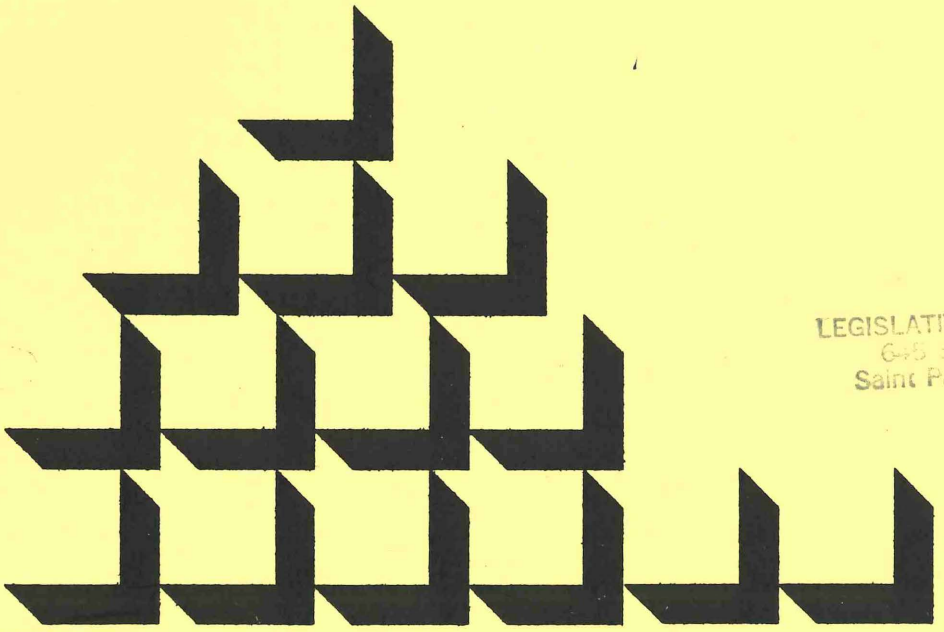
1991 MENTAL HEALTH REPORT TO THE LEGISLATURE



Minnesota Department of Human Services
Mental Health Division

Pursuant to.....inside page

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1991 MENTAL HEALTH REPORT

TO THE LEGISLATURE

February, 1991

This report is written to comply with Minnesota Statutes, sections 245.476, subdivision 1 (screening of adults), 245.73 (Rule 12), 245.463, subdivisions 3 (increasing community beds and maximizing use of Medical Assistance) and 4 (mental health funding review), 245.487 (implementation of children's mental health services), 245.4873 (state coordination of children's mental health services), 245.4885, subdivision 1 (screening of children), and 245.4861 (Public-Academic Liaison Initiative).

TABLE OF CONTENTS

TABLES

PAGE

I. EXECUTIVE SUMMARY

Implementation of the Comprehensive Adult Mental Health Act

With the passage of the Comprehensive Adult Mental Health Act in 1987, Minnesota laid out an array of mental health services to be provided in all areas of the state. Counties, responsible for direct or contracted provision of nine mandated mental health services, submit biennial plans to the Department for review and approval prior to allocation of funds. Services must be provided according to priorities stated in law.

The Mental Health Division, which administers state funding for community services as well as four federal grants supporting a variety of service-related activities, provides administrative services related to statewide mental health planning, resource development, standard setting, consultation and quality assurance.

Case management services, by which individuals with serious and persistent mental illness are assisted toward community living, are currently provided to approximately 9,000 adults per year statewide. Services to about 3,800 of these individuals are reimbursed by Medical Assistance or General Assistance Medical Care. Division staff have worked with a range of groups involved in the provision of case management to maximize funding for the services and to determine what modifications are necessary to the rule governing their reimbursement.

The use of community support services (CSP) and/or day treatment has increased to 8,500 persons during FY 1990. With new programs and service enhancements occurring around the state, some counties are experiencing such rapid growth in demand for this array of services that service availability is unable to meet identified need. One CSP component, Housing Support Services, has benefited from a state allocation permitting development of 11 pilot projects. The projects have assisted persons with mental illness to obtain safe, affordable housing of their choice and to maintain these living arrangements through receipt of a variety of supportive services. Unfortunately, these projects have also shown that basic housing for persons with mental illness is not available statewide. Likewise, joint efforts between the Division and the Department of Jobs and Training's Division of Rehabilitation Services have shown the need for expanded employability services for persons with mental illness.

The Division developed the OBRA-87 project in response to federal P.L. 100-203, which requires that nursing facilities serve only those individuals whose physical health needs require that level of care. The state's Alternative Disposition Plan, approved by the Health Care Financing Agency (HCFA), projected that a total of 300

persons with mental illness, who do not require nursing facility care, will be relocated with appropriate mental health services by June, 1992. In addition to a very complex federal statute, draft HCFA requirements for screening these persons have changed repeatedly, making the state task of assuring compliance with the OBRA process very difficult. State funds have been awarded to 11 counties with financial responsibility for the first groups of persons requiring relocation. Despite the difficulty in setting up processes for compliance with federal law, it is anticipated that most of these individuals can make a transition to the community with intensive services provided through state funds.

A second effort, the Anoka Alternatives Project, has demonstrated the effectiveness of a coordinated discharge planning process with availability of funding for intensive services. This one-year project, set up to help eliminate overcrowding of the Anoka Metro Regional Treatment Center, made $500,000 available to counties responsible for persons whose mental illness made them difficult to serve in the community. To date, 22 persons have been discharged and are utilizing funding for intensive services, 48 are in the discharge planning process, and another 30 have been discharged as a result of the process, without need for additional funding.

These projects, as well as the Department's project to provide mental health services for homeless persons, have highlighted the need for increased housing services in accord with the Housing Mission Statement which is already in statute. Needed services include expansion of housing support projects, development of a pilot housing subsidy program for persons with mental illness, downsizing of several Institutions for Mental Diseases along with development of alternative services for those moving as result of downsizing, and development of Medical Assistance reimbursement mechanisms for services provided in some Rule 36 facilities. A cooperative effort by a number of agencies and DHS divisions has resulted in a detailed plan for providing housing to persons with mental illness in the community.

Adult Screening for Inpatient and Residential Treatment

A task force representing a wide array of adult interest groups has completed recommendations about provision of currently mandated screening services by counties. The group recommended eliminating screening as a distinct service, substituting statutory requirements that counties assure placement decisions based on the clinical needs of the adult. In addition, the group recommended that contracts for the provision of services be required to have admission, continued stay and discharge criteria, as well as linkages between counties and other providers of services. These amendments will be proposed during the 1991 Session.

Funding and Statistical Review of Adult Mental Health Services

National prevalence studies indicate that Minnesota likely has about 30,000 adults with serious and persistent mental illness. Computerized cross-matching of client service records across different information systems (social services and MA/GAMC) indicates that about 16,800 Minnesota adults with serious and persistent mental illness receive some publicly financed mental health services during F.Y. 90.

There is a large overlap in the functioning levels of clients in community programs, compared to clients in RTCs, according to client assessment studies conducted for the state by Policy Research Associates, Inc. at Minnesota RTCs in 1989 and at Rule 14 and Rule 36 programs in 1990. Staff from the programs completed assessments on clients in their programs. The RTC study found, when applying a statistical procedure developed previously in New York to the assessment data, that at least 22% of RTC residents could be appropriately served in community programs. The 22% figure from the RTCs may be a low estimate and the statistical procedure should be reexamined in light of the community survey findings.

Public funding for adult mental health services is provided through more than 10 different funding programs. The single largest fund is the RTC state share (including Medical Assistance for RTCs for children and persons aged 65 and over).

