet the needs of children with emotional disturbance was introduced in the 1989 Legislature. The passage of that legislation has significantly increased the MHD's responsibilities.

Since January, 1988, four 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 to be in place by 1992. The Act required counties to submit their first biennial children's mental health plans in November, 1989. Finally, the DHS funded eight demonstration projects which are modeled after the CASSP (Child and Adolescent Service System Program of NIMH) framework of interagency coordination and service delivery. These four efforts form the foundation for future Department work on children's mental health.

The 1989 legislation was designed to accomplish three primary goals:

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

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. 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 occur by January 1, 1992.

As required by statute, the Department has provided 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. A copy of this report is attached.

Required services in each county and their 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
- Therapeutic foster care.....1/1/92

State level coordination is provided by the required interagency group defined in Minnesota Statutes 245.4873. The annual report and recommendations of that group are found elsewhere in this document.

The Legislature directed that 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 were required to 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 eligible children for services. Review of initial county biennial children's mental health plans indicates variable compliance with this provision.

By January 1, 1990, counties were required to establish local coordinating councils 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, councils must also include representatives of juvenile court or the court responsible for juvenile issues and law enforcement. Members of councils must meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbances. Councils must provide written interagency agreements and report annually to the Commissioner about unmet children's needs, service priorities and the local system of care.

Initial reviews of proposed county biennial children's mental health plans indicate these councils are being established as required, although a few counties have been slow in appointing representatives.

The case manager is required to coordinate with other persons responsible for planning, development, and delivery of social services, education, corrections, health or vocational services for the individual child. This mandate is effective July 1, 1991; however, some counties, especially those with demonstration project grants, have already begun providing the service to children with severe emotional disturbance. 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.

Statutes establish three target populations for children's mental health services:

A. All children (for Emergency Services, Education and Prevention, and Early Identification and Intervention).

B. Children with emotional disturbance (for Outpatient, Acute Care Hospital, and Residential Treatment)

   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.

C. Children with severe emotional disturbance (screening, professional home based family treatment, case management, family CSP, day treatment, therapeutic foster care).

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

A. Admission within the last three years or at risk of being admitted to inpatient or a residential treatment program for

an emotional disturbance; or

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

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

   (1) psychosis or clinical depression; or
   (2) risk of harming self or others as a result of an emotional disturbance; or
   (3) psychopathological symptoms as a result of being a victim of physical or sexual abuse or psychic trauma within the past year, or

D. 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.

Children with mental health needs have received services at the county level funded largely through the Community Social Services Act (CSSA). This block grant fund, consisting of 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 Medical Assistance system.

The 1989 Legislature's appropriations for the 1990-91 biennium included $2.3 million in new funds for children's mental health services. The Mental Health Division, working with counties and with the Children's Services and Health Care Management Divisions within DHS, has begun to develop these services. In particular, efforts are underway to promulgate or amend rules for case management and home-based family treatment services. Early identification/intervention services are being developed with the assistance of a multidisciplinary interagency group established for that purpose (see report elsewhere in this document).

The Department is developing mechanisms to serve children with severe emotional disturbance who are not currently MA eligible through the TEFRA (Children's Health Care Option) MA option. A study of mental health services provided to children under MA is being utilized to assist in implementing services through the Children's Health Plan. The outcome of this project and a mandated study of current mental health funding to be completed over the next year will direct future funding requests. Additional funding will be necessary before the Comprehensive Children's Mental Health Act is implemented. Current DHS

estimates are that the Legislature will need to appropriate $27 million in the next biennium to fund newly mandated children's mental health services.

The 1989 Legislature appropriated two staff positions for children's mental health within DHS. (This included replacement funding for an existing position originally financed by temporary federal funds.) Because the amount of funding provided covered only one position, the second position was filled through salary savings in the second half of SFY 1990. New staff received should be compared to the four positions recommended by the Governor. The lack of staff, combined with the review of county biennial children's mental health plans, has severely limited efforts to develop and implement services and to provide much-requested technical assistance to counties.

Children and Adolescent Mental Health Demonstration Projects

During the past year, DHS has undertaken a major effort using block grant funds to establish pilot projects to serve severely emotionally disturbed children. Projects were required to use the CASSP service delivery model developed by NIMH. A summary of the eight projects currently funded with federal block grant dollars is listed below. Unfortunately, Minnesota's federal mental health block grant for the current year has been reduced to the point at which these projects will need to be cut by approximately 15%, with no new projects being added. The MHD is working with each program to develop alternative funding wherever possible.

A. 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 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 were recruited and began accepting children.

B. Isanti County

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

The objective of the project is to initiate and expand 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.

C. Itasca County

The project strengthens early intervention and service coordination activities for children and adolescents with serious emotional disturbance by providing information and resources to parents, active involvement in suicide prevention activities, foster care training and crisis supervision of children in foster homes, and work on early identification of "at risk" children. Funds are used to support regional service coordinators who will serve these functions.

D. Kandiyohi County

The project brings together local community agencies to coordinate services for children. About half of the funds are being used to expand prevention and education and outpatient services including assessment. Lutheran Social Services contracts to provide professional family based services in the county through this project.

E. McLeod County

The project is expanding services to children with emotional disturbance by use of a care coordinator who assists in the identification of children in need, and provides necessary linkages between providers and the child's family to assure that services and parent education are available.

F. 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 provide consultation and training for foster care families, prevention and education activities, and foster home recruitment.

G. 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 is the lead agency in fostering the interagency collaboration on the comprehensive community based service system for children with severe emotional disturbance. Funds will be used for an extended family home and emergency home.

H. Ramsey County

Funding focuses on development of one specific professional family based enhancement to a school program. The project serves 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.

An evaluation has been completed of the first 18 months of operation under these grants under contract with an outside evaluator. (Mary Anne Casey, Ph.D., First Year Evaluation of the Child and Adolescent Mental Health Comprehensive Service Delivery System Pilot Projects, January, 1990.) Data provided in this evaluation indicate that:

-- Prior to the grant, an average of three agencies were meeting formally in the demonstration counties. By September, 1989, that number had risen to an average of ten organizations meeting monthly per county.

-- Services most frequently available as a result of the grant dealt with prevention, assessment, and early intervention.

-- State level barriers most often encountered by grant county coordinators were financial management (the flow of funding from state to county and delayed disbursements) and lack of technical assistance because of lack of DHS Mental Health Division staff.

-- Improved working relationships among agency representatives, information exchanges, and funding for added or augmented services for children were cited as the greatest benefits of the program.

2. EARLY IDENTIFICATION AND INTERVENTION EFFORTS

Minnesota Statutes, section 245.487, subdivision 4 require inclusion of recommendations to provide coordinated, interdepartmental efforts to ensure early identification and intervention (EI/I) for children with, or at risk of developing, emotional disturbance.

As a preliminary step in the development of an EI/I system, the Minnesota Department of Human Services Mental Health Division, in cooperation with the Minnesota Department of Education, sponsored a multi-agency collaborative planning effort to design a system of EI/I services which would:

-- identify children who are at risk of needing or who need mental health services; and

-- offer prevention and treatment to each child who is identified as needing mental health services.

The objectives of this planning activity were to:

-- identify the agencies, systems, and programs currently conducting EI/I activities;

-- reach a consensus on a working definition of EI/I;

-- define the critical components of a system of EI/I; and

-- strategize the processes and methods to effectively reach and identify children at risk of emotional disturbance.

The group identified key principles underlying a comprehensive, quality system of EI/I:

- child and family centered;
- multidisciplinary in nature;
- varied in service setting;
- community-based;
- flexible in design to meet the unique needs of individual children and families;
- accessible, affordable, and accountable;
- valid and reliable; and
- provided by competent individuals.

Twelve key issues or components were identified by the group as integral to the development of an EI/I system:

1. Professional training/continuing education;
2. resource information dissemination;
3. service coordination;

4. data privacy and data management;
5. identification and screening;
6. systems evaluation;
7. funding;
8. public education;
9. geographical accessibility;
10. administrative functions;
11. intake functions and processes; and
12. technical Assistance.

Preliminary recommendations of the group include:

A. The need to identify currently existing resources for early identification and intervention within the state and nationally. Resources include existing agencies and program which conduct screening activities such as Early Periodic Screening Diagnosis and Treatment (EPSDT) and Early Childhood Screening (ECS) as well as screening tools currently in use within Minnesota and nationally.

   While initial service development will need to focus on expansion of current services such as EPSDT and ECS for early identification of mental health problems, it is clear that a comprehensive system must be broader than any one particular screening tool or system. Initial development efforts must also address future utility and effectiveness of the screening tool and processes across systems and agencies to ensure broad access for children and families.

B. The need to build capacity and child mental health professional expertise within and across systems.

   Significant need exist in all communities to educate professionals regarding the risks, predictors, and early symptoms of emotional disturbance in children. Promotion of interagency collaboration efforts which target a comprehensive and multidisciplinary approach to early identification and intervention are also needed. The local advisory and coordinating councils which are mandated by the Children's Comprehensive Mental Health Act are key vehicles to utilize in multi-system, multi-disciplinary service development.

C. The need for continued collaborative planning to pursue resource identification, methods of service development, and a targeted schedule of service implementation.

   Several members of the initial planning activity are willing and interested to participate in an ongoing work group to carry out "next steps" in system development.

D. The need for all communities to promote sound mental health as a top priority for its children.

3. PLAN FOR USE OF WILLMAR REGIONAL TREATMENT CENTER TO SERVE CHILDREN PLACED IN OUT-OF-STATE MENTAL HEALTH TREATMENT

BACKGROUND:

Since 1965, the Adolescent Treatment Unit (ATU) at Willmar Regional Treatment Center (WRTC) has provided specialized residential treatment to adolescents with severe emotional disturbances. The ATU is a statewide program serving the treatment needs of Minnesota's most severely emotionally disturbed adolescents ages 12-17.

Adolescents admitted to the ATU have demonstrated the need for a highly structured specialized psychiatric treatment setting, 24 hours a day and have long-standing severe emotional and behavioral problems in their families, schools, and communities. These problems include thought disturbances, mood disorders, authority and peer conflicts, chemical abuse, antisocial/delinquent behavior, sexual acting out, assaultive/aggressive behavior, property destruction, suicidal/self-mutilation, truancy, hyperactivity, and learning disability. The adolescents admitted to the ATU tend to have exhausted less restrictive community alternatives with multiple treatment failures. Average length of stay is 11 months.

The ATU includes three residential programs in two buildings: Boys Unit (22 beds); Girls Unit (14 beds); and Protective Component Unit (6 beds). Since 1979, the Protective Component Unit has provided secure treatment for highly aggressive severely emotionally disturbed adolescent boys. All three programs generally operate at, or near, capacity, with waiting lists.

The mission of the ATU is to help adolescents develop skills to deal responsibly with their problems and return to a more normal life, thus preventing further emotional problems. This mission is carried out by use of:

-- A highly structured, predictable environment with easily recognizable boundaries which helps to provide a framework for emergence of inner controls.

-- Experienced professional and direct care staff who teach adolescents new ways to handle life stress so that they can become capable of making decisions and of accepting the consequences of their behaviors. Relearning and the development of patterns of responsible behavior are key elements in treatment goals.

-- An educational program designed to address learning problems. Completion of high school is emphasized.

The ATU utilizes campus-wide support services; however, all programming is separate from the adult populations on the Willmar Regional Treatment Center. Adolescents are not integrated into adult groups; all therapeutic activities are provided specific to the adolescents' needs.

The ATU is accredited by the Joint Commission on Accreditation of Healthcare Organizations and is licensed by DHS' Rule 5 and the Minnesota Department of Health.

LEGISLATIVE MANDATE

Following discussion of out-of-state placements of Minnesota children for mental health treatment, the 1989 Minnesota Legislature (Minnesota Statutes, Chapter 282, Article I, Section 2, Subd. 8), required that the Department:

> ...present a plan to the Legislature by February 15, 1990, on methods of increasing the use of staff and resources at the Willmar Regional Treatment Center to serve children with severe emotional disturbances who would otherwise be placed in treatment in other states.

PROCESS

A work group comprised of Department of Human Services (DHS) and Willmar Regional Treatment Center (WRTC) personnel focused on this out-of-state placement issue. Members were:

Jan Gibson Talbot, Mental Health Division
Jerry Storck, Mental Health Division
Kay Ehrhart, Residential Management Program Division
Lou Brelje, Children's Services Division
Carolyn Noehl, ATU
Patrick Carroll, ATU

The work group's task was to determine (1) why children were placed out-of-state and (2) whether they were different from the children admitted to the Adolescent Treatment Unit.

A questionnaire to determine the reasons for out-of-state placement was developed and sent to directors of all Minnesota counties or to specific social workers within those counties who were most knowledgeable about the placement of children. Responses were received from all 87 counties and are shown in Table 1. In addition to providing information on the number of children out-of-state, counties were asked to provide information on the reason for use of these facilities and the type of children they place out-of-state.

A second questionnaire was developed and sent to 25 out-of-state facilities that were listed by counties as receiving Minnesota

children for placement. This information was used as a cross-reference check on the accuracy of the data provided by counties. Twelve of these facilities supplied information concerning their programs and the number of Minnesota children served.

DISCUSSION OF FINDINGS

A. Currently, approximately 78 Minnesota children are placed in out-of-state facilities for mental health treatment. This number is believed to be typical of that number of children whose out-of-state placements can be expected to be funded publicly at any given time.

B. Over the course of one year, counties place between 125-160 children in out-of-state facilities for mental health treatment. More than one-third of these children are placed by metropolitan area counties.

C. These numbers do not include children who are placed by their parents without county involvement or public funding and, as such, may represent an under-estimate of the actual number who may be placed out-of-state.

D. No currently utilized method is available for accurately identifying and tracking children who are placed out-of-state.

E. Thirty-three counties placed children in out-of-state mental health treatment facilities in the past year. Approximately one-third of these counties are in the Willmar Regional Treatment Center catchment area.

F. Many counties utilize treatment facilities in other states because of the proximity of those facilities to the referring counties. Of the 33 counties that placed adolescents out-of-state in 1989, 15 were within 50 miles of the border of the receiving state.

G. According to county reports, county staff are frequently faced with emergency situations in which children need placement immediately and in which no in-state facility that is appropriate to the needs of the child has an opening available. In-state facilities contacted indicated they had waiting lists and that openings were not expected for at least two months. (A study by the Child Welfare League of America indicated that immediate discharge from facilities is the most frequently used method for dealing with the difficult behavior problems such as stealing, running, refusal to cooperate, destruction of property, inappropriate sexual behaviors, use of drugs or alcohol, self-injurious behaving and fire-setting. The practice of immediate discharge is believed to create emergencies which lead to out-of-state placements.)

H. Counties utilize out-of-state placements when they feel specific treatment needs of the child do not match well with in-state facilities that are available to that child. Such needs include treatment for: eating disorders; closed head injuries; significant history of sexual dysfunctioning; and acting out.

I. A number of counties find it less expensive to purchase services from private facilities in neighboring states than from in-state facilities. Of the facilities surveyed, ten had costs ranging from $52 to $85 per day and accounted for 65% of the adolescents currently out-of-state. Three facilities had costs ranging from $320 per day to $670 per day and accounted for 6 of the adolescents currently out-of-state.

