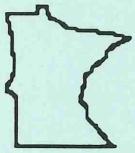

Local Advisory Council
INFORMATION GUIDE

1990

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SUMMARY OF COMPREHENSIVE MENTAL HEALTH ACT
LOCAL ADULT MENTAL HEALTH ADVISORY COUNCILS

From Minn. Stat. 245.466, Subd. 5 --

Adult Local Advisory Councils:

1. Are established by the County Board of Commissioners;
2. May be combined with other counties;
3. May be part of human services council;
4. Shall meet <u>at least</u> quarterly.

Members must include at least:

1. One consumer (from each county) of mental health services;
2. One family member (from each county) of an adult with mental illness;
3. One community support services representative;
4. One mental health professional.

Statutory duties of the Adult LAC:

1. Review, evaluate, make recommendations regarding the local mental health system and report <u>at least annually</u> to the County Board;

2. Arrange input regarding coordination of care between Regional Treatment Center and community-based services, at least annually;

3. Identify for the County Board -- individuals and agencies to receive information on predictors and symptoms of mental disorders, where mental health services are available in the county, and how to access the services;

4. Report its evaluations and recommendations regarding the local mental health system to the State Advisory Council on Mental Health.

SUMMARY OF COMPREHENSIVE MENTAL HEALTH ACT
LOCAL CHILDREN'S MENTAL HEALTH ADVISORY COUNCILS

From Minn. Stat. 245.4874, Subd. 5 --

Local Children's Advisory Councils:

1. Are established by the County Board of Commissioners;
2. May be combined with other counties;
3. May be combined with adult local advisory council, may be a subcommittee of adult council, or may meet independently;
4. Shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly.

Members must include:

1. At least one person who was in a mental health program as a child or adolescent;
2. At least one parent of a child or adolescent with severe emotional disturbance;
3. One children's mental health professional;
4. Representatives of significant county minority populations;
5. A representative of the children's mental health Local Coordinating Council;
6. One family community support services program representative.

Statutory duties of the Children's LAC:

1. Seek input from parents, former consumers, providers, and others about the needs of children with emotional disturbance in the local area and services needed by families of these children;

2. Review, evaluate, make recommendations regarding the local children's mental health system and report <u>at least annually</u> to the County Board. The County Board is to consider the advice of the advisory council in carrying out its responsibilities;

3. Arrange, at least annually, input from local providers regarding coordination of care between services;

4. Identify for the County Board -- individuals and agencies to receive information on predictors and symptoms of emotional disturbances, where mental health services are available in the county, and how to access the services.

STATE OF MINNESOTA
COMPREHENSIVE MENTAL HEALTH ACT 1989

Children's Section

"Local Coordinating Councils"

The local coordinating councils (LCCs) are established as part of the administrative framework critical to the development of the children's mental health system. Recognizing that mental health needs impact all areas of a child's functioning, that children are served by a wide variety of professional disciplines, and that children with severe emotional disturbances are seen in multiple child-serving agencies, these interagency councils were established.

The objective of the councils is to provide a mechanism to establish interagency linkages at the community level on behalf of the mental health needs of children. Turf issues frequently block successful, comprehensive treatment of children with multiple needs, since each system has eligibility, funding, and service criteria of their own. The children's mental health system attempts to address this fragmentation through interagency mechanisms.

Meetings of the county LCC should be designed to address the coordination issues of the individual county and be of a frequency which provides ample time to do this. Funding is a key issue that LCCs will be faced with, since money flows through different systems in very different ways. Eight counties in Minnesota were funded beginning in late 1988 to demonstrate various ways to develop and use LCCs, as well as to develop a comprehensive set of children's mental health services. These counties include Kandiyohi, Isanti, Itasca, Carver, Mower, McLeod, Olmsted and Ramsey. Each project has had different experiences in establishing LCCs. The individuals involved in these projects will be providing information on their experiences in various arenas over the next several years to assist counties in the development and use of a LCC. In addition, information this topic as well as on group process issues has accumulated from the experiences of other states that have preceded Minnesota in developing children's mental health systems.

Membership on the LCCs must include representatives from all of the "local system of care", which includes:

- mental health services
- social services
- correctional services

- education services
- health services
- vocational services
- Indian Reservation Authority (where a reservation exists within the county)
- juvenile court (when possible)
- law enforcement (when possible)

The LCC must meet at least quarterly and is mandated to develop recommendations to improve coordination and funding of services. The LCC must provide at least:

1. Interagency agreements to coordinate the delivery of services to children.
2. An annual report of the council on the unmet children's needs and service priorities.
3. An annual report on information collected by the LCC, including:

    - description of services provided through each of the service systems represented on the council.