Total FY 91 DHS expenditures for adult mental health services are estimated at $227,500,000, including 54.5% for inpatient services (RTC and community inpatient), 13.2% for community residential 31.7% for community non-residential (outpatient) and .6% state administration.

Over the last seven years, MA/GAMC outpatient expenditures have experienced the largest percentage growth - 166%, while the RTC funds have experienced the largest dollar growth - an increase of over $33 million. The basic trend, especially for MA/GAMC, is toward more focus on outpatient/community services, as opposed to inpatient services. However, the change is very gradual and most of the dollars are still expended for inpatient services. At the current rate of change, inpatient expenditures from these funding sources will continue to far exceed outpatient expenditures far into the next century.

RTC costs have increased 89% over the past seven years, while RTC client numbers have increased only 6%. At the same time, state grants for community programs have increased 129%, while Rule 36/CSP clients have increased 113%.

County plan data for 1990 indicates that counties are now budgeting about $89 million of county funds for adult and children's mental health services, for an increase of 74% over six years. However, due to inconsistent reporting methods, it is not clear how much of this increase is due to changes in reporting methods. Most counties are reporting much higher county spending for mental health services than the minimum maintenance of effort required by law.

Minnesota spends less, on a per capita basis, for state mental health agency administration than most other states in the country. Lack of sufficient state staff has been a key factor in the delayed implementation of new services mandated by the 1987 and 1989 Legislatures, and has caused Minnesota to forego available federal financial participation.

The Department's specific fiscal recommendations are contained in the Governor's budget to be submitted to the Legislature Feb. 20, 1991. The issues considered in developing the recommendations include: maximizing MA funding already authorized for case management, downsizing Institutions for Mental Disease (IMDs), Medical Assistance rehabilitative services and housing subsidies.

Implementation of the Comprehensive Children's Mental Health Act

Calling for the development of a comprehensive, appropriate and accessible mental health system, the 1989 Comprehensive Children's Mental Health Act mandated phase-in of an array of mental health services for children by 1992. Key to the development of this array is coordination among providers of services to children and families on the state and local levels. Counties submitted their first biennial plans for these services for FY 90-91. The first new funding for children's mental health services will be awarded in March 1991 to counties wishing to establish Family Community Support Services. With legislative approval, these grants will become the foundation for an Integrated Children's Mental Health Fund.

Efforts to develop coordinated early identification and intervention services are underway following multi-agency planning. These include regional meetings during 1991 on Child Mental Health Awareness for professionals serving children and families.

An informal children's case management advisory group is examining local and national models of case management for children, as well as developing potential funding strategies for this service. Children's case management is viewed as the primary mechanism for coordination between service providers from multiple systems and the child and family.

In order to bring the licensing rule for children's residential treatment facilities (Rule 5) into compliance with contemporary

standards of practice, preparations to revise this rule are underway. In addition, the Division is attempting to address both the high cost to counties of Rule 5 services and to assure that funding options do not establish incentives for out of home placement.

The lack of funding to counties for service provision and to the Division for developing service standards, consultation, and technical assistance has delayed implementation of the Act. Therefore, the Department will propose extension of the implementation time-lines during the 1991 legislative session.

Funding and Statistical Review of Children's Mental Health Services

National prevalence studies indicate that Minnesota has about 57,000 children with severe emotional disturbance. Computerized cross-matching of client service records across different information systems (social services and MA/GAMC) indicates that about 19,000 Minnesota children with emotional disturbance are received some publicly funded mental health services during F.Y. 90. Reliable data is not available to identify how many of these children have severe emotional disturbance. About 950 are receiving case management services. Data is also not available to unduplicate counts of children with other departments at this time.

Public human services funding for children's mental health services is provided through more than 10 different funding programs, with the single largest source being county social service funds. Although the state share for adult mental health services averages 57%, the state share for children's mental health services averages only 23%.

Total FY 91 DHS expenditures for children's mental health services are estimated at $63,100,000, including 23.8% for inpatient services (RTC and community inpatient), 37.3% for community residential, 38.7% for community non-residential (outpatient) and .2% for state administration.

Funding disparities for different services seem to be greater for children's mental health than for adult mental health. The average county share for RTC services is 6%, compared to 68% county share for case management and community support services, and 62% county share for community residential treatment.

An updated estimate of the total cost of full implementation of the Comprehensive Children's Mental Health Act indicates a need for new funding totalling about $11 million for the coming biennium. This estimate is based on a phase-in plan which projects full service use by F.Y. 1995.

The Department's specific fiscal recommendations are contained in the Governor's budget to be submitted to the Legislature Feb. 20, 1991. The issues considered in developing the recommendations include: maximizing MA funding already authorized for case management, Medical Assistance rehabilitative services, integrating new children's mental health funds and equalizing the county share for RTC and community residential services.

State Level Coordination of Children's Mental Health Services

For the past year, the State Interagency Coordinating Committee has focused on obtaining reliable and consistent data on the number of children with emotional disturbance being provided mental health services by various state agencies and on the services being provided. This data indicates that funding is not being duplicated for the same services by the various agencies.

Members have worked cooperatively to develop compatible eligibility criteria for services, including developing special education criteria for these children. During the next year, the Committee plans to address the administrative requirements for each agency in order to obtain a comprehensive picture of services and expenditures across agencies for children's mental health services.

Children's Screening for Inpatient and Residential Services

The task force studying this issue recommended maintaining the screening requirement currently in statute, but also recommended that the process should include both diagnostic and functional assessments of the child by a mental health professional as well as addressing services needed to maintain the child in the community. As with adults, contracts between counties and providers would be required to assure compliance with admission, continued stay, and discharge criteria and continuity of care between service providers. These changes will be proposed to the 1991 Legislature.

Major recommendations of the group were that duplicate screening should not be necessary for children screened for hospital admissions through the Medical Assistance program and that Medical Assistance regulations should be amended to permit consideration of the lack of available alternatives in the community. Finally, the group recommended that counties be required to collect summary data on screening recommendations and the degree to which these are followed in placement decisions.

Mental Health Planning Simplification

Because the biennial mental health and community social services planning process had become extremely burdensome for both county

and state staff, administrative staff from the Mental Health, Community Social Services, and Intergovernmental Relations Divisions worked closely with county representatives to develop methods by which planning efforts can be simplified. The result of this months-long effort is a 1992-93 county planning document which merges several previously separate documents, including both adult and children's mental health plans, into one.

Criteria for approval were developed by the group, and it was agreed that information requested would be limited to that not obtainable through other means. Goals would be set by the state agency; measurable objectives would be developed by individual counties. Whether counties accomplished the objectives specified in their plans would be determined through the Department's reporting and monitoring systems. Initial response by county staff to the new planning format, distributed in January, has been very positive. In order to implement fully the county-state agreement on plan simplification, the Department will propose amendments to the current planning statutes.

Special Initiatives

Although no state funding has been made available for accomplishment of the Public-Academic Liaison Initiative (PALI), many ongoing Division activities, as well as new activities funded by a federal Human Resource Development (HRD) grant, have facilitated the PALI function. These include Division involvement with staff from higher education institutions in research grant funding applications, participation of these staff on Division committees and advisory groups, and selection of the Department for consultation with the State/University Collaboration Project (S/UCP) of the Pew Memorial Trust and the American Psychiatric Association.

As a result of this consultation, several PALI activities are planned, including development of continuing medical education in order to reduce the isolation of psychiatrists practicing in public sector settings in Greater Minnesota, collaboration between the Department and the University of Minnesota in simplifying procedures necessary to obtain research approval in state facilities, exploration of joint funding by the Department and the University for a research coordinator at the Anoka Metro Regional Treatment Center, and collaborative efforts between the two agencies as the University recruits new psychiatric faculty.