J. Some counties have developed very good relationships with private providers in other states and continue to refer to them based on the reputation of particular programs and because services offered by those programs are not provided by in-state treatment facilities.

K. Access to a secure treatment setting for children in Minnesota facilities is currently limited to six beds for boys in the Protective Component Unit of the ATU. Waiting lists for this unit usually have between two and six individuals. The time from placement on the waiting list to actual admission is approximately 6 months. Secure treatment options at Twin Cities hospitals are very costly to counties and access to non-treatment facilities, i.e., detention facilities, is not always possible or desirable. Children who commit serious offenses such as murder, sexual assaults and rapes, and serious fire setting are usually excluded by in-state facilities.

L. Children with both low intellectual functioning and emotional disturbance or chemical dependency and emotional disturbance have limited access to residential programs because of their dual diagnoses. Wyalusing Academy in Wisconsin, offering services for children with emotional disturbance and developmental disabilities, has become a placement of choice for the child with this dual diagnosis. Dual diagnosis programs for children with chemical dependency and emotional disturbance are virtually non-existent.

M. A number of Minnesota children have long histories of treatment failure and have bounced from program to program until they have exhausted all possibilities within the state. The concept of the most appropriate, but least restrictive, treatment alternative is apparently not fully understood by counties making placements. Current practice creates a history of successive failures for children that must be

undone in subsequent treatments.

N. Limited beds in in-state residential programs are available for Minnesota children who are 12 years of age or younger. Fifteen to twenty percent of the children currently out-of-state were placed due to the lack of available bed space in Minnesota for children of their age.

O. County convenience weighs in the decision-making process. Proximity, program costs, and program reputation appear to be primary factors in placement decisions. These do not necessarily take into account the most appropriate and least restrictive placement available to the child.

P. Based on review of the out-of-state data and discussion with referring county workers, children placed in out-of-state facilities do not appear significantly different from those at the Adolescent Treatment Unit. Possible exceptions include: (1) out-of-state children may not have as many treatment failures as those placed at the ATU; (2) some children placed out-of-state are younger than those accepted at ATU; and (3) some children placed out-of-state have developmental disabilities or chemical dependency diagnoses in addition to emotional disturbance.

RECOMMENDATIONS

Because the number of children placed out-of-state exceeds the current capacity of the Adolescent Treatment Unit, provision of services for these children would require expansion of ATU staff resources and/or bed capacity.

Three alternative suggestions for creating this treatment capacity could include:

-- Expansion of the Adolescent Treatment Unit capacity by using additional buildings on the campus of WRTC which could provide several program components, including crisis/evaluation, security, adolescent boys, adolescent girls, and children's units. Each of the additional buildings needed would require approximately $280,000 in remodeling costs to accommodate the residential treatment needs of children with severe emotional disturbance. In addition to the capitol budget needs, staff would be required at a ratio of approximately 2:1, staff-to-child. Start-up funds and an annual budget for the expanded ATU would also be needed, as would school personnel and classroom space. It should be noted that this alternative would appear to violate legislative intent as specified in Minnesota Statutes (1989), section 253.018 as well as the priorities found in section 245.4873, subdivision 6.

-- Using the staff and resources at the ATU to develop multiple programs in the Willmar area in order to remain in proximity to experienced ATU staff, school personnel, and support services from WRTC. Each 10-12 bed state-operated community facility would cost approximately $488,000 in capitol costs, in addition to the operating costs listed above. The community facilities would be comprised of modules for crisis/evaluation, security, adolescent boys, adolescents girls, and children's units. While this option would not place additional children on an RTC campus, it would not provide the specialized services near their own homes needed by children currently being placed out-of-state.

-- Utilizing ATU staff expertise to assist counties in developing an array of mobile intensive mental health services designed to serve children with severe emotional disturbance in or near their families and home communities. Staff could make available to counties their extensive experience by providing (a) evaluation services and crisis intervention as part of professional home-based family services, (b) training as part of therapeutic support of foster care, and (c) assistance in establishing day treatment services. This model has the advantage that it assists in providing services in home communities and is consistent with statutory requirements for the development of a system of mental health services for children.

Table 1
Reasons for Placement
As Indicated by Counties

REASON	RESPONSE RATE*
Proximity to out-of-state facility	45%
No treatment beds available when needed.	42%
Out-of-state treatment more appropriate to child's needs	36%
Program cost much less expensive	30%
Good reputation or specific services unavailable in-state in Minnesota	27%
Need for secure placement	15%
ED/DD dual diagnosis	15%
Continuous treatment failures by child	15%
Court placed out-of-state	12%
No availability for age range	9%

*Percentages are based the number of responses for each out-of-state placement reason by the 33 counties which placed children out-of-state in 1989.

4. STATE LEVEL COORDINATION OF CHILDREN'S MENTAL HEALTH SERVICES

Minnesota Statutes, section 245.4873, subdivision 1, directs the coordination of the development and delivery of children's mental health services on the state and local levels "...to assure the availability of services to meet the mental health needs of children in a cost-effective manner."

Subdivision 2 requires the Commissioners or their representatives of the Departments of Human Services, Health, Education, State Planning, Corrections, and Commerce, along with a representative of the Minnesota District Judges Association Juvenile Committee, to meet at least quarterly through 1992 to:

-- educate each agency about the policies, procedures, funding, and services in all agencies represented for children with emotional disturbances;

-- develop mechanisms for interagency coordination on behalf of children with emotional disturbances;

-- identify programmatic, policy or procedural barriers that interfere with delivery of mental health services for children with all agencies represented;

-- recommend policy and procedural changes needed to facilitate the development and effective delivery of mental health services for children in the agencies represented;

-- identify mechanisms for better use of federal and state funding in the delivery of mental health services for children; and

-- prepare an annual report on the policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system.

This report, to be submitted to both the Legislature and the State Mental Health Advisory Council annually through February 15, 1992, is to include information from each agency represented on:

-- the number of children in each department's system who require mental health services;

-- the number of children in each system who receive mental health services;

-- how mental health services for children are funded within each system;

-- how such services could be coordinated to provide more

effective, appropriate mental health services for children; and

-- recommendations for the provision of each screening and identification of mental illness/emotional disturbance within each system.

Committee membership includes:

-- Department of Corrections, Richard Quick, Executive Officer, Juvenile Release
-- Department of Health, Dr. Carolyn McKay, Director, Maternal and Child Health
-- State Planning Agency, Ann Jaede, Manager, Criminal Justice
-- Department of Commerce, Chuck Ferguson, Policy Analyst
-- Department of Education, Norena Hale, Manager, Unique Learner Needs
-- Minnesota District Judges Association, The Honorable J.B. Gunderson
-- Department of Human Services, Jerri Sudderth, Acting Director, Mental Health Division, and Janet Wiig, Assistant Commissioner, Family and Children's Services.

Because this state group was convened shortly after the effective date of the Comprehensive Children's Mental Health Act, only three meetings have been held. The primary focus in these initial meetings was on items (1) through (4) of the legislative mandate. As a result, both data obtained and recommendations developed must be considered preliminary in nature. Further study on these issues is required and will be completed in subsequent years.

Available Data and Service Description of State Agencies

Health:

No mental health services are provided directly through the Department of Health's Services to Children with Handicaps Program. Psychological evaluation is provided for children with **PKU** and as needed to establish a diagnosis for any Minnesota child.

Corrections:

Substantial reductions in the number of children served by the state corrections system have occurred between 1965 (approximately 1,000) and 1989 (180), due to the advent of the Community Corrections system. Data on the number of children served by the community correctional system or other community-based programs is not currently available. Many of the children in out-of-home placements residing in Rule 5 facilities licensed by the Department of Human Services. Of the 180 children served

by the state, the number needing or receiving mental health services is unknown. However, estimates are that approximately 30% of the children coming before the judiciary have mental health needs.

Data from the State Planning Agency's State Judicial Information System indicates that, in 1988, Minnesota juvenile courts ordered inpatient psychiatric treatment for 210 children and outpatient psychiatric treatment for 314 children. Children who had multiple court dispositions within the year are counted more than once.

Education:

Minnesota is currently serving 1.2% of its school age population through special education Emotionally/Behaviorially Disordered (E/BD) programs and services. Incidence of actual need is extremely difficult to project due to definitional problems, as discussed below. Data on the number of children in the "Emotionally Disturbed" target population through Minnesota school districts are found in Table 2.

Human Services:

Table 3 provides projected children's mental health data, as provided by counties in their biennial Children's Mental Health Plans for calendar years 1990 and 1991.

Tables 4 and 5 show the number of clients (ages 0 through 18) for whom Medical Assistance payments were made for mental health services in both 1987 and 1988. The numbers in both tables are unduplicated within each service, but the same child may be counted as receiving several different services.

Barriers to Effective Delivery of Mental Health Services

Departmental representatives identified the following issues as barriers to delivery of mental health services to children having or at risk of having emotional disturbance:

Access to Services/Fragmentation:

A. The target population for mental health services is not clear to those who control access to services within the various systems.

   Physicians, for example, may not diagnose conditions for which they have no "cure". They tend not to identify children or families needing supportive services such as respite or day care. Without such services, some otherwise healthy families become dysfunctional and symptoms of the child intensify.

Service eligibility criteria are not well-defined among service systems. A common understanding of who needs mental health services is critically needed. That definition should cut across geography and disciplines so that effective service provision may occur without disruption to children and families.

Like the medical profession, social services and special education programs tend to identify only those needs for which they can provide services. Services tend to be available only to those in severe need; i.e., children and families whose behavior cannot be tolerated by the community. Prevention and early intervention activities tend to be lacking for the broader range of children and families who need them. Early Intervention resources are not always utilized to the fullest extent possible: public health nurses are cited as an example of an underutilized resource for intervention.

In addition, few professionals trained and experienced in working with children with emotional disturbance exist. Neither schools nor county agencies have access to adequate numbers of trained staff to provide services. (Within state school districts, 50% of all provisional licenses are held by teachers in EB/D classrooms; additionally, 44% of all one-year variances granted for teachers are in EB/D classrooms. The result is that 20% of all EB/D staff working in classroom have either provisional licenses or variances.)

Locally, very little communication occurs among systems serving the same children and families. The possibility thus exists that multiple case planning can occur, with the planning being disjointed and sometimes contradictory, as well as confusing to families.

Case management is an excellent means of providing access to and coordination of services across systems. Parents need help understanding the benefits of case management and family community support services, as do pediatricians and other professionals involved with these families.

Mental health services should follow families when they move. Multi-agency collaborative planning and co-location ("one-stop shopping") would assist both families and providers in obtaining access to services.

TABLE 2

CHILDREN WITH EMOTIONAL DISTURBANCE
SERVED BY MINNESOTA SCHOOL DISTRICTS

1982-1989

Age	Actual FY 82	Actual FY 83	Actual FY 84	Actual FY 85	Actual FY 86	Acutal FY 87	Actual FY 88	Acutal FY 89
0-2	0	2	2	3	3	1	1	2
3	7	7	6	10	13	29	8	1
4-5	204	246	227	221	251	234	108	87
6-11	1,174	1,448	1,689	1,967	2,257	2,492	2,837	3,151
12-21	3,584	4,143	4,846	5,465	6,333	6,816	7,200	7,439
+ 21								3

UNDUPLICATED CHILD COUNT OF CHILDREN AND YOUTH WITH HANDICAPS
BY AGE AND DISABILITY AS REPORTED UNDER P.L. 94-142.
Unique Learner Needs Section, Special Education
March 1989

Table 3
CHILDREN'S MENTAL HEALTH SERVICE PROJECTIONS*

SERVICE	1990 Projection	1991 Projection
Outpatient		
Eligible for Case Mgmt.	3,561	4,000
All Other	11,996	12,545
Case Management	6,196	6,595
Day Treatment	1,359	1,626
Residential	1,896	1,930
Acute Care Inpatient	285	316
Screening	769	830
Pre-Petition Screening	162	183
RTC Inpatient	194	223

*Data were provided by counties as part of their initial submission of county Children's Biennial Mental Health Plans. Because they are preliminary data, they are subject to change. Data also reflect only those children for whom counties are providing funding of services.

TABLE 4

FY 1987 MEDICAID AND GAMC PAYMENTS FOR MI DIAGNOSES

CLIENTS AGES 0-18

FY87-# OF CLIENTS	GAMC-TOTAL	SSI/MSA	AFDC	MA-NEEDY	MA-TOTAL	TOTAL
GENERAL HOSPITAL(INPATIENT)	2	57	551	375	983	985
MENTAL HEALTH CENTER	0	88	3,254	795	4,137	4,137
HOSPITAL OUTPATIENT	1	72	1,520	425	2,017	2,018
PHYSICIAN/PSYCHIATRIST	3	175	2,903	1,060	4,138	4,141
PSYCHOLOGIST	0	124	3,423	988	4,535	4,535
RTC/STATE HOSPITALS	0	12	42	154	208	208
OTHER	0	0	0	2	2	2
PUBLIC HEALTH	0	2	123	20	145	145
REHABILITATION	0	5	26	7	38	38
TOTAL	6	535	11,842	3,826	16,203	16,209
UNDUPLICATED TOTAL	4	392	9,661	2,839	12,892	12,896

NOTE: THESE DATA EXCLUDE PAYMENTS AND CLIENT COUNTS FROM HMO DEMONSTRATION PROJECTS.
PREPARED BY MENTAL HEALTH DIVISION.

TABLE 5

FY 1988 MEDICAID AND GAMC PAYMENTS FOR MI DIAGNOSES

CLIENTS AGES 0-18

FY88-# OF CLIENTS	GAMC-TOTAL	SSI/wMSA	AFDC	MA-NEEDY	MA-TOTAL	TOTAL
GENERAL HOSPITAL(INPATIENT)	5	58	534	393	985	990
MENTAL HEALTH CENTER	0	71	3,294	955	4,320	4,320
HOSPITAL OUTPATIENT	9	81	1,759	573	2,413	2,422
PHYSICIAN/PSYCHIATRIST	21	204	3,142	1,198	4,544	4,565
PSYCHOLOGIST	0	135	3,560	1,135	4,830	4,830
RTC/STATE HOSPITAL	0	9	48	172	229	229
OTHER	0	8	251	63	322	322
PUBLIC HEALTH	0	1	103	19	123	123
REHABILITATION	0	4	42	7	53	53
TOTAL	35	571	12,733	4,515	17,819	17,854
UNDUPLICATED TOTAL	22	401	10,178	3,340	13,919	13,941

NOTE: THESE DATA EXCLUDE PAYMENTS AND CLIENT COUNTS FROM HMO DEMONSTRATION PROJECTS.
PREPARED BY MENTAL HEALTH DIVISION.

Formalized methods exist on the state level for coordination among the Departments of Health, Education and Human Services in planning and implementing services for children with handicaps, from birth to age 6. No formalized methods exist on the state level for coordination among departments for children and adolescents 6 to 14 years old (ninth grade). Formal methods do exist for coordination among departments for adolescents 14 years to 21. However, mental health services are not currently included in this latter interagency coordination effort on behalf of the 14 to 21 year old population who need transitional assistance to adult services. Such coordination is needed to assure that children with emotional disturbance continue to receive needed services as they approach adulthood.

Recommendation:

State agencies should collaboratively develop training needed for multi-system service providers, such as physicians, educators, public health nurses, and child protection workers, to help them clearly identify the target population for children's mental health service provision and to provide information on connecting with decision-makers who control access to services in other systems.