    - various sources of funding for services and the amounts actually expended.

    - description of the numbers and characteristics of the children and families served during the previous year.

    - an estimate of unmet needs.

Every county must develop the LCC by January 1, 1990. An existing interagency, child-focused task force may be used, if it is expanded to include the requirements of this statute.

For more information, please contact Joan Sykora, Department of Human Services, (612) 296-7905.

STATE ADVISORY COUNCIL ON MENTAL HEALTH

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ROLE OF LOCAL ADVISORY COUNCILS

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Local Advisory Council Liaison
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I. Contact with Community and Providers

A. Provide information re. predictors, symptoms of mental illness and serious emotional disturbance.

B. Provide information on how to access mental health services.

C. Collect information on needs of community (consumers, family members) and needs of providers.

D. Collect information on quality of existing services and coordination of services among providers.

II. Contact with County Social Services

A. Provide review of information on quality of existing services and allocation of future resources.

B. Receive information regarding existing services, statistics, legal requirements and grant information.

C. Review of County Mental Health Plan, involvement in its preparation and revisions.

III. Contact with State Legislators and County Commissioners

A. Minimum of annual report to commissioners on mental health system.

B. Other contact with commissioners on important mental health issues (possibly attend LAC meetings).

C. Phone/mail contact with state legislators on important mental health policy issues (possibly invite to an LAC meeting or schedule a Mental Health Awareness event).

IV. Contact with State Advisory Council, Department of Human Services and other Local Advisory Councils

A. Receive information regarding state trends and mental health policy issues.

B. Contact DHS, through LAC Liaison, with any questions/comments regarding mental health programs or under Mental Health Act.

C. Contact State Advisory Council, through LAC Liaison, with any questions, comments or feedback regarding mental health policy or needs.

D. Contact LAC Liaison for technical assistance regarding Local Advisory Council.

E. Interact with other Local Advisory Councils.

LEAGUE OF WOMEN VOTERS

LOCAL ADVISORY COUNCIL CHECKLIST

Adult Local Mental Health Advisory Council

Get a list of advisory council members. If possible, talk to the chair or a council member.

Mandated :

1. Do the council members reflect "a broad range of community interests"?

Yes No

If no, please specify.

2. Is there at least one consumer, one family member of a person with mental illness, one mental health professional and one community support services program representative?

Yes No

3. Does the council meet at least quarterly to "review, evaluate, and make recommendations regarding the local mental health system"?

Yes No

4. Does the county board consider the advice of the local mental health advisory council in carrying out its authorities and responsibilitiies?

Yes No

If no, please specify.

5. Is the advisory council arranging annually for input from the regional treatment center review board regarding coordination or care between the regional treatment center and community-based services?

Yes No

Comments:

6. Are barriers cited to effective advisory council operation?

Yes No

--If so, what are they?

Important but not Mandated :

1. Does the council have more than four members (if it is for one county) and at least six members (for a multicounty advisory council)?

Yes No

2. Does the council have access to the commissioners?

Yes No

If so, how and how often?

3. Does the council actively participate in the county board's ongoing activities and responsibilities for mental health services?

Yes No

If yes, how?

4. Does the council communicate regularly with the director of mental health services or the social services director?

Yes No

--If not, please comment.

5. Does the council review the long-range priorities for county mental health programs?

Yes No

--If so, does it provide feedback?

Yes No

6. How often does the council meet?

-Is this sufficient to participate actively in the planning process?

Yes No

7. Is attendance good at MHAC meetings?

Yes No

--Do most of the members actively participate?

Yes No

8. Has the advisory council been briefed on all aspects of county mental health services?

Yes No

9. Has the advisory council been briefed on the budget process, on state mandates and on the history of county mental health expenditures?

Yes No

10. Do council members understand "maintenance of effort"?

Yes No

11. Does the advisory council have a process for communicating with interested citizens?

Yes No

12. Does the advisory council respond to requests from advocacy groups, consumers, interested citizens?

Yes No

Comments:

Education and Prevention Services

Mandated :

1. Is the county providing services designed to educate the general public about mental illness?

Yes No

If yes, please specify.

--to increase people's awareness of the availability of resources and services?