During 1990, the Department continued support of Indian Mental Health projects with a 25 % set-aside from the federal Alcohol, Drug Abuse, and Mental Health Block Grant. These funds provided mental health services on eight reservations and two urban communities. Coordinated with county services, many of these projects utilize traditional healers as well as mental health professionals in serving the Indian communities. In addition, the

Department is attempting to assist Indian communities in addressing an increase in the number of attempted and completed suicides by Indian people.

The Community Mental Health Reporting System (CMHRS) became fully operational in 1990, providing the Division with the capacity to produce routine and ad hoc reports. The system permits electronic transfer of client-specific data from counties and contracted providers semi-annually, providing the foundation for a statewide database. The existence of CMHRS and its ability to permit analysis of data from counties are critical to the mental health planning simplification effort.

The stigma of mental illness affects not only persons with mental illness and their families, but also has an impact on the availability of services. Therefore, the Division, through a contract with the Department of Health, developed an extensive anti-stigma campaign, including education and media materials in kit format. With approximately 500 kits distributed, plans are now underway for designation of February 17-23, 1991 as Mental Illness Anti-Stigma Week.

II. IMPLEMENTATION OF THE COMPREHENSIVE ADULT MENTAL HEALTH ACT

A landmark piece of legislation, the Comprehensive Adult Mental Health Act (1987), forms the basis of Minnesota's mental health system. Minnesota Statutes 245.461 - 245.486 focuses on the provision of an array of services in all counties or regions of the state, based on priorities stated in law:

*emergency services
*outpatient services
*community support programs
*acute care inpatient services
*Regional Treatment Center services
*case management
*education/prevention
*day treatment
*residential services

Under the Act, counties are required to submit biennial mental health plans, developed in conjunction with local advisory councils, to the Department for review and approval prior to allocation of funding. The Acts also specify priorities in the delivery of services, providing counties with direction regarding which services must be developed. Services for adults with serious and persistent mental illness and acute and emergency services are listed as the highest priority. Certain services may be provided on a regional basis due to the intensive nature of the services or the low incidence of service need.

Addition of children's mental health service responsibilities in 1989 highlighted the Mental Health Division's need for organizational restructuring in order to conduct activities related to statewide planning, resource development, standard setting, consultation, and quality assurance for the full array of community mental health services for both adults and children. Therefore, the Division's 24 professional staff are organized into three program and one technical support units to provide specialty expertise to county agencies and service providers. In addition to state funding, the Division currently administers four federal grants which support a variety of service-related activities around the state as well as providing funding for some Division staff.

Staffing for the State Mental Health Advisory Council, required under Minnesota Statutes 245.697 and P.L. 99-660, was originally provided by funding from a federal mental health planning grant. During the past year, these staff salaries came from a time-limited state appropriation and salary savings. After June 30, 1991, these funds will no longer be available.

A. Case Management

Case management services for adults with serious and persistent mental illness became effective statewide January 1, 1989. Based on a conservative estimate, 15,000 adults in Minnesota qualify to receive these services. According to county biennial plans and Medical Assistance information, about 9,000 adults with serious and persistent mental illness received case management services during F.Y. 90. Of the total, Medical Assistance is paying for case management for about 2,900 individuals while General Assistance Medical Care (GAMC) pays for about 900 who are currently residing in Institutions for Mental Disease. Case management services for the remainder are provided with Rule 14 Community Support Program and Community Social Service Act funding.

Case Management is a key option for persons with serious and persistent mental illness who are working toward independent life in the community. The case manager assists the individual to obtain services that facilitate growth and independence and then monitors the person's progress. Coordination between the case manager and other community service providers is both critical and required by statute.

The necessity for restructuring county administrative systems to accommodate Medical Assistance billings and to maximize funding for case management has become a major issue. The Division continues to provide technical assistance to counties in this effort and has also worked collaboratively with the County Monitoring and Policy Coordination Division to devise a monitoring instrument for surveying actual implementation of case management throughout the state.

In addition, a Case Management Implementation Committee, comprised of county representatives, advocates, contracted case management providers and consumers, met for over a year to examine assumptions and principles involved with rule implementation. Results from a statewide survey initiated as a result of the committee's work is being analyzed to provide insights into ways to improve on existing administrative practices. In particular, the survey examined assumptions with respect to the costs of providing the service and optimal caseload size. Some modifications of Rule 74 are likely to be proposed as a result of the committee's efforts.

B. Community Support Program Services

In 1990, the number of persons with serious and persistent mental illness receiving community support program (CSP) services increased by approximately 7 percent from 1989. As eligible individuals become aware of the availability of CSP services, some counties with larger populations report such rapid growth in the number of residents requesting services that they are having difficulty in fully meeting the identified need.

Statewide, mandated CSP services are still in a developmental phase. Approximately 500,000 hours of CSP services (excluding day treatment) have been provided to an estimated 7,010 individuals during 1990 (based on data from the Community Mental Health Reporting System). New programs and service improvements are occurring in many areas of the State, reflecting local needs and increased efficiencies. For example:

> Carver County has opened a successful consumer drop-in center within the mental health center. Community participation has been good, with many donations of equipment and supplies received.
>
> Kittson County has opened a part-time day treatment program at two community sites, provided rent-free. The number of participants has been more than double the number projected.
>
> In 1990, Hennepin County opened 4 additional Regional Community Service Sites. Each of the 8 regions in the county now has a local center where individuals can participate in CSP activities, as well as other mental health services.

The CSP rule (Rule 14) is currently in revision. This revision will more clearly define the program aspects of CSP (in a new Rule 15) and the funding process (through a revised Rule 14) in order to promote the continued development of high quality CSP services.

With the restructuring of the Mental Health Division, technical assistance is provided by staff who specialize in the area of CSP. This provides counties with consultation that is distinctive to CSP by staff knowledgeable about CSP services statewide and nationally.

The second annual statewide CSP conference saw growth of over 100 people from the previous year. Scholarships were provided for consumers of mental health services and Local Advisory Council members. Response from the 470 participants was extremely positive to this training and networking opportunity. A third annual conference is planned for the Spring of 1991.

C. Employability Services

The Division continues to work cooperatively with the Department of Jobs and Training's Division of Rehabilitation Services (DRS) to implement the Joint Interagency Cooperative Agreement. As specified in the agreement, quarterly meetings are held to discuss program and budget issues and legislative concerns.

In the last year, the two agencies have collaborated to develop and provide training on supported employment and mental illness to DRS counselors, case managers, and service providers. This training

has been successful in helping mental health and rehabilitation agencies to better understand the multiple systems affecting their joint clients.

Community-based employability and vocational services for persons with mental illness are seen as a priority by both agencies, although no new funding has been made available to expand the current and historically limited availability of these services. Both DRS and the Division are currently working together on proposals to develop and expand options for community-based employability services.

D. Housing Support Development

In 1988, the Legislature allocated $500,000 for the development and implementation of housing support pilot projects. The purpose of these projects was to provide supportive services to persons with mental illness to remain and live in safe, stable and affordable housing of their choice. The selection of this housing was to be from those living environments available to the general public.

Pilot housing support projects began in November, 1988. By the end of the first fiscal year, ten counties had implemented eleven projects. The Department requested and received approval from the legislature to continue the pilot projects in FY 1990-91, serving 448 persons with $535,000. Four hundred ninety persons are projected to be served in FY 91 with $549,445 in allocations.

A Housing Mission Statement, enacted in 1989, gave the Commissioner the responsibility to ensure that housing services provided as part of the comprehensive mental health services system:

- allow all persons with mental illness to live in stable, affordable housing, in settings that maximize community integration and opportunities for acceptance;

- allow persons with mental illness to actively participate in the selection of their housing from those living environments available to the general public; and

- provide necessary support regardless of where persons with mental illness choose to live.

Since the passage of the Housing Mission Statement, the Division has incorporated its principles in the grant programs it has developed and administers.