Recommendation:

The Departments of Human Services and Education should cooperate in developing mental health community education programs and school curricula to assist families and children in recognizing symptoms which may indicate the need for mental health services.

Recommendation:

State agencies should assure that children and adolescents with severe emotional disturbance are commonly defined and eligibility criteria are compatible to the greatest extent possible. Where compatibility is not possible, differences should be based on state or federal law or rule and should be clearly delineated. In particular, the Department of Education should study and recommend to the Legislature local and statewide coordination of services including compatible definitions and eligibility criteria for children with emotional disturbance.

Recommendation:

To the extent feasible, state agencies should encourage co-location of service eligibility determination sites locally in order to facilitate access to services.

Recommendation:

The Department of Human Services should include mental health involvement in the State Transition Interagency Committee to assist children in the transition into the adult mental health service system.

B. Funding Resources

Because resources are compartmentalized within service systems, it is unclear what additional funding is necessary to provide services. The problem may be one of distribution of and access to funding, rather than of amount of funding available.

Recommendation:

Pooled funding and shared resources, rather than categorical funding, to address the needs of the target population, should be studied as a means to address this barrier. If funding streams must remain discrete for federal purposes, state agencies should provide models for collaborative use of funds by local agencies.

C. Data Privacy

Coordination on the local level is hampered by statutory constraints on sharing of information about specific children and families needing mental health services. This is especially true when chemical dependency or child protection services are needed by a child with mental health service needs due to federal laws which restrict release of information. Frequently neither service providers nor recipients of services understand the need for, benefits of, and means of sharing information to facilitate service planning and access.

Recommendation:

Training on appropriate use of the Data Practices Act and the Tennessen Warning should be provided to staff of agencies working with children and families. Children, families, and service providers should be provided information regarding the need for and benefit of information sharing for the purpose of coordinated service planning and delivery.

D. Public Attitudes

Because the public does not generally recognize the need for early identification and intervention for children with emotional disturbance, these services are not adequately funded

at the local level, despite being given a high priority by the Legislature. County commissioners tend to fund only those services for which there is known support. Mental health services for children may not receive the type of support which facilitates appropriate funding decisions.

An estimated 50% of families represented in juvenile court are identified as being dysfunctional. Courts have limited authority over families in juvenile proceedings. They also have limited authority to create or mandate the services provided to juveniles or their families. Often available services do not meet needs of children or families. Follow up by schools and social services agencies with these families is often lacking, especially when families under pressure view intervention efforts as coercive. Many dysfunctional families tend to move, disrupting whatever services are implemented.

A sense of community ownership of children needing mental health services is lacking, largely due to fragmentation of services and their lack of visibility. The result is that these families tend to end up in court, where, "non-legal issues that have taken 14 years to develop are expected to be resolved in 14 minutes" (Gunderson).

Although services need to be family-focused, among children whose mental health problems force them into court, family reunification is not always an appropriate goal.

Recommendation:

The Departments should develop interagency agreements to assure coordinated development of early identification and intervention services among systems serving children. These agreements should address the provision of intervention services which follow identification of children having, or at risk of developing, emotional disturbance.

Chapter V

County Planning for Adult and Children's Mental Health Services

V. COUNTY PLANNING FOR ADULT AND CHILDREN'S MENTAL HEALTH SERVICES

NOTE: This section has been written to comply with reports required by Minnesota Statutes 245.461 and 245.487.

Initial Process:

The 1987 and 1989 Comprehensive Mental Health Acts for Adults and Children require counties to submit written plans biennially to indicate to DHS how they plan to comply with the requirements of the Acts. Initial instructions for the 1990-91 county biennial CSSA and mental health plans were sent to counties in February 1989; draft adult plans were due in August 1989 and final plans in November 1989. For the first time, the CSSA and the adult mental health plans followed the same schedule. Draft children's plans were due in November 1989 and final plans in the spring of 1990. Two plans (adult and child) were necessary because of the new children's legislation.

Counties were also sent county-specific information including: funds available, historical use of various programs, and prevalence of service mental illness for adults and emotional disturbance for children.

Plans include both planning data and compliance data. When the mental health information system becomes fully operative (January 1990), data available through that system can be used for planning, monitoring, and evaluation.

The plan format, at the request of county directors, is a fill-in-the-blank model. Instructions from DHS (including statutory definitions and requirements) made up about one-third of the plan document.

Format

Counties were required to answer questions about:

-- access and service problems for special populations (elderly, American Indians, blacks, refugees, hearing impaired, homeless persons, people with multiple disabilities);

-- county program goals and objectives for adults with mental illness and children with emotional disturbance (statewide goals and objectives were supplied);

-- local needs, including input from the local mental health advisory council;

-- barriers to services and accessibility (for example, transportation or cultural barriers);

-- coordination of services for individuals and between programs;

-- membership and activities of the local mental health advisory councils; for children only, the membership and activities of the local coordinating committee (a group with representatives of agencies providing services).

Information by Services

For each mandated service, counties were asked about:

-- goals and objectives,
-- availability within or outside of the county,
-- specific services that will be available,
-- who will receive the service,
-- numbers of persons to receive the services,
-- days or hours of service per person; and
-- projected cost and sources of funding.

A discussion of the specific services and the dates by which counties are required to provide them can be found under the adult and children's annual report sections of this document.

Plan Review Process

The county plan review process at the state level included a number of steps and was similar for both the adult and children's mental health plans. Each plan was compared to a standard program review checklist by the respective regional program staff person in the Mental Health Division and by Special Project staff (older adults, Indian, homeless persons, rural Human Resource Development). A parallel review was conducted by Mental Health Division grants management staff based on a standard fiscal and data checklist.

Data from all plans were computerized and analyses prepared based on per capita and other measures. Counties were compared with one another and to measures of service adequacy established in national studies. A copy of these analyses is available from the Mental Health Division.

Mental Health Division staff also obtained input from the regional treatment centers and the Social Services, Children's Services, and other departmental divisions. A number of external reviewers, including the major mental health advocacy groups, also reviewed the plans. Department staff were impressed by the level of interest shown by these groups and their willingness to spend long hours reviewing plans in detail. It is important to note that all comments from all reviewers were carefully evaluated regarding their statutory relevance.

Department staff prepared feedback letters summarizing the results of each plan review. The letters included:

-- requests for additional clarification whenever county plans appears to be unclear or inaccurate;
-- corrective action required for areas in which counties were clearly not in compliance with statute; and
-- recommendations for improvement.

In addition, Division staff provided most counties with individualized technical assistance to ensure development of plans that are in compliance with the Acts.

Penalties for Non-Compliance

As a result of the review process, and after plan revisions, the Department identified eleven counties whose adult mental health plans were not in substantial compliance with the Act (see article). The eleven counties were notified that payment of general social service funds would be delayed until substantial compliance was achieved. The key service areas on which the Department focused were the top priorities specified in the Mental Health Act: locally available emergency services and locally available case management and community support services for persons with serious and persistent mental illness.

Revision of County Plans

As of February 1, 1990, all counties (including the eleven mentioned above) have revised, or are in the process of revising their adult and children's plans in compliance with statutes. Individual technical assistance is being provided to counties to the extent of staff time available.

In cases where compliance issues have related to inadequate levels of service availability, the Department has considered the individual situation of each county. This has included recognition of variations in need, funding availability, availability of qualified personnel, and the need for a phase-in period. The Department and the counties are making significant progress toward the statewide, comprehensive mental health system required by the Acts. However, it is important to recognize that progress cannot occur in exactly the same manner and at the same rate in every county.

Mental Health Division Staff Impressions from County Plan Reviews

-- Most counties have been very cooperative and have made every possible effort, within available resources, to develop the service system envisioned in the Mental Health Acts. For most counties, additional technical assistance and additional state funding are still needed to comply with both the Adult and the

Children's Mental Health Acts.

-- Counties appear to be almost uniformly frustrated in meeting the needs of the Mentally Ill/Chemical Dependent and, to a lesser extent, the Mentally Ill/ Developmentally Disabled dually disabled populations, although several addressed these issues creatively. Counties are attempting to find programs to meet the needs of these clients. Service development for these populations should be addressed on the state level, perhaps by putting together training or special project grants to encourage program development for the dually disabled.

-- The fact that so many counties are actively using the D/ART materials as part of their Education/Prevention Service indicates that need for more availability of public education materials statewide. It seemed evident to reviewers that if the state provides materials of high quality, counties are will to use them.

-- Some counties still have a great deal of difficulty in defining mental health services as distinct from social services. Several dozen counties, for several dozen counties, for example, planned to provide parenting services, services for battered women, and services for sexual offenders. These are needed, but in most instances the planned services were not mental health services; i.e., they did not relate to the target populations listed in the Mental Health Act.

-- Counties have expressed frustration over the amount of planning and planning documentation required. The adult and children's plans will be combined into a single biennial document, in the next planning cycle. In addition, the MHD has committed to working with counties to develop a process which will meet state statutory requirements and assist counties in their planning efforts. Related issues are discussed elsewhere in this report under "Consolidate Fiscal and Reporting."

Star Tribune/ Thursday/December 7/ 1989

Delay in funds imposed on Hennepin County

By Sam Newlund
Staff Writer

A $1 million delay in federal aid was imposed on Hennepin County Wednesday for submitting allegedly substandard plans for serving the mentally ill.

The state Department of Human Services, which funnels federal social service money to the counties, also penalized 10 other counties, but none approached the magnitude of the action against Hennepin.

While the $984,006 action is a delay, not a cutoff of funds, it will be no help to an already badly pinched county spending program. The delay involves all social services supported by a federal block grant known as Title 20, not just mental health.

Jerri Sudderth, acting mental health division director in Human Services, said Hennepin County could avoid the delay only by correcting deficiencies in its plan and resubmitting them by Friday — an unlikely event.

To avoid the fund delay, the county would have to submit a revised plan and have it approved by Jan. 1, according to Human Services Commissioner Ann Wynia.

The main problem was the short shrift that the state said Hennepin County is giving to case management services for the seriously mentally ill.

Among many reforms contained in the 1987 law, counties are required to offer case management to the "seriously and persistent mentally ill." In general this means the counties should help people plan improvements in their mental health and then work with them to find the help they need.

Tish Halloran, Hennepin County's mental health director, disputed figures used by the state in concluding that the county had "seriously underestimated" the number of people needing case management. It's impossible to give priority to case management in the way the state wants, she said, because clients who need case management also need other kinds of help.

She predicted that the delay in funds would have "a serious impact" on the county's mental health program.

But Kevin Kenney, associate county administrator for social services, said he doubted that programs would be harmed by a delay of several weeks. He said he was troubled, however, by the state's lack of communication.

"I thought I had an agreement with the state that we obviously couldn't present a County Board-approved plan until the budget had been settled," he said. This year's budget deliberations lasted longer than usual; the board's final adoption of the 1990 budget came Nov. 16.

Although the state approved much of the county's preliminary plan, it criticized several other items. Outpatient and day treatment services were cited for projected use the state considered too low.

The $984,006 being withheld was one month's worth of Title 20 funds that would have been paid Jan. 15, according John Zakelj, a Human Services mental health supervisor. Each year Hennepin County spends about $11.8 million of Title 20 money for mental health, child protection, the mentally retarded, programs for the elderly and other services, he said.

Other counties receiving delays in Jan. 15 allocations of Title 20 money were Waseca, $13,202, Houston $13,351; Lake of the Woods, $3,479, and Roseau, $11,025.

Counties receiving delays in Dec. 15 allocations from the state Community Social Service Act were Grant, $21,536; Benton, $16,660; Cass, $24,745; Goodhue, $37,161; Hubbard, $12,566, and Pope, $12,260.

Chapter VI

Task Force Reports on Screening for Residential and Inpatient Treatment Services

VI. TASK FORCE REPORTS ON SCREENING FOR RESIDENTIAL AND INPATIENT TREATMENT SERVICES

This section has been written to comply with reports required by Minnesota Statutes (1989), Section 245.4885 (for children), and Minnesota Statutes 245.476 (for adults).

1. REPORT ON SCREENING FOR CHILDREN

Background

The 1989 Legislature, in Minnesota Statutes, section 245.4885, mandated a screening service for children being considered for residential or inpatient treatment services when public funding will be used to provide those services:

> The county board shall ensure that all children are screened upon admission for treatment of emotional disturbance to a residential treatment facility, an acute care hospital, or informally admitted to a regional treatment center if public funds are used to pay for the services. If a child is admitted to a residential treatment facility or acute care hospital for emergency treatment of emotional disturbance or held for emergency care by a regional treatment center under Section 253B.05, Subdivision 1, screening must occur within five working days of admission. Screening shall determine whether the proposed treatment:
>
> 1. is necessary;
> 2. is appropriate to the child's individual treatment needs;
> 3. cannot be effectively provided in the child's home;
> 4. the length of stay is as short as possible consistent with the individual child's needs; and
> 5. the case manager, if assigned, is developing an individual family community support plan.
>
> Screening shall be in compliance with Section 256F.07 or 257.071, whichever applies. Wherever possible, the parent shall be consulted in the screening process, unless clinically inappropriate.
>
> The screening process and placement decision must be documented in the child's record.
>
> An alternative review process may be approved by the Commissioner if the county board demonstrates that an alternative review process has been established by the county board and the items of review, persons responsible for the review, and review criteria are comparable to the standards in clauses (1) to (3).
>
> No later than January 1, 1992, screening of children for residential and inpatient services must be conducted by a mental health professional. Mental health professionals providing screening for inpatient and residential services must not be financially affiliated with any acute care inpatient hospital, residential treatment facility, or regional treatment center. The Commissioner may waive this

requirement for mental health professional participation in sparsely populated areas.

The Legislature also established a task force to report on and recommend changes in screening mechanisms. The purpose of the task force shall be to:

> . . .examine and evaluate existing and available mechanisms that have as their purpose determination of and review of appropriate admission and need for continued care for all children with emotional disturbances who are admitted to residential treatment facilities or acute care hospital inpatient treatment. These mechanisms shall include at least the following: precommitment screening, preplacement screening for children, licensure and reimbursement rules, county monitoring, technical assistance, hospital preadmission certification, and hospital retrospective reviews. The task force shall report to the Legislature by February 15, 1990, on how existing mechanisms may be changed to accomplish the goals of screening as described in Section 245.4885, Subdivision 1.

A list of Task Force members is found at the end of this section.

The impetus for the children's screening mandate arose primarily from the perception of many parents, providers, clinicians and advocates that far too many children in need of residential treatment were being denied entry (i.e., undertreated) while simultaneously, less disturbed children were placed in restrictive treatment settings prior to having established that community-based interventions would be ineffective (i.e., overtreated). A strong perception persists that existing screening mechanisms have been used as a barrier to services by requiring all children to move lock-step through a service continuum regardless of individual treatment needs.

Frustration concerning treatment (and placement) decisions made by both the counties and the juvenile court system continues to exist. Both are perceived to have acted arbitrarily, making treatment and placement decisions for children with emotional disturbance without regard to the recommendations of mental health professionals, school officials, parents, and others with intimate knowledge of the children in question. The perception exists that poor decisions are often due to <u>cost</u> factors (i.e., county financial incentives or disincentives).