Yes No

Children's Checklist I
FIRST NEW MANDATED SERVICES

County

Names, addresses and phone numbers of Reporters

Organizations involved in monitoring

Name(s) of persons interviewed (Please include titles and addresses or phone numbers)

Date(s) of interview(s)

LOCAL CHILDREN'S MENTAL HEALTH ADVISORY COUNCIL

(Councils should have been established by October 1, 1989)

Has your county board, either individually or with other county boards, established 1) a local children's mental health advisory council OR 2) children"s mental health subcommittee of the existing local mental health advisory council, OR 3) has it included persons on its existing advisory council who are representatives of children's mental health interests?

Yes No

Which type of Children's Advisory Council has your county established?

Single county

Multi-county

Separate Children's Advisory Council

Subcommittee of existing Advisory Council

New children's representatives on existing Council

However formed, the Children's Advisory Council must include at least one person from each of the following groups.

Does your county council include

1) a former client in a mental health program as a child or adolescent?

Yes No

2) the parent of a child or adolescent who is eligible for case management?

Yes No

3) a children's mental health professional?

Yes No

4) a representative of minority populations residing in the county which are of significant size?

Yes No

5) a representative of the Local Coordinating Council?

Yes No

6) a provider of Family Community Support Services?

Yes No

If some of these questions were answered "no", does the county plan to recruit persons in these categories to council membership?

Yes No

Comments:

Does the county report barriers to forming a Children's Mental Health Advisory Council including the required members?

Yes No

If so, what are they?

LOCAL COORDINATING COUNCIL

(Formation of Local Coordinating Councils at the county level is required by January 1, 1990.)

Has your county formed a Local Coordinating Council?

Yes No

If, No, why not? Please explain.

If the county has formed a Local Coordinating Council are there representatives from

1) mental health services

Yes No

2) social services

Yes No

3) correctional services

Yes No

4) education services

Yes No

5) health services

Yes No

6) vocational services

Yes No

If the answer to some of these representatives is "no," why is this. Please explain.

Does the county report barriers to establishing a coordinating council?

Yes No

If so, what are they?

LOCAL MENTAL HEALTH PLAN FOR CHILDREN

Did your county submit the Local Mental Health Plan for Children by November 15, 1989?

Yes No

If not, why not?

Does the county report barriers to submitting the plan?

Yes No

If so, what are they?

STATE ADVISORY COUNCIL ON MENTAL HEALTH

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STATE ADVISORY COUNCIL ON MENTAL HEALTH

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Michael Weber, Director Hennepin County Community Svcs. A-1005 Government Center Minneapolis, MN 55487 (612) 348-3454	county social services director (urban)

two current vacancies:

1. one rep. of state agency for corrections
2. one rep. of higher education

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STATE ADVISORY COUNCIL ON MENTAL HEALTH

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KEY PHONE NUMBERS FOR CONTACTING STATE LEGISLATORS AND TRACKING LEGISLATION

With the phone numbers provided below, one can find out who their legislator is, whether he or she has introduced legislation, and the progress of any introduced legislation through the law-making process. These phone numbers should be saved for future reference.

To find out who your state legislator is, call:

Senate Information	296-0504
House Information	296-2146

These numbers are also useful for asking general questions about issues, Committees, or legislators.

Bills that are introduced in the state House and Senate are assigned file numbers. These file numbers (preceded by HF in the House, SF in the Senate) help busy legislators keep track of specific bills among the flood of over 2600 pieces of legislation introduced each biennium. To find the file number of a specific bill of interest to you; to determine whether your or another legislator has introduced legislation; and to receive information on whether bills of interest have progressed through the law-making process, call:

Senate Index	296-2887
House Index	296-6646

You may also receive a copy of bills at no charge. To order a copy of a bill, you must have the file number given to you by the Index departments. Then call:

Secretary of the Senate	296-2344
Chief Clerk of the House	296-2314

To determine the schedule of Committee hearings on any particular day, as well as the agendas for such hearings, call:

Senate Committee Hotline	296-8088
House Committee Hotline	296-9283

Finally, the phone number for the Governor's Office is 296-3391.

INTRODUCTION AND OVERVIEW OF COUNTY MENTAL HEALTH PLANS

THE MENTAL HEALTH SYSTEM

The "mental health system," viewed either locally or at the state level, includes the clients, the services provided, the organizations providing and managing provision, and mechanisms of coordination among these elements.

Target Population and Special Target Populations

Persons with Mental Illness are those diagnosed as having "an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III, and that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, and recreation. [M.S. 245.462, Subd. 20]

Within this target population there are a number of identified "special" target populations. The first distinction is between adults and children. There are meaningful differences between these two populations that require the mental health system to include elements that address them separately. Some of these differences lie in the nature of the problem condition, or diagnosis. Other differences are related to responsiveness to treatments (services).