A consumer satisfaction survey conducted in May, 1990 obtained responses from 91 persons receiving housing support services. Results indicated that consumers were receiving a variety of

supportive services and were satisfied with the services they received. The types of assistance most commonly received included finding a place to live, maintaining their home (cooking, cleaning, and budgeting), mental health crisis services, moving, locating furniture and housing supplies and obtaining low cost housing. These housing support pilot projects have shown that increasing supportive services enables persons with serious and persistent mental illness to obtain and maintain safe and affordable housing of their choice. However, the projects have also shown that stable, affordable housing is not available statewide. Additional work with state, local and federal housing agencies is needed to develop such housing and coordinate services for those requiring housing support.

In May, 1990, a mental health program consultant position was established to oversee the housing support pilot projects and Stewart B. McKinney mental health services for homeless persons (MHSHP) program. Additionally, this person is responsible for providing technical assistance on implementation of the housing mission statement and coordination with housing and housing support agencies.

E. OBRA-87

The federal Nursing Home Reform Act, included in OBRA-87 (P.L. 100-203), established processes to assure that persons residing in nursing facilities require that level of nursing care and, conversely, that persons with mental illness who do not have physical health needs requiring nursing facility services are relocated. P.L. 100-203 required that states have a process in place by January, 1989, to ensure that these procedures are operational and that the Health Care Financing Agency (HCFA) provide minimum regulatory guidelines by October 1, 1988. The complexity of P.L. 100-203 is reflected in the number of draft regulations and major technical amendments passed by Congress during each budget session since the law's initial passage. As of January, 1991, final federal regulations have not been promulgated.

According to Minnesota's Alternative Disposition Plan (ADP) approved by HCFA, 50 persons in Minnesota were to be relocated by April 1, 1990. An additional 100 are to be relocated by March 31, 1991, and an additional 150 by June 30, 1992.

$1,495,399 in state funds to support activities of the ADP were awarded to counties to assist in relocating these persons during the FY 90-91 biennium. Eleven counties with financial responsibility for 100 residents currently found to need relocation applied for these state dollars. These counties are: Hennepin, Ramsey, Washington, Dakota, Goodhue, Winona, Wabasha, Houston, Olmsted, McLeod and Blue Earth. Most of the residents to be relocated have serious and persistent mental illness and

histories of psychiatric hospitalization. It is anticipated that most of these individuals can make the transition successfully to the community with intensive case coordination, supportive housing and specialized mental health or other health services provided with state funding.

Mental Health Division program staff responsible for OBRA and Alternative Disposition Plan grants has provided 38 training sessions for counties and 17 training sessions for nursing facilities and hospitals on this complex issue, as well as four state conferences, during calendar year 1990.

Although HCFA approved Minnesota's Alternative Disposition Plan, representatives from that agency are now indicating a change in their definitions of those affected by the law. This new interpretation could potentially mean that the 300 persons identified and approved under the Plan would need immediate discharge. Such a change would also have major budget implications for the state. The Division is in the process of obtaining an opinion from the Attorney General regarding this possible change.

F. Anoka Alternatives Project

To address overcrowding at the Anoka-Metro Regional Treatment Center (AMRTC) due to insufficient community services to meet the needs of persons with serious and persistent mental illness, the 1990 Legislature authorized that $500,000 be used for alternative services for people being discharged from the facility. This FY 1991 funding has been awarded to the six metro counties served by the AMRTC.

Mental health and supportive services eligible to be reimbursed by these grants include an array of services: housing support services, housing subsidies, home care services, family supports, enhanced foster care, enhanced community support services, friendly visitor services, transportation assistance, parenting supports and transition services. Anoka Alternatives funding has been used to provide parenting classes, child care while the parent is receiving outpatient services, transportation to outpatient services, someone stopping in to visit on a regular basis, and 24-hour access to a mental health worker, if needed.

Counties have projected that they will be able to assist between 40 and 60 persons to move out of the RTC with services created by these dollars. In the first six months of the project, 22 persons were discharged and discharge planning was occurring with an additional 48 persons.

Five persons moved into their own apartments and are receiving housing support services. Fourteen persons moved to Rule 36 Residential Treatment facilities, two persons moved to a nursing facility and one person moved to a boarding care home.

While project dollars have been very useful in helping these 22 persons receive enhanced services to achieve discharge, the impact has not been limited to these individuals. An additional 30 persons have been referred to the project as requiring additional services. Each of these was reviewed by the discharge planning team. Although a few were found not ready for discharge, others were found to need no additional services beyond those currently available in their home communities, once county, AMRTC, and Division staff discussed options. The project has thus demonstrated the effectiveness of the collaborative discharge planning process.

County, AMRTC, and state administrative and staff commitment to this one time, short-term project has been commendable. Creative programming based on individual needs and choice as well as coordination by the county, RTC and providers has produced successful project results.

Anoka Alternative funds were also used to sponsor a one day workshop on supportive and mental health services for persons with serious and persistent mental illness. One hundred and seventy-five people representing counties, providers, housing agencies, consumers and RTC staff involved in the Anoka Alternative and OBRA Alternative Disposition Plan Projects participated in the event. Sinnika McCabe, Technical Assistance Director for The Center for Community Change through Housing and Support, provided the keynote presentation on "Consumer Empowerment and Housing as Housing." Ms. McCabe also provided consultation to counties and providers on their housing support services and technical assistance to state staff on the Department's proposed mental health housing initiative.

G. Housing Initiative

The Division's concept of a housing initiative to meet the needs of persons with mental illness would consist of:

- an expansion of housing support pilot projects to include additional counties;

- the development and implementation of a pilot housing subsidy program;

- the downsizing of several Institutions of Mental Diseases (IMDs) which captures new federal funding along with development of alternative services for persons moving because of downsizing: and

- development and implementation of the Medical Assistance Rehabilitation Services Option for reimbursement of some Rule 36 facility services.

This concept has been developed in coordination with the Health Care Management, Assistance Payments and Long Term Care Divisions of the Department, as well as local, state and federal housing agencies. Other state and national agencies who currently have or are implementing housing support and housing subsidy programs were also contacted for information and advice.

Among the agencies involved was the Minnesota Housing Finance Agency, which received one-time funds of $250,000 from the 1989 Legislature to develop housing for persons with serious and persistent mental illness. The agency decided to utilize these dollars for a two-year housing subsidy program, which was announced in early December, 1990. Mental Health Division staff worked very closely with this agency's staff to develop the guidelines for the housing subsidy program. Staff will continue to collaborate and provide technical assistance during the implementation and evaluation stages of this project. Both agencies view coordination on this and other projects involving housing and housing support to persons with mental illness as critical to their success.

H. Mental Health Services for Homeless Persons

The Mental Health Services for Homeless Persons program has three major objectives:

- To provide services to homeless persons with mental illness so that they can receive the basic needs of life, one of these basic needs is mental health services;

- To support the efforts by homeless service providers to assist homeless persons with mental illness; and

- To engage the entire mental health provider system in providing services to the persons who are the hardest to find and in maintaining contact with them.

In FY 1990, Stewart B. McKinney federal ($505,325) and state ($200,000) funds served 2,351 homeless individuals with mental health problems in seven counties: Anoka, Blue Earth, Clay, Hennepin, Polk, Ramsey, and St. Louis. The same amounts were distributed again in FY 91.

Counties were expected to address six mandated services in order to receive the federal funds: outreach, mental health services, referral to medical services, training, case management, and housing support. Each county was not required to provide all of these services, but all services had to be provided within the state. However, all counties chose to provide these services. Many of the services were provided in conjunction with existing mental health or homelessness services. Extensive networking took place between these two types of providers.