Parents have sometimes turned to the juvenile court to request a court order for out-of-home placement for a child with an emotional disturbance when the county social service agency has refused to take such action. The juvenile courts are accused of having sometimes acted arbitrarily by ordering restrictive placements in the absence of sufficient justification (sometimes

under conditions of extreme parental pressure) or, alternatively, ignoring the recommendations of mental health professionals for residential treatment.

Most juvenile court judges see themselves as advocates for children. As advocates, judges may fear that mental health screening has the potential to be used as a barrier to services needed by children. Believing that psychiatric diagnoses may be less valid and reliable for a child population, they are conservative in employing diagnostic labels (based on screening). Though they appreciate that diagnoses are needed to qualify children for some mental health services, they feel that diagnostic "labels" will negatively affect children as adults (including those children who recover from childhood emotional disturbance). As an alternative to what they see as "rigid screening", these judges favor what they view as more flexible screening mechanisms (e.g, short-term inpatient hospitalization for psychiatric evaluation of the level of care needed by a child).

Advocates are concerned that the legal status of children renders them even more vulnerable than adults to rights' violations. Children basically lack the right to refuse treatment. Parents sometimes lack sophisticated understanding of legal and treatment issues needed to make decisions that are in their children's best interest.

Children are sometimes placed (and/or retained) in restrictive service settings solely because the needed array of community services is either not locally available or the county is unwilling to fund such services in another county. Some counties in Minnesota, for example, may be sending children out-of-state for residential treatment rather than developing new community-based and family treatment options.

There is concern that implementation of screening requirements in any section of the service system (e.g., chemical dependency, corrections, inpatient hospitalization) will impact the mental health system and that numbers of placements will increase in other service sectors where screening requirements are less stringent.

Some mental health professionals have had positive experiences with counties' screening practices. Washburn Child Guidance Clinic, for example, serves a very young population, most of whom are extremely socially aggressive. Treatment consists of behavioral parent training and family based services as well as day treatment. Last year, a ratio of 1 in 500 of the children treated at Washburn (i.e., 1:500) were screened and subsequently recommended for residential treatment by the clinic's consulting psychiatrist. The county has generally supported the agency's recommendations for residential treatment of the few children

from this very homogeneous population who have needed it.

Not all agree that additional screening requirements are needed, or that screening is the most direct avenue for accomplishing the goals of quality improvement and rights protection. Some mental health professionals believe that more attention should be given to developing outcome evaluation, quality assurance, and community oversight mechanisms that directly monitor and influence the programs and services being provided to children by focusing on individual practitioners and providers.

Review of Existing Screening Mechanisms

A. Pre-Commitment Screening. (Minnesota Statutes, Section 253B.07)

The Mental Health Commitment Act does not specifically address commitment of children; however, counties are required to carry out pre-petition screening for any juvenile for whom an interested party desires to file a commitment petition. It is possible for children of any age to be committed (to either a regional treatment center or community-based treatment). A parent or guardian can request commitment of a child who is 15 or under. A child of 16 or above can make an independent request for voluntary admission for treatment of mental illness.

Hennepin County staff screen only 2 to 3 children for commitment in an average month. The county's Family Services Division works with the county attorney in determining whether or not to pursue a juvenile commitment in cases where children are hospitalized on a 72-hour hold order. The intake social worker goes out immediately to the hospital to review the chart, talk with the psychiatrists, and interview the child (and family when possible). An interdisciplinary team meeting is held the next day to consider the social worker's findings and to decide whether or not the team feels there is evidence sufficient to pursue the proposed commitment. The team includes a licensed psychologist, the social workers involved in the case, one or more supervisors, and community resource staff who know the alternative resources to commitment. The county attorney makes the final decision regarding the proposed commitment.

B. Permanency Planning Grants to Counties Act. (Minnesota Statute, Section 256F.07, Subdivision 1.)

Preplacement Reviews are required under this act which states that "each county board shall establish a preplacement procedure to review each request for substitute care placement and determine if appropriate community resources have been utilized before making a substitute care placement."

The Preplacement Review is a prospective review of the appropriateness of all out-of-home placements, requiring counties to review all cases where out-of-home placement is being considered by a worker (as part of the permanency planning grant requirements). In the larger counties, the case may be reviewed at an internal staffing which functions as a peer quality review of clinical practice. In a small county, one worker and a supervisor may make the determination on whether a child should be placed out of the home. Currently, there is no requirement for the involvement of a mental health professional in decisions to place a child in a mental health treatment program.

In brief telephone interviews with representatives of Dakota, Hennepin and Ramsey counties concerning their respective permanency planning screening mechanisms, all three counties referenced the 962 Administrative Review requirement -- a retrospective placement review required after 6 months of out-of-home placement. This review is apparently more commonly utilized by counties than the preplacement reviews. In recent reviews of preliminary county children's mental health plans, approximately one-half of Minnesota counties were apparently unaware of current requirements for Permanency Planning preplacement reviews for children being placed for mental health treatment.

In 1987, the latest year for which data are available, 84 of 87 counties had a Preplacement Review Procedure in place. "Fourteen percent of children who were screened for placement in 1987 did not enter substitute care. This indicates that preplacement screening procedures are not a "rubber stamp" for approval of out-of-home placement, but are a means a (sic) reviewing alternatives to removal from the family for each child" (Permanency Planning in Minnesota, March 1989, DHS Executive Summary, page 12.)

Counties are required to report quarterly to the Department of Human Services on how the Permanency Planning Grant monies are being spent, a means of monitoring standards and enforcement. However, there are no state Permanency Planning screening criteria or standards to which the counties must adhere, and the state's enforcement powers are limited to control of the grant award process. As a result, widespread variation exists in how effectively the counties are complying with the Permanency Planning Law.

C. Licensing Program Rules.

Programs providing mental health residential treatment for children are licensed under Rule 5 (Child-Caring Institutions) and perhaps Rule 8 (Group Homes).

Rule 8 requires the facility to have written admission and discharge policies. It also requires that psychiatric consultation be available on an individual case basis and for overall group treatment goals. Psychological consultation is required to provide testing for assessment throughout the stay or at the time of discharge.

Rule 5 licenses programs in child-caring institutions (10 or more children). Promulgated in 1971, it needs updating with respect to contemporary program standards. Rule 5 requires a "social study" upon which admission decisions "by an admissions committee" shall be based. The admissions committee must include at least one professional social worker. "The social study shall include all information that will permit a careful analysis of each case to make sure that each child admitted is in need of the type of care and service the institution can provide." The institution is required to have an admission policy to be used as the basis for admission decisions.

Willmar Regional Treatment Center Adolescent Program. In keeping with the Joint Commission on Health Care Organizations Accreditation (JCAHO) standards with which the Willmar program complies, this state-operated program is more intensively staffed and secured than is required by Rule 5.

Willmar's Adolescent Treatment Program has developed a comprehensive screening policy and last year "screened out" approximately 80% of the referrals it received for both sexes. A two-to-four week waiting list currently exists, with boys having the longest wait. Referrals to alternative treatment resources are facilitated when appropriate.

Screening procedures start informally with a telephone call, followed by an admission information screening, and finally an interdisciplinary team pre-admission interview on the unit. Corrections cases and cases not requiring the level of care provided by the program are screened out first. Application materials are reviewed for placement appropriateness. If the referral is deemed appropriate, the prospective adolescent is invited to tour the unit. The final step in the screening process is a pre-admission interview conducted on the unit by an interdisciplinary team. Participation in the interview is required of the prospective adolescent, the youngster's parents, and the county social worker or probation worker, (the school counselor is often invited). Willmar staff, representing the clinical, educational, and administrative areas of the program, participate in the screening process. The interdisciplinary team considers problems leading to the referral, previous placements tried and their respective outcomes, other alternatives reviewed by the county worker and

considered to be inappropriate at the present time (and why), the client's "self-presentation" on the unit, and the extent of parental support or opposition for placement at Willmar.

D. Other Existing Screening Mechanisms.

The screening mechanisms which apply to Rule 48 (preadmission hospital certification and retrospective reviews for MA and GAMC recipients) and to county monitoring and technical assistance can be found in the Adult Task Force Report. The only obvious difference for children is the perception by some people that it is easier to get children and adolescents hospitalized (under Rule 48) than adults. No confirming evidence is immediately available on this point.

E. The "Screening by a Mental Health Professional" Requirement.

None of the existing screening mechanisms currently require that screening be conducted by a mental health professional. (The Mental Health Commitment Act requires the examiner, not the screeners, to be either a physician or a licensed consulting psychologist. Minnesota Statutes, section 245.4885, subdivision 2 requires that counties must provide screening of children for residential and inpatient services by an independent mental health professional by January 1, 1992.

Task Force Problem Identification

Task Force members identified the following problem areas:

-- Screening mechanisms currently being used are disjointed and separate, even though they may accomplish their intended individual goal.

-- In the absence of integration, balance is lost, and the result is that the focus of the screening activity becomes either the rationing of care (under treatment) or the filling of beds (over-treatment).

-- Screening mechanisms tend not to be multidisciplinary in nature.

-- Rather than being based on clinical factors, admission to or denial of inpatient or residential program services may be based on administrative considerations, including: payment source (e.g., third party insurers or county funds); likelihood of subsequent payment denial; and the number of beds available in a particular facility or hospital at the time placement is considered. These non-clinical factors are believed to exclude children from needed programs as often as they result in admission to inappropriate programs.

Discussion

Members concluded that, while good models for screening exist, the use of guidelines requires reliance both on professional judgment and on consistency across treatment settings. Variables such as the "personality of the program under consideration" must be assessed, as should the level of restrictiveness needed by the child. Although diagnosis was felt to be important to the placement decision, both child and family functioning were seen as equally important. Participants indicated that, too often, the characteristics of either the child or the family exclusively become the focus, rather than the child's service needs. Assessments of both family and child are necessary to decision-making about the need for placement and about which placement to recommend. The participation of both the individual child and the family were felt to be critical to effective use of a screening process.

Methods of assuring that information is available and organized for appropriate decision-making were discussed. One suggestion was the use of a score sheet by a multidisciplinary team. However, members felt such a process could become as inflexible as the current mechanisms. In addition, it was feared that such a system would be costly to administer, draining financial resources from service delivery. The conclusion reached was that "fat" can be trimmed from the various screening processes by an emphasis on less gathering of detailed information and more emphasis on integrating existing knowledge about the child, the family, and the service options available.

Task Force members felt that often economic issues determine whether a facility accepts a particular child and how long the child remains within the facility. Some participants indicated that acute care psychiatric hospitals are often encouraged by the impact of third party payors' retrospective reviews to admit based on clear compliance with paper criteria, rather than on appropriate professional judgment. Discharge decisions are also are also influenced by such non-clinical processes. Similarly, Rule 5 facilities may be encouraged to admit based more on their need to fill beds than on their ability to provide appropriate treatment for the specific child.

While the group conceded that financing does influence admission practices, the only suggested solution was a switch to concurrent reviews by third party payors. Several participants pointed out that such an approach is extremely costly, and could divert needed resources from treatment services, a result uniformly viewed as undesirable.

In addition to the screening process two additional issues must be considered: **admission** and **continued stay criteria** for Rule 5

facilities (Child Caring Institutions as licensed by DHS). Currently Rule 5, which was written in 1971, has no uniform admission criteria. Members supported the inclusion of admission criteria in the revision of Rule 5. Participants also indicated that the question of whether a child, once placed in a residential facility, should remain there must be addressed as part of continue stay criteria. Some children are believed to remain too long and other are forced out despite therapeutic progress. In the latter instance, therapeutic relationships are disrupted by the lack of continuity of care, resulting in the loss of hard-won treatment gains. Case management services were seen as assisting in addressing continuity of care issues. Counties were viewed as responsible for both provision of case management for these children and, ultimately, for the quality and appropriateness of the services they purchase for children.

The task force concluded that screening processes should be based on the following principles:

-- Screening processes should be simple and consistent, based on common guidelines which seek to organize and integrate information gathered about the child, the family, and available community and residential service options in order for mental health professionals to make appropriate recommendations regarding placements.

-- Screening processes should have the capability to respond differentially to emergency and non-emergency situations.

-- The screening mechanism must provide an effective and immediate linkage between counties (as the funder of services for individuals receiving publicly funded services) and service providers, to assure comprehensive planning and continuity of care between needed services, in accordance with data privacy requirements.

-- Screening functions must be separate and distinct from ongoing case management services unless the case management model used for mental health services in Minnesota is changed.

-- Screening must provide a structure which has as its primary focus the clinical needs of the child and family and which results in decisions soundly based on clinical needs.

<u>Recommendations</u>

Recommendation:

The screening team should be comprised of, at minimum, the child, his/her family (unless clinically contraindicated), the referring agent, and a mental health professional.

Recommendation:

A well-publicized appeal process should be available to those families and children who believe the screening process has not met their needs. Such a process should be multidisciplinary in nature (much like the case review process used in some states for decisions about whether placement should occur).

Recommendation:

Rule 5 must be revised to include common admission and continued stay standards for all residential treatment facilities serving children. These standards should be linked with the Permanency Planning Process.

Recommendation:

Upon revision of the rule, DHS should monitor Rule 5 facilities randomly as part of its licensing process to assure that appropriate services and lengths of stay are being provided. Full scale reviews should be undertaken when facilities do not meet licensure guidelines.

Recommendation:

Further study of screening issues and existing screening mechanisms is needed to address current inconsistencies and to identify successful models from which to build an effective and coordinated screening system for children.

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2. REPORT ON SCREENING FOR ADULTS

Background

The 1989 Legislature amended Minnesota Statutes, section 245.476, subdivision 1, as follows:

> No later than January 1, 1992, the county board shall screen all adults before they may be admitted for treatment of mental illness to a residential treatment facility, an acute care hospital, or informally admitted to a regional treatment center if public funds are used to pay for the services. Screening prior to admission must occur within ten days. If an adult is admitted for treatment of mental illness on an emergency basis to a residential facility or acute care hospital or held for emergency care by a regional treatment center under section 253B.05, subdivision 1, screening must occur within five days of the admission. Adults must be screened within ten days before or within five days after admission to ensure that:
>
> 1. an admission is necessary,
> 2. the length of stay is as short as possible consistent with individual client need, and
> 3. the case manager, if assigned, is developing an individual community support plan.
>
> The screening process and placement decision must be documented in the client's record.
>
> An alternative review process may be approved by the commissioner if the county board demonstrates that an alternative review process has been established by the county board and the times of review, persons responsible for the review, and review criteria are comparable to the standards specified in clauses (1) to (3).

The same year, in Minnesota Statutes, section 245.476, subdivision 4, the Legislature also required the appointment of a task force to:

> ...examine and evaluate existing mechanisms that have as their purpose review of appropriate admission and need for continued care for clients admitted to residential treatment, acute care hospital inpatient treatment, and regional treatment center inpatient treatment. These mechanisms shall include at least the following: precommitment screening, licensure and reimbursement rules, county monitoring, technical assistance, nursing home preadmission screening, hospital preadmission certification, and hospital retrospective reviews. The task

force shall report to the Legislature by February 15, 1990, on how existing mechanisms may be changed to accomplish the goals of screening as described in subdivision 1.