The adult population includes three subpopulations defined on the basis of diagnosis.

1) persons with serious and persistent mental illness,
2) persons with acute mental illness, and
3) persons with other mental illness.

Definitions of these adult subpopulations can be found in the Mental Health Act.

Other special adult target populations include the elderly (age 65 or older), American Indians, Blacks, Refugees, the hearing impaired, and two dual diagnosis groups: Mentally Ill with chemical dependency and Mentally Ill with developmental disability.

Special child target populations are being defined as this document is being prepared. Until new terminology is available, the three subpopulations used for adults are sometimes applied to children as well. Amendments to this Plan may request information on new or redefined child populations.

Each of the special target populations mentioned above requires some special consideration in the formulation of your local plan.

Services

This Plan must address each of the following mental health services:

1. Education and Prevention
2. Emergency Services
3. Outpatient Treatment
4. Community Support Services
5. Case Management
6. Day Treatment
7. Residential Treatment
8. Acute Care Hospital Inpatient Treatment
9. Regional Treatment Centers
10. Pre-Petition Screening
11. Screening

Each of these services is defined in the Mental Health Act. When all these services are available, accessible, and affordable within the local system, and meet the standards of quality described in law or rule, they constitute a "complete array" of mental health services.

If and when the Mental Health Act is revised, this list of services may need amendment, particularly in regard to children's mental health services.

Organization

The resources of the system are contained in a "core" set of organizations--the State agency, the county agencies, and contracted providers--and various other organizations that shape legal requirements, set policy, and provide resources. The latter include the State Legislature, the Federal Congress and federal agencies, provider organizations, and advocacy groups.

The roles to be performed within the system are divided among the core organizations as follows:

State Agency: Monitors progress of each local system toward statewide goals; identifies resource needs of state and local systems; provides technical assistance to county agencies; develops standards of service delivery and new service programs; allocates federal and state fiscal resources among local agencies; plans for changes to the statewide system.

County Agency: Allocates fiscal resources among service programs and provider agencies; coordinates service delivery to individual clients and to special target populations; identifies service needs of individual clients; develops new services and programs; delivers or contracts for delivery of services; evaluates effectiveness, quality, efficiency of services and programs; plans for changes to the local system.

Contracted Providers: Provide services under the conditions specified in contracts with county agencies; provide data to county and State as requested, under limitations of state statutes.

Coordination

To ensure that resources are well spent and that clients receive the best possible treatment within the system, mechanisms for coordinating service delivery must be functioning. Some of these mechanisms are:

1. County Plans
2. Case Management
3. Local Advisory Councils
4. State advisory groups
5. Information systems
6. Inter-agency meetings among providers

The county planning process collects information and ideas for improving the system from various sources. The County

Plan document is used as a summary of this information.

Case Management is a service designed specifically for coordinating other services to clients with serious and persistent mental illness, and it includes development of individual community support plans.

Local and state advisory groups ensure that proposed changes to the system are workable and in the best interest of the client.

Information systems support all other mechanisms by distributing data and information among the various organizations.

One of the major outcomes of the coordination activities mentioned above is mental health system goals. Goals in the first mental health Plan for 1988-1989 were focused on development of the full service array in all counties. Goals in this year's Plan should focus on coordination in the delivery of these services. The primary State goal for 1990-1991 is for improved coordination of local service delivery, reflected in appropriate use of services by special target populations, and in delivery of services appropriate to individual client needs. The county planning process must include identification of specific goals and objectives suited to the local populations. For many counties, and especially for children's mental health services, this will still need to include expansion of services to ensure adequate availability to meet client needs.