Each county's program is unique to the needs, service providers and homeless population of that county. Specialized projects have grown out of these programs, such as the Duluth program's successful application to purchase a $1 HUD home for conversion to a transitional home for homeless persons with serious and persistent mental illness. The Moorhead program has worked with the city of Moorhead to begin a drop-in center for homeless persons with mental illness. The Crookston program has assisted the community in breaking down racism by coordinating a celebration of ethnic diversity.

I. Rule 36 Revision

Rule 36 is the licensing rule which regulates the delivery of 24-hour rehabilitative services to adults with mental illness who live in residential settings. The rule, promulgated in 1982, is being revised to reflect contemporary standards of practice.

As recommended by the Legislative Audit Commission in its 1989 report, the revision is aimed at increasing the ability of Rule 36 programs to address the needs of clients who are difficult-to-serve. The revision will focus on encouraging providers to deliver services in a broader range of settings, including those which are smaller and more integrated into the community. The modifications would provide opportunities for collecting Medical Assistance reimbursement for some Rule 36 services under the Rehabilitation Option.

III. ADULT SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT

This chapter has been prepared to comply with Minnesota Statutes, section 245.476, subdivision 1.

Minnesota Statutes (1990) Section 245.476, Subdivision 1, requires that:

> 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 alternate review process may be approved by the commissioner if the county board demonstrates that an alternate 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).

Subdivision 4 of the same statute required the establishment of a task force on residential and inpatient treatment services for adults. The purpose of the task force was 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....

That group, established in August, 1989, submitted its initial conclusions and preliminary recommendations as part of the Division's 1990 Report to the Legislature. (Readers are referred to that document for a more complete discussion of the issues.)

One recommendation of the group included in the 1990 report was:

> 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.

As a result, the task force continued its work until June, 1990, discussing issues which had not been resolved in its previous work. In June, 1990, members modified their previous recommendations, concluding that screening as a distinct service should not be mandated by the State due to the costs of service implementation, duplication with other processes, such as hospital admission precertification, and because of the clinical complexity of the process. Instead, the task force recommended that the functions of screening be included in several on-going activities. In addition, members felt screening functions, while not a separate service, should be responsive to both emergency and non-emergency situations.

Final recommendations of the task force are as follows:

1. Screening as a mandated service for adults, as required by Minnesota Statutes 245.476, subdivision, 1 should be repealed, with requirements reflected in Recommendations 2 and 3, below, added to Minnesota Statutes 245.472 and 245.473.

2. Counties should be required to assure that placement decisions are based on the clinical needs of the adult as identified by the individual, family or significant others (if appropriate), referral agency and the mental health professional involved.

3. Each entity providing inpatient hospital or residential 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. Contracts should assure linkages between the county, as the funder of services for individuals receiving publicly funded services, and service providers to ensure comprehensive planning and continuity of care between needed services, in accordance with data privacy requirements. Appeal mechanisms should also be included in these contracts.

4. The current revision of Rule 36 should address general admission, continued stay, discharge criteria, and an appeal mechanism which can be readily accessed by the individual or the individual's legal representative.

5. Any screening functions undertaken by a county must be separate and distinct from on-going case management services being provided to a client unless the case management model used for mental health services in Minnesota is modified.

6. DHS should establish a work group to examine the feasibility and costs of requiring third party payors to cover all costs of treatment which have prior authorization until such time as concurrent review shows the treatment to be inappropriate. The work group should include representatives of the hospital associations, third party payors, DHS' Surveillance and Utilization Review unit and Mental Health Division, and the State Mental Health Advisory Council.

Following receipt of these recommendations, the Department has proposed statutory changes to eliminate screening as a separate service within the adult mental health system and to add requirements for contractual agreements to assure compliance with admission, continued stay, and discharge criteria for publicly funded services. (Inpatient services funded under General Assistance Medical Care and Medical Assistance would not be subject to these contractual requirements because these services are not arranged or directly funded through the county.)

IV. FUNDING AND STATISTICAL REVIEW OF ADULT MENTAL HEALTH SERVICES

This chapter has been prepared to comply with Minnesota Statutes, sections 245.73 (Rule 12 report), and 245.463, subdivisions 3 (increasing community beds and maximizing use of Medical Assistance) and 4 (mental health funding).

A. Prevalence Estimates for Adults with Mental Illness

The National Institute of Mental Health (NIMH) conducted a series of 5 studies across the country in the early 1980s to estimate the prevalence of mental illness in the general population of persons 18 and older. From these studies, prevalence rates nationwide were estimated for the different types of mental illness.

Regier and other researchers estimated that during any one month period, 12.6% of the adult population has a mental illness disorder. Among the more severe disorders, they estimate that .7% of adults have a schizophrenic disorder and 5.1% have an affective disorder such as major depression or manic-depression. The estimated number of adults in Minnesota with these diagnoses is obtained by applying these percentages to the total adult population in 1988 (See Table 1). Rates for these disorders appear to vary in prevalence depending on sex and age. Schizophrenia appears to occur equally among men and women, while women have a higher occurrence of affective disorders. Regier et al found that higher rates for most disorders were found among younger respondents, especially for those under 45. Affective disorders tended to have a higher rate up to age 65 before decreasing.

TABLE 1

MENTAL ILLNESS PREVALENCE AMONG ADULTS

DISORDERS	1 MONTH PREVALENCE	LIFETIME PREVALENCE
ANY MENTAL ILLNESS	12.6%	22.1%
Est. Adults in MN	398,817	699,513
SCHIZOPHRENIA	.7%	1.5%
Est. Adults in MN	22,157	47,478
AFFECTIVE DISORDER	5.1%	8.3%
Est. Adults in MN	161,426	262,713

In examining the extent of serious mental disorders in the NIMH report Mental Health, United States, 1987, Goldman and Manderscheid discuss three components: diagnosis, disability and duration. Their review of studies indicates that, even among the more severe mental disorders such as schizophrenia, not all cases will be chronic or long-term. They cite several national studies which estimate that approximately 800,000 individuals in the community have a severe mental disability and 700,000 more are moderately or partially disabled. This means that approximately .5-1.0 % of the adult population **living in the community** have a disabling mental illness. This estimate excludes adults who are in institutions such as nursing homes or state hospitals/regional treatment centers. (The number of adults with a mental illness in nursing homes is described in Chapter II of this report.)

Applying the .5% to Minnesota's adult population means that approximately 15,826 adults have a totally disabling mental illness and 31,652 adults have at least a partially disabling mental illness. The 31,652 figure would probably be most appropriate for estimating the number of adults with a serious and persistent mental illness living in the community.

As part of the NIMH study of the prevalence of mental disorders Shapiro et al examined the use of ambulatory health services and/or mental health services over a 6 month period. Shapiro et al examined the results from 3 of the 5 survey sites (Baltimore, New Haven and St. Louis) of those surveyed. Of those persons with a schizophrenic disorder, approximately 78% had some type of health or mental health visit in the last 6 months. At the 3 sites the percent with mental health visits ranged from 39% - 53%. Of those persons with an affective disorder approximately 78% had some type of ambulatory health/mental health visit. Thirty-one percent of these visits were for mental health reasons.

Although the prevalence of mental disorders can be estimated, mental health service use does not necessarily follow its occurrence. For a variety of possible reasons, persons with the disorder do not seek mental health care, or they may seek care from other than a mental health professional.

B. Economic Costs of Mental Illness

The NIMH recently published a study titled *"Economic Costs of Alcohol and Drug Abuse and Mental Illness: 1985"*. This study estimates the total cost of mental illness to society (combining adults and children, but separate from alcohol and drug abuse). In addition to direct costs of treatment, the study includes costs relating to the value of reduced or lost productivity and criminal justice system costs. Although the study provides national

estimates only, a prorated share of the total costs based on Minnesota's percentage of the national population indicates that the total cost of mental illness in Minnesota is more than **$ 2 billion** per year. The NIMH estimates that more than half of this cost is lost productivity and premature deaths caused by mental illness. Additional treatment and prevention may reduce these "hidden" costs of mental illness.