Subdivision 5 required the Commissioner to:

> ...review the statutory preadmission screening requirements for psychiatric hospitalization, both in the regional treatment centers and other hospitals, to determine if changes in preadmission screening are needed. The Commissioner shall deliver a report of the review to the Legislature by January 31, 1990.

A listing of Task Force Members can be found at the end of this section.

Although originally discussed in 1987, the emphasis on screening gradually shifted between 1987 and 1989 from concern about whether or not the admission is appropriate (i.e., in most cases, admissions are believed to be appropriate) to recognition that a "quality review" mechanism is needed to ensure both the treatment provided and the length of stay are appropriate to the individual's needs. However, the statute clearly mandates that screening for adults must be accomplished prior to admission. The focus of screening can be on (1) the adequacy of preadmission screening and/or (2) a quality review mechanism which evaluates the adequacy of the treatment provided and the length of stay in the program. If emphasis is placed on preadmission screening, significant issues are whether to a mental health professional should be required to conduct screening (as it is in the children's statute), as well as whether screening is necessary at all, and what costs are attached to preadmission screening.

A related concern is that Rule 36 should require that program policies more clearly describe the characteristics of the population to be served, the nature of the treatment program, and measurable outcomes of the treatment provided. It has also been suggested that admission criteria, length of stay criteria, and discharge criteria should be specified in law.

Review of Existing Screening Mechanisms

A. Pre-Commitment Screening (M.S.253B.07 Judicial Commitment; Preliminary Procedures).

> This statute requires a preliminary investigation be held by a screening team appointed by the designated agency to protect the individuals due process rights. The screening team conducts an investigation which includes a personal interview with the proposed patient and others who appear to have knowledge of the proposed patient's condition; identification and investigation of specific alleged conduct which underlies

the application for commitment; identification, exploration, and listing of reasons for rejecting or recommending alternatives to involuntary commitment. The screening team has access to all relevant medical records of the proposed patient if he or she is currently in a treatment facility. The screening team must refuse to support a commitment recommendation without sufficient evidence. If the screening team recommends commitment, a written report is sent to the attorney for the county in which the petition is filed.

This mechanism is used to screen prospective admissions (and periodically to assess and report to the judge on the need for continued court-ordered confinement) for patients who are committed to regional treatment centers, community-based residential treatment programs, and non-residential treatment programs. In practice, the Commitment Act is rarely used to commit patients to community-based treatment.

The law defines standards for serving as a psychological examiner. However, it does not define standards concerning qualifications for membership on the screening team, nor does it specify the number of necessary members for a screening team. The lack of standards may conceivably weaken the effectiveness of screening.

B. Draft DHS Residential Program Management Division Policy for Voluntary Admission, Continued Stay, and Discharge Criteria for Adults/Adolescents with Mental Illness.

This policy should be approved for implementation shortly. When implemented, the policy will have far reaching referral and placement implications for the courts, the counties, and providers who are used to referring to the regional treatment centers with the expectation of relatively automatic admission.

The draft policy incorporates the state's regulatory authority governing payment for care with Medicare reimbursement criteria. (MA Inpatient Preadmission Hospital Certification -- Rule 48 -- does not apply to regional treatment centers.) It will require physician certification of medically necessary care at the time of admission. The policy will ensure that all persons admitted require active treatment. It establishes a standard and guidelines for the determination of competency, establishes admission procedures when a patient is determined incompetent and refuses treatment, and establishes procedures for subsequent referrals of non-certified admissions.

C. Hospital Preadmission Certification and Retrospective Reviews/DHS Rule 48.

These screening mechanisms are administered for the Department of Human Services under contract with Blue Cross and Blue Shield of Minnesota. The prospective payment rule establishes standards and procedures for admitting physicians and hospitals seeking Medical Assistance (MA) or General Assistance Medical Care (GAMC) payment for inpatient hospital services to MA or GAMC recipients under Minnesota Statutes, Chapters 256B and 256D. The funding rule is based on a system of DRGs (diagnosis related groups in the diagnostic classification system established under Minnesota Statutes, Section 256.969, Subdivision 2, and defined in Part 9500.1090 to 9500.1155.

The screening mechanism ensures that MA and GAMC recipients are appropriately admitted and treated for inpatient treatment of mental illness in private hospitals. The rule includes criteria for concurrent reviews, continued stay reviews, and retrospective reviews. According to DHS utilization review staff, payment denials are indeed higher for mental illness than physical illness where assessment criteria and/or clinically valid indicators for treatment are available.

The retrospective denial rate for psychiatric admissions for children and adults is 4.7%. While the medical review agent reviews approximately 40% of medical/surgical admissions retrospectively, 100% of psychiatric admissions are retrospectively reviewed because of the subjective nature of clinical indicators of these conditions.

As a result, over the last five years the prospective payment system has had some negative impacts for mental health service recipients because patients tend to be hospitalized just long enough to become stabilized and for a discharge placement to be found (i.e., short-term crisis management). For many discharged patients, support systems outside the hospital are not sufficient to maintain the person in the community. When readmitted, progress is sometimes lost.

In a substantial number of cases where reviews have determined that hospitalization was "over-utilized", it was later learned that extended hospitalization was needed because alternatives to hospitalization were not available. The Task Force was mindful that screening requirements will do nothing to remedy problems of lack of system capacity. Screening was seen as useful in documenting the system's lack of capacity, however.

A DHS report to the 1988 Legislature studied the effects of the Rule 54 payment system for hospitals (based on DRG's) on

"practice patterns" in mental health. The report concluded that there was no evidence that hospitals are taking advantage of the rate setting system in a way that is detrimental to patients and that the system should be continued. The "problem" in mental health, according to the report, is with the prospective payment system -- not the DRGs. During the study period the denial rate was only 1%, including mental health. (Denial rates for later periods may be slightly higher.) The study concluded that appropriate services are being provided and that the trend for readmissions during the study period actually decreased. The report recommended consideration of developing a "severity index" for mental health treatment, continued development of alternatives to hospitalization, and separation of program costs from other costs included in the rate.

Similar screening mechanisms have been established to certify and recertify admission for inpatient treatment for mental illness in acute care hospitals by other third party insurers of private pay patients (e.g., private carriers, HMO's, self-insured employers). Again, the problem is apparently not necessarily that people are being inappropriately admitted, but that they are being discharged prematurely. (There is also the problem of people who are uninsured, or who have insurance which lacks mental health benefits or contains benefits totally inadequate to meet their mental health needs.)

Many observers believe that the prospective payment system has negatively impacted on Rule 36 (Residential Treatment Program) providers and regional treatment centers which do not operate under the same payment system as hospitals and find themselves on the receiving end of the hospital system's "fall out." Patients are typically discharged from acute care hospitals having only been stabilized. They often require considerably more care and supervision than was the case when hospital stays were longer.

D. Licensing Program Rules

Rule 36 requires the license holder to establish admission criteria (delineating the types and characteristics of persons who can and cannot be served by the program) and discharge and transfer policies and procedures. Only Category I programs have the additional requirement that intake information must document that a prospective resident has been diagnosed as mentally ill and requires treatment. Diagnoses must be based on medical, social, psychological and psychiatric information and histories obtained for each resident.

E. Nursing Facility Preadmission Screening and Annual Resident Review (PASARR).

Subtitle C of P.L. 100-203, also known as the federal Nursing Home Reform Act or OBRA-87, was intended to assure that persons with mental illness, mental retardation or related conditions are not inappropriately residing in Medicaid-certified nursing facilities. The law requires each state to establish a preadmission screening program to assure that persons who have mental illness are not inappropriately admitted to such facilities after January 1, 1989. Since Minnesota already had a successful nursing home preadmission screening program, it was decided to add mental health screening and, as needed, diagnostic assessment to the existing preadmission screening program rather than to develop a new and separate screening program. Preadmission screening teams refer persons who have, or may possibly have, a mental illness to the local mental health authority for further evaluation and possible diagnostic assessment.

The law also requires each state:

1. to assess the service needs of all persons with mental illness, mental retardation or related conditions currently residing in nursing facilities;

2. to determine the necessity and appropriateness of their current services; and then, by April 1, 1990, to:

   (i) relocate persons who have mental illness or mental retardation or related conditions who are inappropriately placed; or

   (ii) enhance services for persons who are not receiving appropriate services.

Minnesota is utilizing an existing program, the Minnesota Department of Health Quality Assurance and Review (QA&R) program, in order to meet the federal requirements. During annual visits to each Medicaid-certified nursing facility, the QA&R team reviews evidence of mental illness, need for active treatment and need for nursing facility care and then make appropriate referrals to the state or county mental health authority or makes recommendations to the nursing facility staff regarding additional follow-up and evaluation.

F. County Monitoring and Technical Assistance.

The DHS Policy Coordination Division is responsible for county monitoring and technical assistance; however, this Division does not provide technical assistance on programmatic mental

health issues which come under the responsibility of the Mental Health Division.

Task Force Problem Identification

Task Force members identified the following problems:

-- Mechanisms for, and logistics of, screening are inconsistent across services, systems, and counties. Currently, each facility and each clinician sets individual criteria for admission.

-- Criteria for admission, especially to acute care hospital psychiatric programs, may focus more on administrative issues such as funding sources, likelihood of subsequent payment denial, and availability of beds rather than on clinical factors or judgments. Appropriateness of the proposed placement is not always the primary criterion which determines admission. Available funding and the number of beds may dictate clinical practice.

-- Screening can identify gaps within systems, but specific information on those gaps is hard to capture, especially if an individual is provided community services which do not require screening, rather than residential or inpatient services. Screening mechanisms should be broad enough to deal with whatever services are needed. The dichotomy is one of the ideal placement for a given individual versus the most appropriate placement given available resources. A data collection system is required to capture the difference between the two.

-- Retrospective reviews by third party payors force hospitals to pick up costs of services after the fact, even when prior authorization has occurred. The state is directed to use both these review mechanisms to safeguard against unnecessary or inappropriate use of Medical Assistance services. The result is that the burden for screening out in advance anyone who might later be found to be inappropriately placed by the payor has fallen on hospitals, making them unwilling to take admissions except in very clear cut cases.

-- A unified screening system may be easier to implement in rural or small town areas; such systems may be logistically impractical for large metro areas in which there are multiple providers and numerous options for placement and community services.

-- Three major problems exist:

  o lack of community-based alternatives to residential and inpatient services;

- o lack of appropriate funding for community and residential and inpatient programs; and

- o lack of beds within residential and inpatient programs.

What is available has an impact on who is admitted to residential/inpatient programs. An adequate array of both community based services and residential/inpatient services is a key to resolving inappropriate placement problems.

-- Funding for the Regional Treatment Center system reduces the availability of funding for other service development.

-- Often delays in discharge are necessary because the individual does not have adequate funds to pay for the costs of room and board outside the facility. No mechanism currently exists to address this issue, so clients must wait until their next assistance payment check arrives to move. The result is that stays can be unnecessarily long.

-- Multiple screenings are costly, yet the system sometimes encourages them.

Recommendations

Recommendation:

Requiring third party payors to cover all costs of treatment which have prior authorization, until such time as a concurrent review shows the treatment to be inappropriate, should be studied.

Recommendation:

Each entity providing mental health services under contract with a county should be required to have admission, continued stay, and discharge criteria as part of the service contract.

Recommendation:

The current revision of Rule 36 should address general admission, continued stay, and discharge criteria and all providers of licensed services should be required to adhere to these standards.

Recommendation:

Screening processes should have the capacity to respond differentially to emergency and non-emergency situations.

Recommendation:

The screening mechanism must provide an effective and immediate linkage between counties (as the funder of services for individuals receiving publicly funded services) and service providers, to assure comprehensive planning and continuity of care between needed services, in accordance with data privacy requirements.

Recommendation:

Screening functions must be separate and distinct from ongoing case management services unless the case management model used for mental health services in Minnesota is changed.

Recommendation:

Screening must provide a structure which has as its primary focus the clinical needs of the adult and which results in decisions soundly based on clinical needs.

Recommendation:

The screening process must be multi-disciplinary in nature, providing a comprehensive assessment of the individual's service needs. Participants should include, at minimum, the individual, family or significant others (if desired), referral agent, and mental health professional.

Recommendation:

The screening process must include an appeal mechanism which can be readily accessed by the individual or the individual's legal representative.

Recommendation:

Additional study is necessary to create a screening mechanism which addresses current screening issues, identifies inconsistencies, and utilizes existing successful models in the development of an effective and coordinated system.

Adult Inpatient and Residential Treatment Services Task Force Members

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Chapter VII

Special Initiatives

VII. SPECIAL INITIATIVES

This section is written to comply with reports required by Minnesota Statutes 245.4861 (Public/Academic Liaison Initiative); 245.98 (Compulsive Gambling Project); and to report on Indian Mental Health Programs, Refugee Mental Health Programs, Mental Health Services for the Homeless, Rural Mental Health Services and Mental Health Services for Older Adults.

1. PUBLIC/ACADEMIC LIAISON INITIATIVE

NOTE: This section has been written to comply with reports required by Minnesota Statutes 245.4861.

A public/academic liaison is essential in improving the quality of services to persons with mental illness; therefore, the Comprehensive Mental Health Act was amended to include a Public Academic Liaison Initiative (PALI) (M.S. 245.4861). The Department is charged with establishing:

> "a public/academic liaison initiative to coordinate and develop brain research and education and training opportunities for mental health professionals in order to improve the quality of staffing and provide state-of-the-art service to residents in regional treatment centers and other state facilities (M.S. 245.4861 subd. 1)."

PALI is to include programs which:

-- encourage and coordinate joint research efforts between academic research institutions throughout the state and regional treatment centers, community mental health centers, and other organizations conducting research on mental illness or working with individuals who are mentally ill;

-- sponsor and conduct basic research on mental illness and applied research on existing treatment models and community support programs;

-- seek to obtain grants for research on mental illness from the National Institute of Mental Health and other funding sources;

-- develop and provide grants for training, internship, scholarship, and fellowship programs for mental health professionals in an effort to combine academic education with practical experience obtained at regional treatment centers and other state facilities, and to increase the number of professionals working within the state" (M.S. 245.4861 subd. 3).

No appropriation was made for the Public Academic Liaison Initiative in 1989. Therefore, no new activities could be started. However, many ongoing MHD activities, as well as new activities funded by the NIMH Human Resource Development (HRD) capacity building grant facilitate public/academic liaison.

Given the potential value to DHS of a constructive relationship with academic institutions, it is important to note that many linkages already exist between the Department and higher education although these linkages are not always well coordinated with each other. However, these linkages can provide a model or basis for a more comprehensive approach to a public/academic liaison initiative. Examples of existing linkages that relate to the outcomes specified in the PALI legislation are:

A. DHS's Institutional Review Board's (IRB) primary function is to coordinate research efforts in state facilities and to screen research projects for appropriate and ethical use of subjects and data. However, the Board also has taken on a mission to advocate for research within the regional treatment centers. The Board's membership is a mixture of representatives from Minnesota's medical schools, DHS, and such organizations as the Institute for Disability Studies and the Minnesota Hospital Association. This membership affords some liaison capacity between DHS and academic institutions interested in researching the biological origins of and treatment for mental illness.