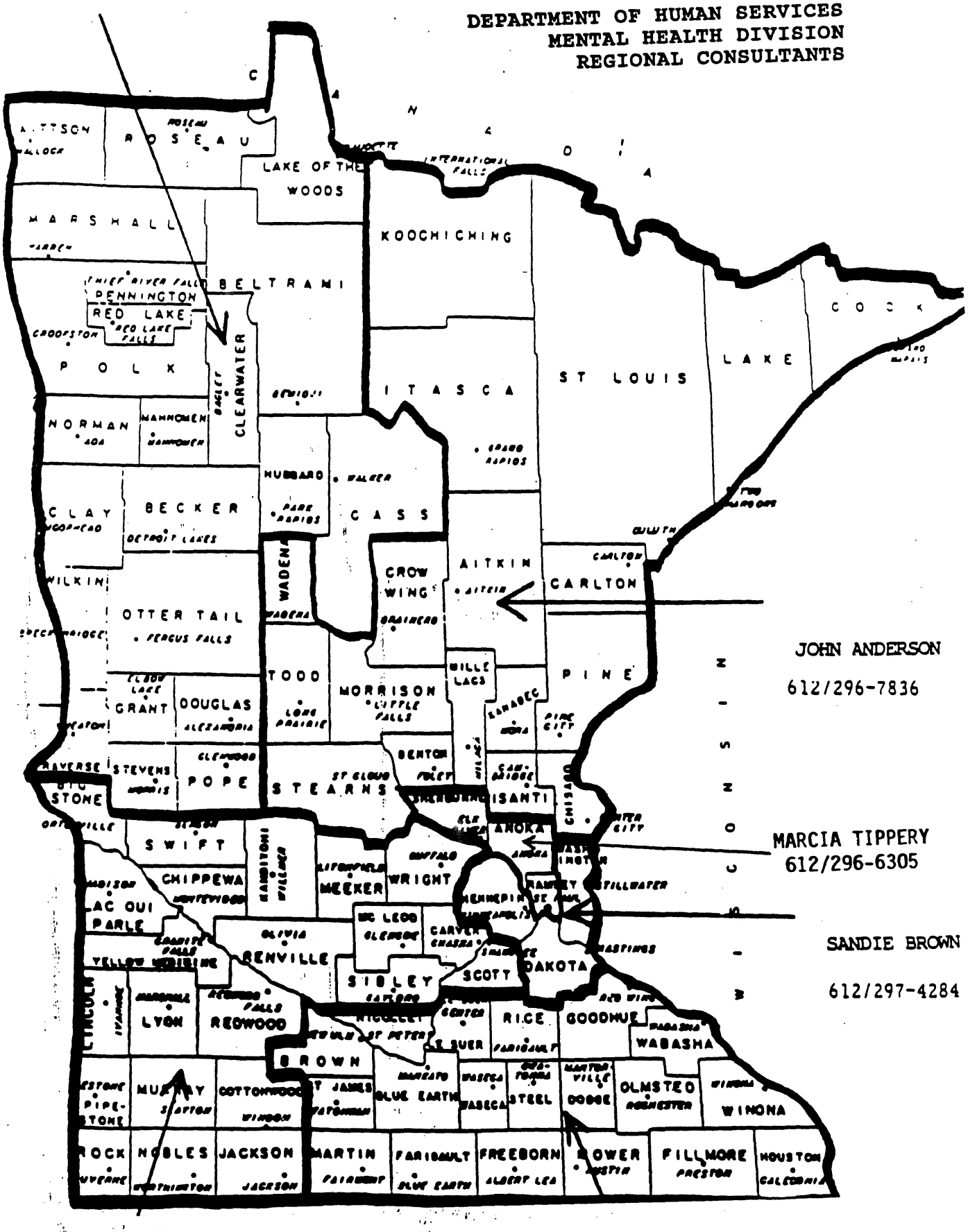
CHILDREN'S MENTAL HEALTH

SERVICE IMPLEMENTATION TIMELINE

SERVICE	*DATE*
Education and Prevention	Current
Early Intervention and Identification	January 1, 1991
Emergency Services	Current
Outpatient Services	Current
Case Management	July 1, 1991
Family Community Support Services	July 1, 1991
Day Treatment Services	July 1, 1991
Professional Home-based Treatment	January 1, 1991
Therapeutic Foster Care	January 1, 1992
Residential Services	Current
Acute Care Hospitalization	Current
Screening	Current (July 1, 1991 by MH professional)

DAN MYHRE
612/296-8980

DEPARTMENT OF HUMAN SERVICES
MENTAL HEALTH DIVISION
REGIONAL CONSULTANTS



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2/16/90

Note:
The first number under each person's name is the telephone number; The numbers in the ( ) are the last 4 digits of the person's 9 - digit zip code.

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Executive Aide
Maryanne Gibbons
6-7557 (3815)

Affirmative Action Director
Mary Jean Anderson
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James B. Campbell
6-3763 (3858)

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Charles C. Schultz
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Secretary
Barb Heck
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7-1872 (3814)

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Roberto Reyna
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Bonnie Becker
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Anne Damon
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George Hoffman
6-6154 (3838)

MAXIS
Linda Ady
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Regional Treatment Centers
(See reverse side)

Nursing Homes
(See reverse side)

MENTAL HEALTH DIVISION
4/90