C. Rule 14 and Rule 12/36 Statistics

1. PRA Survey of RTCs

In June of 1989 Dr. Henry Steadman and his firm, Policy Research Associates, Inc. (PRA) of Delmar, New York contracted for a clinical survey of all residents of RTCs with a mental illness. Using an instrument used in New York state hospitals to assess level of care needed, PRA had RTC staff do assessments of all residents with a mental illness diagnosis. PRA used two procedures to estimate the number of current RTC clients who could be in the community. The first procedure was a statistical procedure previously used in New York and other states which was based on the clinical ratings of clients. They reported that at least 22% of the RTC patients assessed in mental health treatment units could be in the community. Other possible refinements to the statistical procedure could lead to higher estimates (up to 49%).

The second estimation procedure for community readiness was using staff judgments. Table 2 which is based on data from the PRA Report, provides the RTC staff responses to the question, "Is patient now appropriate for placement into community?". The RTC staff thought that 270 or 25% of the adult and geriatric mental health patients would either definitely or probably be appropriate for community placement.

TABLE 2

PRA SURVEY OF REGIONAL TREATMENT CENTERS
STAFF ASSESSMENTS OF COMMUNITY APPROPRIATENESS

	MH PROGRAMS			
Is patient now appropriate for placement into community?	ADULT	GERIATRIC	TOTAL	PERCENT
Definitely Yes	83	12	95	9%
Probably Yes	156	13	169	16%
Possibly	154	31	185	17%
Probably No	181	49	230	21%
Definitely No	331	76	407	37%
Total	905	181	1,086	100%

2. Survey of Minnesota's Rule 14 & Rule 36 Programs

In June 1990 PRA surveyed a sample of community program staff to rate 1,505 clients in Rule 14 and Rule 36 programs. The primary purpose of the Rule 14/36 survey was to develop clinical and functional profiles of clients in community programs and to compare with the survey results from the RTC survey.

In analyzing the community programs, PRA found in comparison to Rule 36 clients, Rule 14 clients were generally older, more likely to be female, need less supervision for their medication, and less psychiatrically disabled. Rule 36 Category I clients had the highest percentage of persons who were younger, male, severely psychiatrically disabled, and required the most supervision for medication. The Rule 36 Category I clients were not statistically different in their psychiatric symptomatology scores (67.9) from RTC clients with a voluntary legal status (71.5).

Rule 14 clients had participated in community support programs for a median stay of 17 months, indicating the ongoing nature of these programs. Rule 36 clients were in Category I and II programs for 10 and 11 months, respectively. The clients who were assessed in the earlier RTC survey had been in a RTC for a median stay of 7 months.

3. Community vs. RTC Clients

Community Support Programs (Rule 14) and Rule 36 - Category II programs had fewer clients with severe disability than Rule 36 Category I programs. The Rule 36 Category I programs in turn had fewer clients with a severe disability than clients in the RTCs. Table 3, which is from the PRA community survey report, provides a comparison of the psychiatric disability score as well as the diagnoses among the community and RTC programs.

While Table 3 shows the differences in the average disability scores, it also shows a large overlap in diagnoses and the range of disability scores. PRA applied the same statistical procedure used for estimating how many RTC clients were appropriate for inpatient stays to the community clients surveyed. They reported that 63% of the clients in the community have assessment ratings which in previous studies had indicated a disability severe enough to indicate that inpatient treatment was needed. Given the long lengths of stay in the community programs, as well as judgment by staff that the majority of clients were in their "most appropriate setting", the statistical procedure applied in the RTC study appears to be conservative in its projection of the number of clients who could be served in the community. PRA writes in its Executive Summary, "It is clear from the data that the aggressiveness of Minnesota's community services programs reflected in these results allows the maintenance of clients whose level of disability might keep them housed in state mental hospitals in other states."

The surveys of both the RTC and community clients clearly indicates that more of the RTC clients could be served in the community. It appears that if the community resources are expanded to handle additional clients, there should be at least a reduction in the length of stay at the RTCs for many clients. The Anoka Alternatives project described in Chapter II.F. describes an approach currently underway to address the issue of facilitating discharges from the RTCs.

TABLE 3

Psychiatric Disability Profile of Clients in Minnesota's Rule 14 & Rule 36 - June 1990 & RTC Programs - June 1989

	Programs			
	Rule 14	Rule 36 Cat II	Rule 36 Cat I	MH RTC
	(N=820) %	(N=283) %	(N=345) %	(N=1087) %
Primary Diagnosis***				
Schizophrenia	52.0	62.2	67.3	61.5
Affective Disorders	30.1	20.1	18.9	16.7
Other Psychosis	2.3	2.5	1.2	2.9
MR - DD	0.5	1.1	0.2	0.3
Alcohol Abuse	0.1	1.4	0.2	1.1
Drug Abuse	0.0	0.0	0.6	0.5
OBS	0.4	2.8	2.6	8.5
Personality Disorder	7.6	4.2	3.2	1.4
Other	7.0	5.7	5.8	7.1
	(N=864)	(N=285)	(N=346)	(N=1086)
Psychiatric Symptom Scale (PSYSUM)***				
Mean	62.9	63.9	67.9	74.5
Range = 32-160	(32-132)	(35-99)	(38-120)	(33-134)
% with Serious Disability (PSYSUM ≥ 70)	31.6	32.3	43.9	59.4

Significance * ≤ .05, ** ≤ .01, *** ≤ .001

4. Comparison of Numbers Served to Total Need

Earlier in this report it was estimated that approximately 32,000 Minnesota adults have some type of disabling mental illness. Due to the nature of the mental illness for this population, it is assumed that most of these people would need some type of mental health care or treatment during the course of the year, with the amount of treatment required varying dependent on the severity of the illness. Some research has suggested that for young adults the symptoms of the illness are more severe, with the severity of symptoms gradually decreasing with age.

Under a contract with the National Institute of Mental Health, Human Services Research Institute (HSRI) of Boston examined Social Security data to estimate the number of people with mental illness disabilities. Based on a sample from December 1986, HSRI estimated that there were 7,722 adults in Minnesota on SSI and/or SSDI due to a mental illness. For FY 1989, 10,024 adults (ages 19 and older) who were on SSI, SSDI or MSA received Medicaid services for a primary diagnosis of mental illness, although these clients may have other disabilities and may not all fit the definition of "serious and persistent mental illness".

Using information from the Community Mental Health Reporting System (CMHRS) and the Medical Assistance Information System for FY 1990, statewide unduplicated counts of persons receiving mental health services can be obtained for the first time. The CMHRS collects data from counties on all publicly funded clients receiving mental health services. In reporting client information, providers and counties indicate whether the client has a serious and persistent mental illness or other mental illness. Some providers who provide publicly funded mental health services through Medical Assistance but are not under a contract or agreement with a county would not be included in this system. However, Table 4 factors into the estimates those clients funded under Medical Assistance but not included in CMHRS. Because the CMHRS does not include unique statewide client identification numbers, some minor duplication in the estimates listed in Table 4 may exist. Approximately 59,000 adults are estimated to have received some type of publicly funded mental health service in FY 1990, and approximately 16,800 clients classified as having a serious and persistent mental illness were provided publicly funded mental health services.

In addition, during calendar year 1989 the DHS Reimbursement Division reported that 3,415 adults received mental health treatment in RTCs. All of these persons were considered to have a serious and persistent mental illness.