B. The DHS's Affirmative Action Office has recognized the need to attract qualified persons of color to positions in the state's residential facilities. The Office has developed recruiting relationships with colleges and universities with traditionally minority enrollees throughout the country. The Minority Recruitment Shortage Occupation Project has focused on the occupational roles in the areas of occupational therapy, physical therapy, and speech pathology. The Project has placed student interns in both Brainerd Regional Human Services Center and Fergus Falls Regional Treatment Center.

C. University representatives are on a variety of advisory groups including HRD Project; Refugee Mental Health; Compulsive Gambling; Case Management; and Rule 36 revision.

During the past year there have been several efforts to link with the University of Minnesota in the area of research and research grants.

In developing a grant application for the NIMH's children's systems grants (CASSP), the University's Center for Urban and Regional Affairs (CURA) was contacted to develop the evaluation /research component of the application. They would have conducted the research component of the project. Unfortunately the grant was not funded.

The Minnesota Center for Survey Research which is also part of CURA conducted a survey on gambling behaviors for the Division's compulsive gambling project. The survey was conducted as part of their Fall 1989 statewide survey. The survey was a follow-up to

a survey also done by the Center in 1984 for the Division on Gambling behaviors.

Dr. Mary Anne Casey from the University of Minnesota's Extension Service conducted the first year evaluation of the Child and Adolescent Mental Health Comprehensive Service Delivery System Pilot Projects. Dr. Casey is currently an assistant professor at the Minnesota Extension Service.

Dr. David Knoke, professor and chair of the Department of Sociology, is currently preparing a research grant application to NIMH. The application will be an interagency coordination research project on children's mental health services. The Division has worked with Dr. Knoke in developing a research project of interest to both the Division and Dr. Knoke. The Division will work with Dr. Knoke in further developing his proposal as well as offering cooperation for the research application to NIMH.

DHS received in October, 1989, a grant from the National Institute of Mental Health (NIMH) for Capacity Building in Human Resource Development. This project has four main goals, one of which is to develop appropriate planning linkages with academic institutions, mental health service agencies and other related agencies. The expected outcomes of the Human Resource Development (HRD) Project are consistent with the program goals of PALI.

The project has assembled an advisory group. Approximately one third of this advisory group's membership is from the academic sector, with representatives from the University of Minnesota School of Nursing, University of Minnesota Dept. of Social Work, and the Higher Education Coordinating Board. Others will be added as the advisory group is developed.

Although NIMH funded line items related to the public/academic collaboration aspects of the project at only 35% of requested levels, the funding is a start. These funds are to be used to engage faculty in planning, implementing, and evaluating the collaboration in education, services, and research.

DHS is also pursuing assistance from the State/University Collaboration Project (SUCP), headquartered in Washington, D.C. This project is a joint effort of the Pew Memorial Trust and the American Psychiatric Association. The SUCP offers in-depth consultative services to states wishing to develop or enhance existing state/university collaborations. DHS is applying for a consultation.

The SUCP also conducts regional workshops designed to assist in creating or expanding collaborative efforts between state mental health departments and departments of psychiatry. The Screening

Committee has scheduled a regional workshop for June 21-22, 1990 in Minneapolis.

While the SUCP focus on psychiatry is far narrower in scope than the collaboration envisioned by either PALI or HRD, it may well form the basis for more extensive collaboration with the academic system in the future.

The National Institute of Mental Health offered grants for the development of public/academic linkages in 1989. Based on the recommendations of the Pew/APA consultation, the Department may consider applying for a PALI grant in a future funding cycle. (NIMH PALI grants are available only upon demonstration of established public/academic liaison activities and commitment.)

The MHD has lent its support to a proposal from the Bachelor of Social Work program of the College of St. Benedict to work with local (county) Mental Health Advisory Councils. The proposal has been submitted to the Blandin Foundation for funding.

2. COMPULSIVE GAMBLING PROJECT

Statutory Basis

Minnesota Laws, 1989, Chapter 334, Article 7, (Minnesota Statutes, section 245.98), designates the DHS as responsible for development of a Comprehensive Gambling Treatment Program. Within DHS, the Mental Health Division (MHD) was assigned to direct and administer the new program. Following a statewide search, the MHD appointed a project director for the Compulsive Gambling treatment program, effective October 25, 1989.

Administrative Plan

In keeping with DHS' administrative policies for community based mental health services, the MHD will limit its role to overall administrative direction of the program and will contract with qualified providers for services authorized by Minnesota Statute 245.98.

At the present time, the State of Minnesota does not provide or contract for any treatment services specially designed for compulsive gamblers and their families. Nationally, there are only seven (7) states with publicly sponsored programs and, with the exception of Iowa, all of these programs are located on the east coast of the United States. Within Minnesota, only one private treatment program designed specifically for compulsive gamblers exists. This pilot program, located in Cloquet is jointly sponsored by the Minnesota Council on Compulsive Gambling and the Phoenix Family Center.

Statewide Advisory Committee

Because currently only a relatively small number of special treatment programs operate in the U.S., there are few research findings or literature on which to pattern Minnesota's program. However, Minnesota has a unique challenge and opportunity to develop an effective model program, and also to provide leadership assistance to other states that already have lotteries, but no treatment programs.

Because of the lack of an existing program structure, the MHD felt it was important to involve a wide variety of stakeholders in the initial program design and development process. To accomplish this goal, a special advisory committee was organized with a broadly representative membership. The first meeting of the new committee was held on December 18, 1989. A second meeting was held on February 2, 1990, with the agenda devoted to providing members with orientation and training related to the problems of compulsive gambling.

The committee chairperson is Steve Dentinger, who is also Chairman of the Minnesota Council on Compulsive Gambling. A complete list of committee members is at the end of this section.

Development of the advisory committee slowed the program start-up process, though the need for careful planning justifies the slower start. Advisory committee members are now actively working on several key sub-committees and important actions are now taking place. These are discussed below.

Statewide Toll-Free Telephone Service

The MHD is preparing a contract with the Minnesota Council on Compulsive Gambling for a statewide toll free hotline to be effective March 1, 1990.

Because of the present lack of availability of community based treatment services for compulsive gamblers, the hotline program contract includes provisions for linking, or referring, calls for assistance with Gamblers Anonymous (GA) and Gamanon groups that exist statewide. While GA and Gamanon are not yet as widely established as needed, it is hoped this new involvement will encourage the establishment of additional groups. Therefore, the contract emphasizes recruiting and training of the GA volunteer members as well as backup support by a qualified mental health professional and linkages with the community mental health human services system to assure the use of the existing system, whenever appropriate.

Resource Library

Development will be coordinated with the Public Education and Provider Training Programs. Currently, the MHD is acquiring a variety of books, pamphlets, a video and other educational materials that are available to the public.

Public Education

Contract specifications for a Compulsive Gambling Public Education Program which will be coordinated with the other programs such as the resource library and the statewide toll-free telephone number are being developed.

While the MHD recognizes Public Education as a high priority, the limited biennial appropriation will restrict the initial scope and delay start up of this aspect of the Compulsive Gambling Project.

Regional In-Service Training Programs and Conferences for Health Care Professionals, Educators, Treatment Providers, Employee Assistance Programs and Criminal Justice Representatives

An RFP for training programs and conferences will include a basic, introductory component (6-8 hours) available to all interested human services (mental health, chemical dependency, addiction) and health services providers in order to increase their awareness of the problem and provide them with guidelines for identifying clients who may have the problem and to facilitate appropriate treatment referrals. The training program must also include specific content which will meet national certification criteria to ensure that state residents have access to certified providers.

The MHD recognizes that provider training is also a high priority. However, only a few qualified trainers exist and the training is costly. Because of the limited biennial appropriation, the Compulsive Gambling Project will delay provider training efforts.

Currently staff are exploring the possibility of incorporating at least the basic, introductory component into ongoing provider conferences and workshops.

Inpatient and Outpatient Treatment and Rehabilitation Services

One remaining authorized program which the MHD may not be able to address this fiscal year due to fiscal constraints is the provision of state grants for community based treatment programs. It is generally agreed that grants will eventually be necessary because health insurance coverage is typically not available for treatment of compulsive gambling. Two or three small grants could be available during SFY 91. Staff will also explore third-party payment for treatment.

Research: Baseline and Prevalence Studies (Adolescent and Adults at Highest Risk)

There is general agreement that research is essential to a sound program planning process. To help guide the state in this important area, the MHD has contracted with Dr. Durrand Jacobs, a nationally recognized expert in the field, to advise and assist with the design and development of a research program.

In addition, the MHD also contracted with the University of Minnesota Center for Survey Research to carry out a statewide telephone survey of gambling attitudes and behaviors as part of their annual survey. This latest survey is a follow-up to the one the MHD contracted for in 1985, the year pull tab gambling was legalized in the state. The follow-up survey allows for the

tracking of changes in gambling behavior to provide information significant to the development of a treatment program.

Although complete survey analysis reports are not available, preliminary findings indicate an increase in the percentage of Minnesotans who gamble for money. In 1989, 67% of greater Minnesota residents and 73% of metropolitan area residents surveyed reported gambling for money in their lifetime; in 1985, 45% gambled in the last year, while in 1989, 53% reported gambling in the last year.

However, a number of respondents who reported having a gambling problem remained essentially unchanged between 1985 and 1989. Both surveys found about 2% of the greater Minnesota respondents and 1% metropolitan area respondents reported a problem with gambling. These findings are consistent with those from other states where residents have comparable access to gambling.

The 1989 survey differed from the 1985 survey in that the 1989 survey included a question regarding the age at which the respondent first gambled for money. This question was added to address gambling behavior among adolescents as well as among adults. Preliminary results indicate that 18% of greater Minnesota residents and 22% of metropolitan area residents first gambled for money before the age of 18.

3. INDIAN MENTAL HEALTH PROGRAMS

The Department of Human Services, Mental Health Division continued support of Indian Mental Health Projects in 1989. The Indian Mental Health Projects are to providing services in education and prevention, crisis counseling, case management and in coordinating with the county community support programs. Additional Indian communities are becoming involved in county mental health advisory and coordinating councils for adults and children.

As a result of 1987 legislation, federal Alcohol, Drug Abuse and Mental Health (ADM) block grant funds (the set-aside portion) were increased from 12% to 25% beginning January 1, 1989. This made it possible for the seven reservation projects to expand their programs. This was done through adding staff and or developing additional programs. An eighth reservation project was funded and, for the first time, two urban projects were funded.

The Indian Mental Health Advisory Council has met quarterly. Membership includes representatives from all eleven reservations as well as from the urban communities. The Council advises the Multicultural Program Consultant on the use of federal grant set aside funds in the delivery of mental health services for Indian populations.

An Indian Mental Health Conference, the second held in the state, was held at Grand Portage in June. The last one was in 1981. The conference was well received by the attendees, who recommended that it become an annual event.

A majority of the projects utilize the services of Traditional Healers as well as the services of the community mental health providers, making mental health services more acceptable and accessible by community members.

Finally, the MHD expanded its Indian Mental Health Program Advisor position to include a multicultural focus. The staff person will work closely with the DHS Refugee and Immigrant Assistance Program.

The following Indian Mental Health Projects were approved for 1989:

PROGRAMS and GRANT AWARDS for	12 MONTH	15 MONTH
Boise Forte	$28,826.00	$34,178.00
Fond Du Lac	38,259.00	36,750.00
Grand Portage	23,260.00	13,475.00
Indian Health Board, Minneapolis	-0-	36,750.00
Leech Lake	36,960.00	27,844.00
Lower Sioux Community	-0-	17,088.00
Mille Lacs	25,500.00	25,813.00
Shakopee	11,015.00	-0-
Upper Midwest A.I.Center, Mpls.	-0-	33,781.00
Upper Sioux	7,031.00	17,088.00
Totals	$ 170,851.00	$ 242,767.00

Total $ Awarded for 1989 $ 413,618.00

Programs are being continued at the same level for 1990. However, for 1991, it appears that a cut in the federal ADM Block Grant will require a 15% cut in these programs.

4. REFUGEE MENTAL HEALTH PROGRAMS

The Department of Human Services, Mental Heath Division will continue to address Refugee mental health concerns though the federal grant supporting specific projects expired in August 1989. The State will continue to require counties to address the unique mental health needs of Refugees in their county service plans, thus ensuring attention to the needs of refugees.

The Mental Health Division has identified a need for a multicultural focal point within the division. The temporary position of the Indian Mental Health Program Advisor has been expanded to include a multicultural focus and has been converted to a permanent position.

The Refugee Mental Health Advisory Council remains active and meets quarterly with the subcommittees meeting monthly or as often as necessary.

The foremost problems identified by the Council continue to be the shortage of bilingual/bicultural persons trained in human services and inadequate funding for specialized services.

Legislation was enacted during the 1989 session, which made $150,000.00 available Social Adjustment/Mental Health Programs for SFY 1991. As a result of a signed agreement between the Refugee and Immigrant Assistance and Mental Health Divisions supervision of the refugee mental health funds will be shared and coordinated between RIAD and MHD,(this includes development of requests for proposals, proposal review and grant awards.)

5. HOMELESSNESS - THE STEWART B. MCKINNEY MENTAL HEALTH BLOCK GRANT

The Mental Health Division is the administrative agent for the Mental Health Services for the Homeless (MHSH) Block Grant. The grant is federally administered by the Alcohol, Drug Abuse and Mental Health Administration (ADAMAHA) and HHS. The State agency distributes money to local programs to provide:

mental health services;
outreach;
case management;
referrals; and
substance abuse treatment

to homeless persons who have mental illness. Money is also available for project staff. Funding to each state is based on the proportion of a state's urban population relative to the nation's urban population.

The 1987 Legislature appropriated $350,000 for the biennium for delivery of mental health services to homeless individuals in Hennepin, Ramsey and St. Louis Counties. This money was used towards the required 3 to 1 match of the McKinney Block Grant. The 1989 Legislature appropriated an additional $400,000 for the next biennium.

Congress allocated $32,200,000 in 1987. Minnesota received $396,190 (1.23%). In 1988, Congress allocated an additional $11,489,000 and Minnesota received $176,083 (1.53%). The initial federal notification of available funds was received in November 1987 (FY 88) and federal approval for the State plan was received in March 1988. The first state spending began in June 1988.

The Mental Health Division used the Department of Jobs and training quarterly shelter data to determine which counties would receive would receive funds and in what percentage. In order, the counties chosen based on the number of sheltered homeless persons and the SY 89 funding amount are:

COUNTY	**% SHELTERED 8/88**	**SY 89 $**
Hennepin	46.6%	$275,000
Ramsey	23.3%	$143,000
Polk	6.4%	$ 59,841
St. Louis	3.2%	$ 59,496
Blue Earth	2.6%	$ 48,429
Clay	2.4%	$ 48,429

With the additional 1988 federal funds two counties received money because they were representative of either rural homelessness or suburban homelessness. These two counties were:

COUNTY	% SHELTERED 8/88	SY 89 $
St. Louis (rural)	6.7%	$ 26,000
Anoka (suburban)	5.2%	$ 44,730

No single county is expected to meet all the federal requirements for the McKinney program; but the state as a whole must provide for each program area. Hennepin and Blue Earth Counties provide services directly through their own county staff, while the other six counties either contract with the community mental health center, community support program or a private agency.

Minnesota's McKinney Mental Health Services for the Homeless (MHSH) allocation for FY 89 was $267,000 (1.89% of the $14,100,000 Congress allocated). On December 23, 1989, notification was received that Minnesota's FY 90 allocation will be $334,000. For SFY 89, the total Mentally Ill Homeless Grant program budget (state and federal dollars) was $740,000. SFY 90 budget is $724,000.