TABLE 4

ADULTS WITH A MENTAL ILLNESS
SERVED BY PUBLIC FUNDING DURING FY 1990

TYPE OF SERVICE	SERIOUS & PERSISTENT MENTAL ILLNESS	ANY MENTAL ILLNESS
OUTPATIENT	13,000	53,500
CASE MANAGEMENT	9,000	11,600
COMMUNITY SUPPORT/DAY TX	8,500	10,100
RTC *	3,400	3,400
ACUTE HOSPITAL**	4,000	5,400
RULE 36	2,750	3,000
ANY MH SERVICE (UNDUPLICATED)* **	**16,800**	**59,000**

NOTE: The figures from this table are primarily based on data from the Community Mental Health Reporting System (CMHRS) for the FY 1990 period. For Case Management, Outpatient and Day Treatment, the CMHRS data was supplemented by data for clients who received Medical Assistance reimbursed treatment but were not included in CMHRS. In the CMHRS there is not an unique statewide client ID number. Therefore, some minor duplication in the estimates may exist. These procedures involved matching on reported client ID number within a county, and across services statewide, and then matching to MA/GAMC records based on county, date of birth and sex. About 500,000 service records were reviewed by computer to develop the above unduplicated count.
* Numbers for RTCs covered calendar year 1989 were reported by the Reimbursements Division, which does RTC billings.
** The acute hospital totals are based on FY 1989 GAMC and Medicaid services provided for a primary diagnosis of mental illness. The "Serious & Persistent" client figures were estimated by calculating 74% of total number hospitalized. Based on diagnosis information for GAMC/Medicaid inpatient billings for FY 1987, it was assumed that diagnoses of Schizophrenia, Affective Disorders, other psychoses and Personality Disorders indicated a serious and persistent mental illness.
*** RTC and Acute Hospital figures were not included in calculating the unduplicated total. It is assumed they would receive some additional services and would not change the unduplicated total.

The table above indicates that case management appears to underserve adults with a serious and persistent mental illness. According to Rule 74, every person with a serious and persistent

mental illness should be offered case management services. However, it appears that, for whatever reason, the number receiving this service is lower than expected. See the section on Case Management for details about Department initiatives in this area.

D. Description of Funding Sources

The Department of Human Services (DHS) has aggressively pursued all available funding sources for mental health services. Complex federal and state legislative requirements associated with each funding source have resulted in a complex funding system. Table 5 provides a funding flow chart for mental health service funding administered by DHS. Under the Comprehensive Adult Mental Health Act, the county is the local mental health authority responsible for provision of a comprehensive array of mental health services. Therefore, most funds flow through the counties. The major exception is Medical Assistance, which is paid directly to providers due to federal requirements, and RTC funding.

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

- State Rule 12 grants ($11 million for FY 90) fund treatment and program services at community residential facilities licensed under Rule 36. Counties must provide a match of 25 percent, but the match can come from non-county sources.

  State Rule 14 grants ($11 million for FY 90) fund non-MA-eligible community support services and case management for adults with serious and persistent mental illness. Counties must provide a match of 10 percent, but the match can come from non-county sources.

- Federal Mental Health Block Grant funds (about $500,000) are targeted to serve special adult populations including American Indians and the elderly. No local match is required for the American Indian projects. Most of the other projects are funded on a three-year demonstration basis with an expectation that other funding must be arranged to pay for an increasing share of the project each year.

  State Special Project funds for adults include $500,000 in FY 91 for the Anoka Alternatives project, which provides 100% state funding for community services for people being discharged from the Anoka Metro RTC. State Special Project funds of $200,000 in FY 91 are also used in combination with Rule 14 funds for housing support services demonstration projects. The housing support projects include a 10% matching requirement.

Community Social Services Act (CSSA) funds include, for FY 91, approximately $45 million from the Federal Social Services Block Grant (formerly Title XX), approximately $51 million from state CSSA funds and about $270 million in county tax funds. These are "generic" social service funds for all disabilities and all age groups. For 1990, counties planned to spend about 14%, or $52 million, of these funds for adult mental health services. These, the most flexible funds available to counties, are used when other funds are inadequate to meet client needs and are often referred to as "County Tax/CSSA/Title XX funds" or simply "county funds."

General Assistance (GA) is a public assistance program for low-income adults who are unable to work and who do not qualify for other public assistance. Minnesota Supplemental Aid (MSA) is a state supplement for federal Supplemental Security Income (SSI). People with mental illness are estimated at around 20% of all people receiving GA, MSA and SSI. These programs are the primary funding sources for room and board costs for Rule 36 facilities. The specific funding source used, and the amount paid from each source, depend on the client's individual eligibility. In FY 90, GA paid about $3.5 million, MSA about $6.5 million and SSI about $4.3 million for clients of Rule 36 facilities. State law has required counties to pay 15% of the non-federal share of MSA and 25% of GA, but the county share is eliminated after January 1991.

Regional Treatment Centers (RTCs, formerly called state hospitals) are funded directly by the Legislature through a separate appropriation. The net state cost for RTC adult mental health services in FY 90 was about $50 million, with an additional $16 million funded by Medical Assistance for eligible individuals. State law requires counties to pay 10% of the cost for non-MA eligible adults.

Medical Assistance (MA) and General Assistance Medical Care (GAMC) cover inpatient services, outpatient services, day treatment and case management within very specific limits. MA includes 53% federal funding and is subject to federal requirements. GAMC is a totally state funded program for low-income people who do not qualify for MA. Although not subject to the same federal rules as MA, GAMC coverage for mental health services is similar to that of MA. State law has required counties to pay 10% of the non-federal share of MA and GAMC, but the county share is eliminated after January 1991. In FY 89, MA paid about $37 million for adult mental health services other than RTCs; GAMC paid about $12 million.

Table 6 illustrates total estimated FY 91 DHS expenditures for adult mental health services, by service category, including county matching funds for state grants. The largest expenditures are in the inpatient and residential categories. **Total expenditures include 54.5% inpatient, 13.2% community residential, 31.7% community non-residential (outpatient), and .6% state administration.**

Table 7 shows funding source by level of government, while Table 8 shows the same funds by program. **The single largest funding source for mental health services is the RTC state share (including MA for RTCs).**