The Mental Health Division has hired a Program Advisor for .4 FTE to provide technical assistance, training and networking for each project and to other MHD staff. Grants management and administration is conducted by the grants manager from the MHD Technical Support Unit.

McKinney Act funding has been used by grantees to hire 18 FTE local staff. They provide direct services to homeless individuals. All project staff work closely with homeless shelters and drop-in providers in their area and they also have training and networking meetings with local law enforcement personnel. Each project has an assessment process to determine homelessness, at risk homelessness and mental illness. If staff determine that an individual has mental illness and is homeless, they attempt to move the person and the needed mental health services towards each other, although much of the initial activity involves meeting basic needs of food and shelter.

This coming year, Minnesota's program will attempt to continue the current eight projects. The rural areas will be asked to focus further on those at risk of homelessness and mental illness as well as on migrant workers who are homeless and also have mental illness. The urban area projects will attempt to have more of their clients accept county mental health case management on an on-going basis.

Continuing full funding for these projects because Congress and

the Legislature have combined to allocate only $534,000 (74%) of the $724,000 needed. A short term solution will be to draw down federal funds at an earlier time than the MHD has been doing. If Congress terminates funding, projects could be terminated before meeting objectives.

(1) The definition of mental illness for this federal program includes acute mental illness as well as serious and persistent mental illness as defined by M.S. 245.462, subd. 20.

6. RURAL MENTAL HEALTH SERVICES

Minnesota was one of four states participating in an 18-month NIMH Rural Mental Health Demonstration Project. The demonstration was limited to 15 counties in the southwest area of the state. The project, designed specifically to be time-limited, terminated in September 1989.

The demonstration project accomplished tasks in a number of program areas. Though the project has ended, efforts have been made to build upon the linkages the project established.

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

Grant staff also initiated adolescent peer counseling programs in a number of high schools, thanks to combined efforts by the DHS and contributions from a state foundation. School folders and folios with community mental health information were distributed at local high schools. Students participated in the artwork and content of the folios.

Peer helping networks were supported through training and organizational help by demonstration staff, and a teleconference disseminated project innovations in August, 1989.

Finally, regular newspaper columns emphasizing rural mental health were well received, according to a survey by the MHD. The State Project Director led a roundtable discussion and moderated a panel on rural community support program services at the annual CSP Conference in May.

Interagency relations developed by the project include the Interagency Committee for the grant. This group helped cement working relationships among its members: DHS, the Minnesota Department of Agriculture, and the Minnesota Extension Service. The three state agencies exchanged information and resources, including expertise on projects, and have continued to do so after the project ended.

A 26-member state advisory committee (composed of representatives from agencies ranging from the Minnesota Bankers Association to Lutheran Social Services) for the grant formulated recommendations to improve mental health services in rural areas.

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

7. MENTAL HEALTH SERVICES FOR OLDER ADULTS

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

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

There continues to be a lack of consensus on the definition of "older adult" with minimum age benchmarks that range from age 55 to 65. Many have adopted the chronological markers of age 65 to 74 as the "young-old" and those age 75 and older as the "old-old" to describe this population. It is this latter group which has increased the most rapidly; by the year 2000, it is estimated that 14 percent of the older adults will be age 85 and older.

The Minnesota State Planning Agency Trend Reports (November, 1987) defines senior citizen status as 65 and older, which is consistent with the Medicare definition of elderly. M.S. 256.03, subd. 2(d) (Community Social Services Act) identifies one of the target populations as "persons age 60 and over who are experiencing difficulty living independently and are unable to provide for their own needs."

Based upon 1990 population projections, there are 722, 098 Minnesotans age 60 and older. Of that number, approximately 52,845 are estimated to be residing in an institutional setting. (Minnesota Department of Energy, Planning, and Development, 1983). National studies indicate:

-- 60 percent of older adults residing in nursing facilities have serious mental health problems. This would translate to approximately 31,850 Minnesotans;

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

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

-- at least 50% of the major mental disorders of old age can be

attributed to physical causes such as Alzheimer's Disease (33,048 to 55,081 Minnesotans).

Hennepin and Ramsey Counties, in the seven county metro area, have the largest population of older adults; 156,345 and 79,012 respectively. During the 1980's, there appears to have been a slight population shift of this group away from Greater Minnesota and toward the seven-county metro area. Older Minnesotan Report, A.H. Wilder Foundation, 1989).

Data on mental health needs of older adults remain inadequate. One cannot readily or accurately ascertain the exact numbers of older adults who are in need of mental health services. The lack of uniformity and comparability in epidemiological data is compounded by different diagnostic criteria and ages used in such studies. Additionally, mental illness diagnoses are frequently restated to meet reimbursement requirements.

Four groups of older adults should be considered when planning for and addressing mental health service needs. These groups are:

-- Persons with long standing mental illness which, with increased age, may be exacerbated due to impaired functional ability and/or losses and social isolation.

-- Persons who develop mental illness, excluding dementia and related conditions, after age 60. Depression is most common for this group.

-- Persons who develop a dementing disorder after age 60.

-- Persons at risk of developing mental health problems as a result of the emotional, physical, social and environmental stressors associated with the aging process.

Barriers to mental health service access include those related to providers, delivery systems, and clients:

<u>Providers</u>:

- Lack of special preparation, training in the area of geriatric psychiatry;
- negative attitudes toward and misperceptions of the treatability of mental disorders in this population, and
- anxieties regarding their own aging process.

<u>Delivery Systems:</u>

- Duplication of services as well as absence of programs geared to this population;
- fragmentation of service delivery; and

- lack of coordination between health, mental health, and social service systems at both the provider and policy-making levels.

Client Related:

- Stigma of mental illness;
- lack of knowledge to access the resources and mental health system;
- physical limitations;
- reluctance to seek professional help or to admit to problems;
- lack of available and affordable transportation;
- inadequate third party reimbursement for mental health services.

Special Projects for Older Adults

1989 was the third and final year for the NIMH demonstration project on community support program services for older adults and the first full year of ADM block grant funding for the eight projects demonstrating different models of community-based mental health services for older adults. Although funding for the state project director position for the NIMH demonstration project will continue until late spring (due to a vacancy in the position for approximately six months of the project), the funds for service provision in St.Louis County were expended as of December 31, 1989, when the contracts with the Range Mental Health Center and St. Louis County expired. The project director will be completing the evaluation strategy of the NIMH project, writing the final report and developing the evaluation for the ADM projects. The Executive Summary of the NIMH project evaluation and final report will be included in the 1991 MHD report to the Legislature.

1. NIMH Project Summary: Community Support Program Services for Older Adults with Serious and Persistent Mental Illness

Site:	St. Louis County, Virginia, Minnesota
Lead Agency:	Older Adults Day Treatment Program; Range Mental Health Center
Supporting Agencies:	St. Louis County, Social Services MHD; State Project Director
Project Summary:	In the third and final year of the NIMH grant, this project addressed four essential components. A brief summary of activities in each area is also provided.

a. Assessment

Local Level: The project staff from the Range Mental Health Center and St. Louis County Social Services collaborated with federal Alcohol, Drug Abuse and Mental Health (ADM) projects to incorporate mental health needs into the basic assessment instruments used for screening applicants for social and mental health services.

State Level: The State Project Director, in collaboration with the Long Term Care Division and the Quality Assurance and Review Section of the Minnesota Health Department, developed mental health screening components for incorporation to pre-existing instruments that were in compliance with the federal OBRA legislation.

b. Coordination of Health and Social Services

Local Level: The project staff have been involved with coordinating a network of service providers to respond to the needs of this target population. Additionally, extensive educational programs have been held for consumers and a wide range of providers in St. Louis County.

State Level: The State Project Director has established linkages with the Long Term Care, Aging, and Social Service Divisions within the Department as well as the gero-psychiatric sections of national associations and organizations. Local mental health proposals from other counties have shown improvement in addressing mental health needs of older adults, but additional technical assistance is needed.

c. Outreach Activities

Local Level: The project staff have provided outreach to approximately 1,500 older adults since the inception of the project.

d. Service Model Development and Statewide Implementation

Local Level: The project has developed services geared to meet the needs of the target population; i.e., older adult day treatment, respite care, adult day care, assisted living, and client advocacy with other health care providers.

State Level: The final report which includes an extensive evaluation component is currently being prepared. The replicability of the model is a

key component of the evaluation design. The ADM Block Grant projects in eight other counties are intended to be a means of disseminating knowledge gained from NIMH projects.

Project Models: Community Based Mental Health Services for Older Adults (Funded by Federal ADM Block Grant), First Year Activity/Progress Report:

a. Senior Outreach Program; Dakota County

Lead Agency: Dakota County Mental Health Center

Other Agency(ies): Community Health Services

1) Project Goals:

a. To reduce the stigma and anxiety experienced by older adults in need of mental health services by providing in-home assessments and brief therapy.

b. To increase the knowledge and sensitivity of health care and social service providers to the mental health needs of older adults.

2) Progress/Accomplishments

Project staff provided assessment and/or brief therapy (average hours/clients = 4.5) to 49 older adults who were not receiving other mental health services. Additionally, 67.5 hours of educational activities were offered to agencies currently providing services to the elderly.

b. Elder Network; Olmsted County

Lead Agency: Olmsted County Community Health Nursing Service

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

1) Project Goals:

a) To decrease client barriers to mental health services through the use of peer educators and friendly visitors.

b) To increase access to service through the use of peer counselors and a loss support group.

c) To decrease provider related barriers to mental health services through educational programs geared to providers.

2) Progress/Accomplishments

A group of 12 peer counselors were recruited and received intensive training sessions during Project Year 01. Project staff provided a total of 25 educational sessions to health care providers caring for the elderly. The project was also involved in developing a data base that would accurately determine mental health service needs of this population.

c. Older Adults, Supporting, Encouraging, Sharing (O.A.S.E.S.); Winona County

Lead Agency: Hiawatha Valley Mental Health Center and Winona County Community Health Nursing Services.

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

1) Project Goals:

a) To improve access to and reduce the stigma of obtaining mental health services through the development of a peer counseling network.

b) To provide training to and supervision of a multidisciplinary assessment team.

2) Progress/Accomplishments

25 peer counselors have been trained to provide services to older adults. Educational presentations covering the scope of mental health services to older adults were provided to 687 consumers and health care providers.

d. 60's Plus; Polk County

Lead Agency: County Social Services Board
Northwestern Mental Health Center
Polk County Community Nursing Service

Other Agency(ies): Area Agency on Aging
County Senior Services

1) Project Goals:

a) To address system barriers by providing mental health consultation to area nursing facilities.

b) To improve service delivery and provide outreach through a collaborative multidisciplinary team of providers.

2) Progress/Accomplishments

Assessments were provided to 66 older adults in the county. In addition, public information (500 hours) to older adults and their families and training sessions (450 hours) for staffs of agencies providing services to older adults were offered.

e. Seniors Mental Wellness Program; Morrison County

Lead Agency: County Social Services and Morrison County Mental Health Services (CSP)

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

1) Project Goals:

a) To reduce the stigma of seeking mental health services through the use of outreach and home visits.

b) To maintain the independent functioning of older adults through providing community programs focusing on prevention and education.

2) Progress/Accomplishments

Eight older adults who are isolated and reside in rural areas of the county received regular home visits and case management services. Educational sessions to senior groups and service providers were also provided.

f. Carlton County

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

Other Agency(ies): Community Health Services

1) Project Goals:

a) To address client barriers to and stigma with receiving mental health services through education to older adults and their families.

b) To increase provider knowledge of and sensitivity to mental health needs of older adults.

c) To develop a quality educational video and instructional manual for distribution throughout the state.

2) Progress/Accomplishments

A two volume educational program for older adults has been developed and distributed to each county throughout the state. Two educational series (4 sessions each) to address the mental health needs of older adults and to assist caregivers in understanding mental health needs were presented during the year. A Telecare Friends Program to support the isolated elderly was developed and is operational.

g. Creative Aging; Hennepin County

Lead Agency: Pyramid Mental Health Center

Other Agency(ies): Hennepin County Senior Services Division

1) Project Goals:

To provide education and training activities addressing the mental health needs of older adults through:

a) peer counseling.
b) older adult leadership enhancement.
c) the use of a senior adult intern worker.
d) educational programs directed toward older adults.
e) Annual educational retreat for providers working with older adults.

2) Progress/Accomplishments

Creative Aging provided direct educational services to 220 older adults and their families as well as provider training to 39 senior workers. A senior intern has been recruited to assist the program and to provide leadership enhancement to other older adults involved in the program.

h. Seniors Reaching Out to Seniors: Carver County

Lead Agency: Carver County Human Services Department (includes Social Services, Mental Health,

Community Health and Aging)

Other Agency(ies): Community Mental Health Center

1) Project Goals

To address client, provider and system barriers through education and outreach in order to assist older adults to utilize services available.

2) Progress/Accomplishments

Conducted training for mental health, health, human services and aging providers.

Conducted public education on mental health and aging for older adults (at senior high rise apartment buildings) and for families.

Developed and distributed wallet-sized reference cards.

Utilized newsletters to discuss mental health and mental illness.

Carver County did not seek a second year of funding, met project goals and/or able to incorporate activities into ongoing programs by end of first year of funding.

Staff from the NIMH Project, as well as the ADM projects, participated in a statewide conference, "Connections '89 -- Mental Health and Aging", held October 2-4, 1989. The conference was planned by Mental Health Division staff and project staff in collaboration with the DHS Long Term Care Division and the Minnesota Board on Aging. A total of 123 people, representing mental health, health, social service and aging service providers, consumers and advocates were registered. Professional groups represented were social work, nursing, psychiatry, recreational therapy, and psychology. Evaluations indicated that the conference was much needed and well received; and, attendees recommended that another conference be held in 1990. MHD staff are evaluating whether to incorporate mental health and aging issues into other conferences or to conduct a separate conference again. Funding is a significant factor in the decision.

Staff from The Range Mental Health Center (NIMH Project), Olmsted County Elder Network (ADM Project) and the MHD were selected to present at the International Association for Psychosocial Rehabilitative Services Conferences, June 1989. They described their projects and innovative methods of providing community-based mental health services to older adults.

Mental Health Division and Project staff (NIMH and ADM) also

presented at other professional and consumer meetings such as district meetings of the Minnesota Nurses Association and the Minnesota Alliance for the Mentally Ill.

The State Project Director led a roundtable discussion and organized a panel presentation on "Community Support Services for Older Adults" at the MHD Community Support Program conference, May 1989.

VIII. CONSOLIDATED REPORTING RECOMMENDATIONS AND MENTAL HEALTH INFORMATION SYSTEM STATUS REPORT

This section addresses two legislative reporting requirements:

Minnesota Statute 245.482 (1989), Subd. 4, requiring the commissioner of human services to report by February 15, 1990 regarding recommended measures to improve the efficiency of mental health funding mechanisms, and to standardize and consolidate fiscal and program reporting; and,

Minnesota Statute 245.721 (1987) requiring the commissioner of human services to establish a mental health information management system by January 1, 1990.

The development of the information system required in #2 has resulted in significant progress towards the objectives listed in #1 above. The information system status report below describes the progress to date, and includes the recommended measures requested in #2 above.

The Mental Health Division's (MHD) ability to carry out its role and meet its responsibilities depends to a large extent on the quality of its information system. This system must be designed to meet well-defined information requirements, must operate efficiently, and must be productive.

Over the past one and a half years, the MHD has developed an information system composed of several parts:

- the traditional annual reports from counties and other providers receiving grants,
- the new Community Mental Health Reporting System,
- extracts from the Minnesota Medicaid Information System,
- extracts from the regional treatment center database,
- biennial county mental health plans, and
- a financial management reporting system.

Data on mental health services and clients are carried into the MHD through each of these "subsystems," and, using database management technology, the MHD has established linkages among them to increase the power of its internal information production capacity.

Annual Grant Program Reports

Mental health services providers receiving Rule 12 or Rule 14 grants have traditionally submitted annual reports containing summary data (statistics) on the amount of services provided, the types of clients receiving these services, and client outcomes. This statistical information is useful in assessing program performance and demonstrating accountability.

Grant program funded under Rule 14 or Rule 12 has been required by the Department of Human Services (DHS) to submit an annual aggregate report for each year that receives funding. Until SFY 1989, these reports included the following components:

- counts of admissions and discharges;
- client characteristics at admission;
- county of financial responsibility of clients served;
- changes to clients who were discharged from the program during the year, including changes in income source, employment status, living arrangement, and psychiatric hospital use;
- changes to clients who were in the program for at least one year at the end of the reporting period;
- follow up information on those clients who were discharged;
- information on waiting lists, unmet needs, etc.

These annual reports were 11 pages in length. With implementation of the CMHRS in 1989 (see below) and a greater emphasis on individual client data, the annual reports were able to be shortened to three pages. These reports now focus on client admission and discharge counts and on identifying counties of financial responsibility. Any information needed about client characteristics and outcomes not available through the CMHRS or annual statistical reports will be obtained through special studies of client samples. Such information would be collected directly from counties or providers as appropriate.

Community Mental Health Reporting System

Because annual grant program reports are "pre-summarized" at the county or provider level, State use of the information has been limited to the predefined content of the report. In other words, reported statistical information cannot be reconfigured to supply new, ad hoc information. This capacity has been added with the new Community Mental Health Reporting System (CMHRS).

The MHD implemented on a test basis during 1989, the system incorporates all publicly funded mental health services provided by counties and their contracted providers--a scope of service activity much broader than that covered by the annual grant reports. The data it contains include individual client characteristics and the type and amount of each service received by each client.

The CMHRS operates as a semiannual transfer of client-specific data from the recordkeeping systems of counties and their contracted providers directly to the State. This direct transfer process eliminates the burden on reporting agencies of producing statistical information at the local level. For most agencies, those with computerized record systems, the transfers

are automated, with the state receiving the data on electronic media.

This data transfer process provides the foundation for a statewide database from which most state mental health reports will eventually be produced. The intention is to replace most, if not all, of the annual reports with this system, once all the necessary data elements are included. This database will also be made directly available to DHS management for rapid response to ad hoc inquiries.

Data Extracts

Starting in July 1989, the MHD became a direct user of the Minnesota Medicaid Information System (MMIS).

As a direct user, the MHD extracts mental health client, services, and cost data from the MA/GAMC Claims database and stores it for processing. This has many advantages over the previous method of obtaining this information by requesting reports from the division that manages the MMIS. The detailed dataset now available specific to the individual MA/GAMC claim provides a very powerful and flexible source of information on the MA/GAMC client population.

Planning is underway to also extract mental health data directly from the regional treatment centers (RTC) database. This database is currently undergoing major revisions, and the MHD is working with the Residential Programs Management Division to ensure needs for data will be met. This system will provide extensive data on those services and clients receiving treatment in the RTCs.

Tracking Clients Across Systems

Legislators and policy makers have often inquired about the overlap between the various service systems. How many RTC residents are getting case management from their home counties? Do Rule 36 facilities help their residents to utilize available community resources? These, and similar questions have led to a number of special surveys in the past, and have added complication and duplication in some of the reports required of providers. There has been no client identifier code across programs. During the past year, the MHD has participated in DHS' Master Index (DMI) project, which originally had the potential to allow the Community Mental Health Reporting System to track clients with a minimum of reporting from programs.

Originally, the MHD had hoped that the DMI project would resolve the tracking problem. While the project continues the development of a Statewide Client ID number, it has a major drawback for the mental health information system. As now

planned, the ID number will be assigned from a DHS central computer through hook-ups with county offices. Since most mental health services are not provided by county agencies but rather by contracted vendors that will not have access to the DMI, the project offers little help with tracking persons with mental illness.

To solve the tracking problem, the Social Services and Mental Health Divisions have started to explore the possibility of developing a uniform procedure for the generation of a unique code for each client. The development of such a procedure would allow an examination of patterns of service use and the generation of unduplicated counts of clients being served. A possible approach would be one used by the DAANES system for chemical dependency providers. The client identifier is unique to the client in almost all of the cases and can only be linked to the client by the provider. If this approach is taken, an ability to convert to the DMI must be built into the system.

County Plans

Each county is required to submit a two-year plan meeting requirements of the Comprehensive Adult and Children's Mental Health Acts. This plan contains data describing the local system of mental health services, including projections of service availability, accessibility to special target groups, general utilization, and cost for the next biennium. These data are incorporated into the MHD's information system. They establish a "baseline" against which report data (actual experience) can be assessed.

Financial Reports

The last major piece of the information system is the financial data. In order to describe reporting associated with these data, it is important to first briefly describe the funding system for mental health services.

There are a large number of funding sources which can, under certain circumstances, be used to pay for mental health services. Most of these sources are not specific to mental health. The reporting for these programs, such as Medical Assistance, is determined by the overall program and mental health services information must be extracted from the larger system.

Family support and medical programs at DHS are in the midst of major systems developments. These new automated systems will provide the reporting functions needed, eliminating the need for county or provider based reporting for these programs.

There are also funding sources specific to mental health which

are administered directly by the MHD. In these cases reporting is independent of larger systems, specific to the county and/or provider, and under direction of the MHD.

RTC mental health units are administered by DHS, independent of the MHD. Reporting on these services is primarily a function of the state accounting system. Reporting does not include counties or providers as a source of information.

Possibilities for simplification and consolidation of fiscal reports are confined by the requirements of the various funding sources. This section of the report describes the current status of and future plans for fiscal reporting on the major sources of mental health funding, given the funding systems which exist. Clearly, any consolidation or other major restructuring of the funding system must address the collection of fiscal information, its analysis, and the management purposes to which the information will be applied at the state, county and provider levels. Fiscal reporting issues should be addressed in the broad context of how to most appropriately deliver and pay for the services needed by the people of Minnesota.

Mental health specific funding sources include Rule 14 (community support projects), Rule 12 (residential programs), the Federal Alcohol, Drug Abuse and Mental Health Block Grant, federal Homeless Mentally Ill funds, state special projects funds, and the children's services grants that are in development.

Rule 12 and 14 Rule funds are awarded to counties. Counties may provide services directly or, more frequently, through contracts. Applications for these funds require submission of a budget which details revenues by source and expenditures by line item. Counties submit quarterly reports which trigger payments and include the same detail as on the application. The expenditures by line item detail is not utilized on a quarterly basis by DHS and will be eliminated.

Federal mental health and homeless funds and state special projects funds are awarded to public and private agencies and Indian reservations. These projects tend to be special purpose demonstrations. Funds are awarded based on specific budgets. Quarterly reporting by line item is seen as an important management tool by the MHD. During the last year a variety of financial report forms used for the federal block grant have been combined into a single form. This effort will continue, with the objective of combining financial reports into one common format.

However, most funding for mental health services comes from programs that offer mental health and other types of services. These programs include Medical Assistance, General Assistance

Medical Care, General Assistance, Minnesota Supplemental Assistance, and "county funds", including the Community Social Services Act, Title XX, and local taxes.

The current operating system for Medical Assistance and General Assistance Medical Care is being replaced by a new system known as MMIS II. Information about services will be received via billing documents from providers, including counties. Subsequent reports will be generated from the data included in the billings.

General Assistance and Minnesota Supplemental Assistance are included in the new MAXIS system, now in development. MAXIS will provide a significant improvement in the information available about how these programs support people receiving mental health services. Client and provider specific data will be available from MAXIS, allowing DHS to track payments to mental health programs as well as payments on behalf of mental health clients to other providers of housing and board and lodging.

Reporting on the expenditure of CSSA, Title XX and local tax dollars by counties is the most problematic part of the financial information picture. The existing summary information provided by counties is not sufficient to reliably calculate expenditures for mental health services. These problems have to do with the structure and content of the reports received from counties and cannot be effectively addressed by the MHD alone. Improvements in this area require a restructuring of the reporting formats and service definitions used for these programs.

The Department has assigned special staff to work on all social service financial reporting during the coming year to address the above issues.

Evaluation of the Information System

Once each subsystem described above is operational, the MHD will continually evaluate it on the basis of three criteria:

1) Performance: the ability of the subsystem to meet the defined information requirements of the MHD, to provide information that is credible (based on complete and quality-assured data), and to replace more costly methods of reporting.

2) Capability: a measure of the subsystem's content and data processing technology, which determine how well information requirements can be met and the "flexibility" of the overall system to meet unanticipated requirements.

3) Decision-support: the extent to which information produced by

the subsystem is actually used in decision making, planning, and other functions of the Division.

Summary of Accomplishments in 1989

Table 6 summarizes the status of the information system as of January, 1990, in terms of those tasks of system development and operation that were scheduled for 1989.

The evaluation status of the subsystems is summarized in Table 7.

Table 6

Information System Accomplishments in 1989

DEVELOPMENT AND OPERATIONAL TASKS	STATUS: COMPLETED	IN PROCESS	NOT STARTED
1. Develop and test procedures for collecting, storing, and processing data in the CMHRS	[X]	[ ]	[ ]
2. Develop and test procedures for correcting and updating data in the CMHRS	[X]	[ ]	[ ]
3. Develop and test procedures for producing reports for local agencies from the CMHRS database	[X]	[ ]	[ ]
4. Develop and test procedures for producing statewide and regional reports from the CMHRS database	[X]	[ ]	[ ]
5. Develop and test procedures for extracting, storing, and processing data from the MA/GAMC claims system	[X]	[ ]	[ ]
6. Develop and test procedures for producing local and statewide reports from the MA/GAMC claims system	[ ]	[X]	[ ]
7. Assist in development of the RTC information system, as it pertains to production of data on mental health clients and services	[ ]	[X]	[ ]
8. Redesign annual grant reports to integrate CMHRS data and continue monitoring program performance and accountability	[X]	[ ]	[ ]
9. Collect, store, and process new grant reports data	[X]	[ ]	[ ]

DEVELOPMENT AND OPERATIONAL TASKS	STATUS: COMPLETED	IN PROCESS	NOT STARTED
10. Produce local and statewide summaries of data from grant reports	[X]	[ ]	[ ]
11. Collect, store, and process data from biennial county plans	[X]	[ ]	[ ]
12. Produce local and statewide summaries of data from county plans	[X]	[ ]	[ ]
13. Obtain federal grant to expand capabilities of data systems in provider organizations and in the state agency	[X]	[ ]	[ ]

14. Recruit agencies to participate in the systems expansion project, hire state staff for the project, and develop the project workplan	[X]	[ ]	[ ]
15. Study feasibility of consolidating fiscal reports	[ ]	[X]	[ ]
16. Study feasibility of coordinating mental health information systems with social services systems	[ ]	[X]	[ ]
17. Study the data systems and information requirements of community support programs to determine the type of data to be collected and reported by these programs	[ ]	[ ]	[X]
18. Conduct onsite quality assurance studies for CMHRS data	[ ]	[ ]	[X]

Table 7

Evaluation of the Information System

EVALUATION CRITERIA	STATUS
1. Percent of information requirements met by the system	Of approximately 100 information requirements identified in 1988, each subsystem now meets the following number of requirements: Grant Applications/Reports: 15 CMHRS 21 MA/GAMC Data Extract 10 County Plans 11 Financial Reports 7 In some cases, more than one subsystem meets the same requirement.
2. Credibility of information	Automated data error detection procedures in the CMHRS found that all data elements had error rates below 2%. However, data on client's race and type of mental illness (acute, serious and persistent, etc.) were found to be missing in a much higher percentage of cases. Data extracted from the MA/GAMC Claims system were found to deviate from other sources of this information. The reasons for discrepancies are currently being studied.
3. Efficiency	The size and scope of grant reports have been reduced, allowing the CMHRS to produce some of the information previously reported by counties and contracted providers. Work on consolidating financial reporting is currently underway. The CMHRS has provided a means of reporting (automated data transfer) that greatly reduces the amount of effort required at service provider agencies. The Division has worked with Community Services Information System, operated by 74 counties, to incorporate this style of reporting, and has produced two microcomputer programs to assist small provider agencies in meeting CMHRS requirements. Efficiency of the system overall can still be improved through expansion of the CMHRS and reduction of statistical reporting in county plan documents and grant reports.
4. Capabilities	System capabilities are still limited to producing about 75% of information requirements. Expansion of the CMHRS is seen as one means of improving capability. Additional staff are needed in the Division to operate the information system at its level of technical capability. Also important are incentives to county and provider agencies to increase automation and content of their data systems. A grant received from the National Institute of Mental Health will allow the Division to work with providers to incorporate national data standards.
5. Decision-support	MIS staff have met with Regional Consultant to explain the

types of information now being produced by the CMHRS, and to discuss how they can access and use this information.

A special report to counties on utilization of MA/GAMC services by their clients has been prepared and will be distributed in February, 1990.

Program staff and regional consultants have reviewed county plan statistical information and used this information to evaluate local service delivery systems.

Goals for 1990

Information system goals for 1990 include:

1. Continued operation of all subsystems;
2. Implementation of mechanisms that assist decision makers in using CMHRS and MA/GAMC data;
3. Streamlining the process of producing and reviewing county plans;
4. Reformulation of the MHD's information requirements in light of new legislation and rules;
5. Completion of the financial reports consolidation study;
6. Completion of the CMHRS data quality study;
7. Continued involvement with efforts to develop the RTC information system, the Minnesota Medicaid Information System, and the project to develop a statewide client index;
8. Completion of studies of community mental health center data systems to determine their current capabilities and the extent to which these organizations can make use of national data standards.

Mental Health Funding Consolidation

DHS recognizes that true simplification of financial reporting requirements will not be possible until there is a simplification in Minnesota's complicated system of mental health funding. DHS also recognizes that the current system of categorical funding may "push" clients towards certain services or certain living arrangements, sometimes contrary to clients' needs, and sometimes contrary to cost effective treatment.

Minnesota Statutes, section 245.463, subdivision 3, requires DHS to review funding for mental health services and make

recommendations to the Legislature for any changes needed by January 31, 1991. During the coming year, DHS plans to develop separate proposals for adult and children's funds, in recognition of the very different needs of adults and children, and the very different service systems involved. Both proposals will probably combine community and RTC funds. Pilot projects will probably be proposed for 1992, with potential statewide implementation in 1993.

As of the writing of this report, the consolidated funding workplan is contingent on the Department's commitment of sufficient staff resources.