ADULT MENTAL HEALTH SERVICES
CURRENT DHS FUNDING FLOW

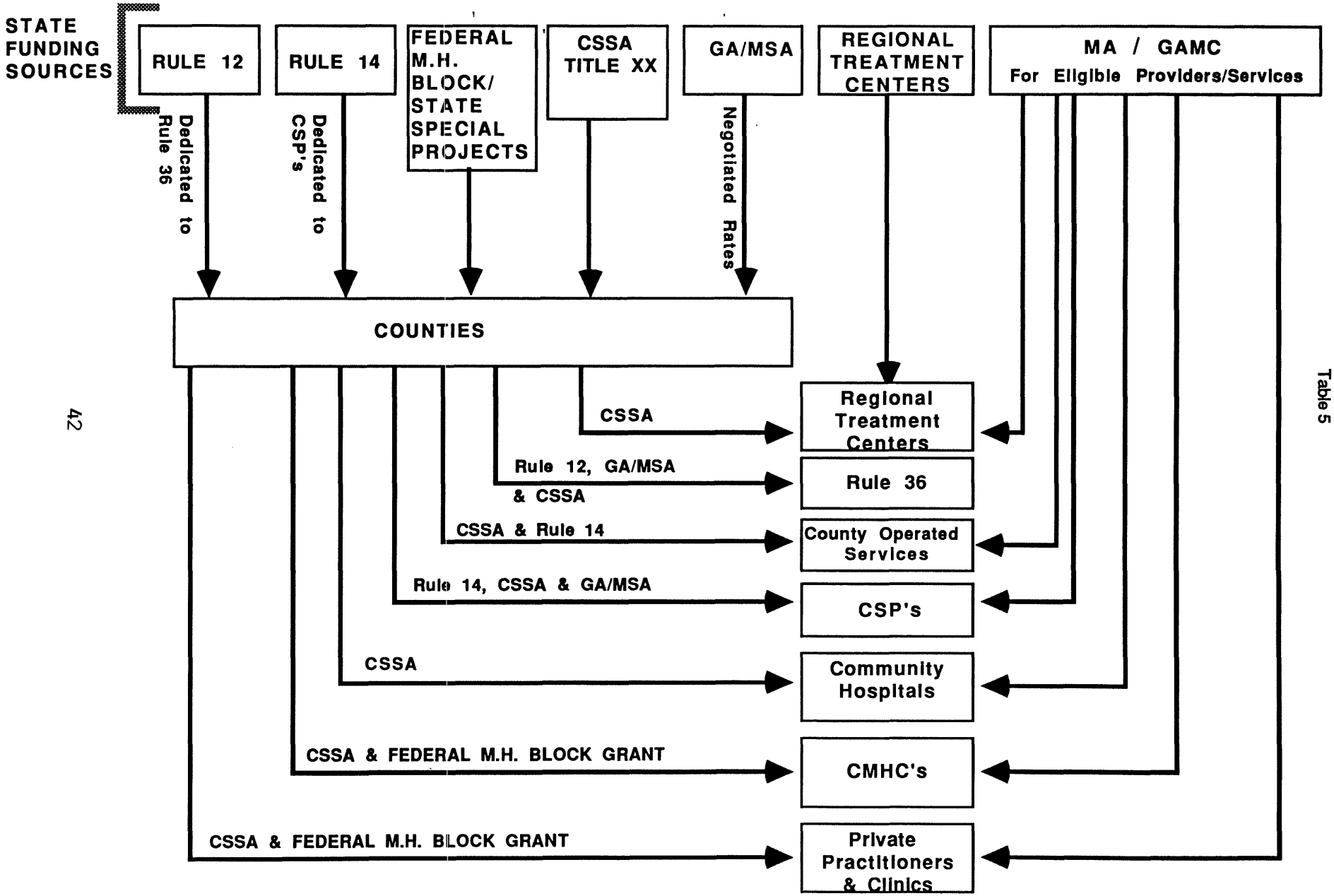
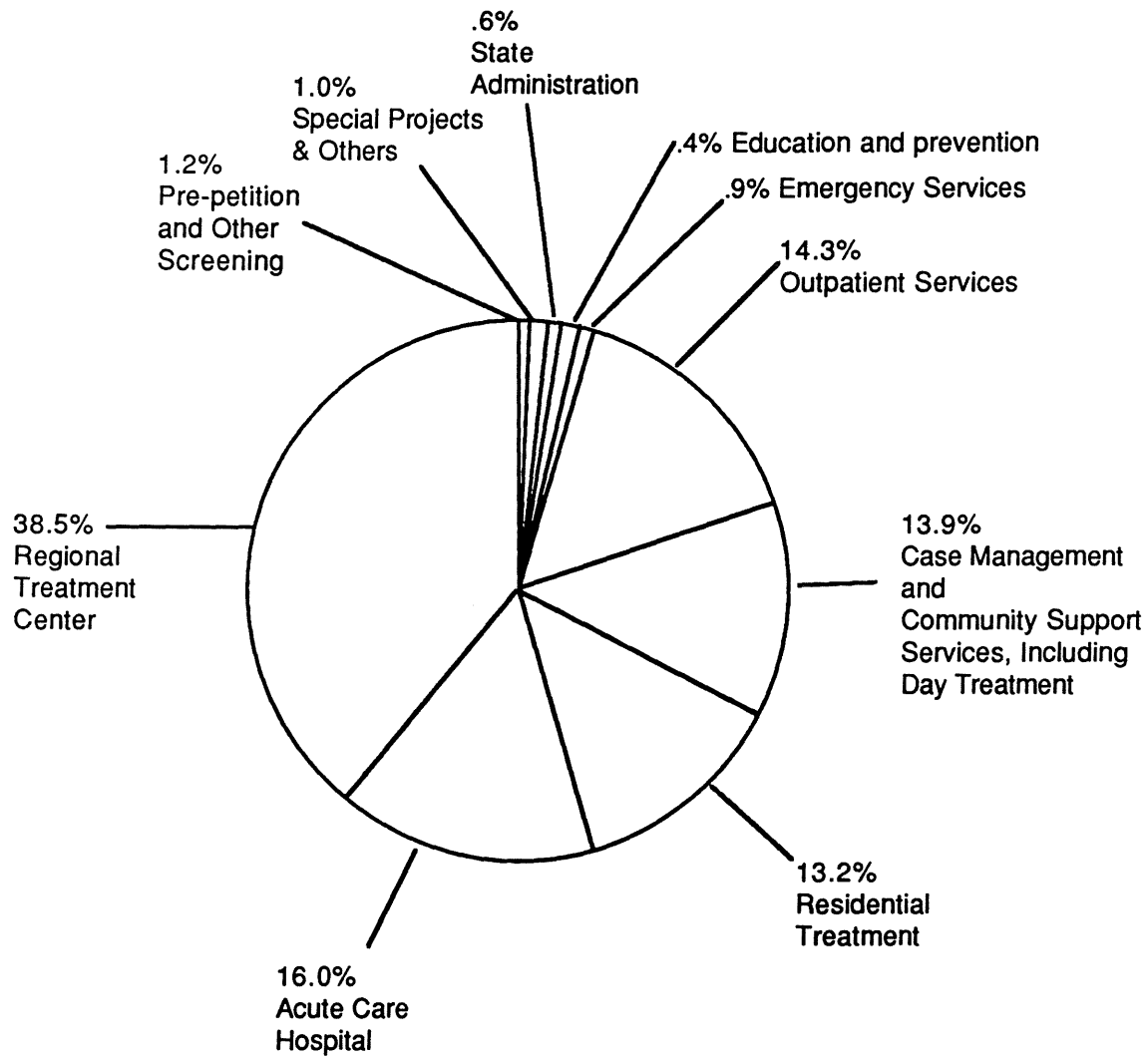


Table 5

FISCAL 1991
Estimated DHS Expenditures
Adult Mental Health Services



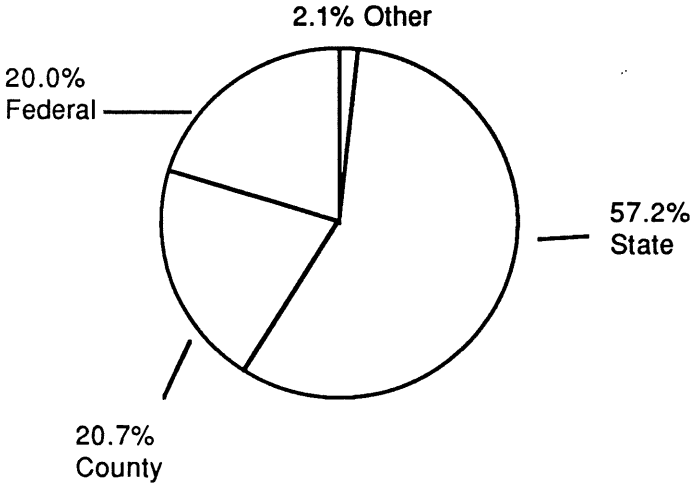
TOTAL: $227,500,000

In addition to the above, MH services are also funded by the Departments of Education, Corrections, Jobs and Training, plus direct federal funding to providers through Medicare and Veterans Administration, plus private insurance and private pay.

This table does not include Income Maintenance payments for nursing homes or living expenses of persons with mental illness who are not residents of Rule 36 facilities.

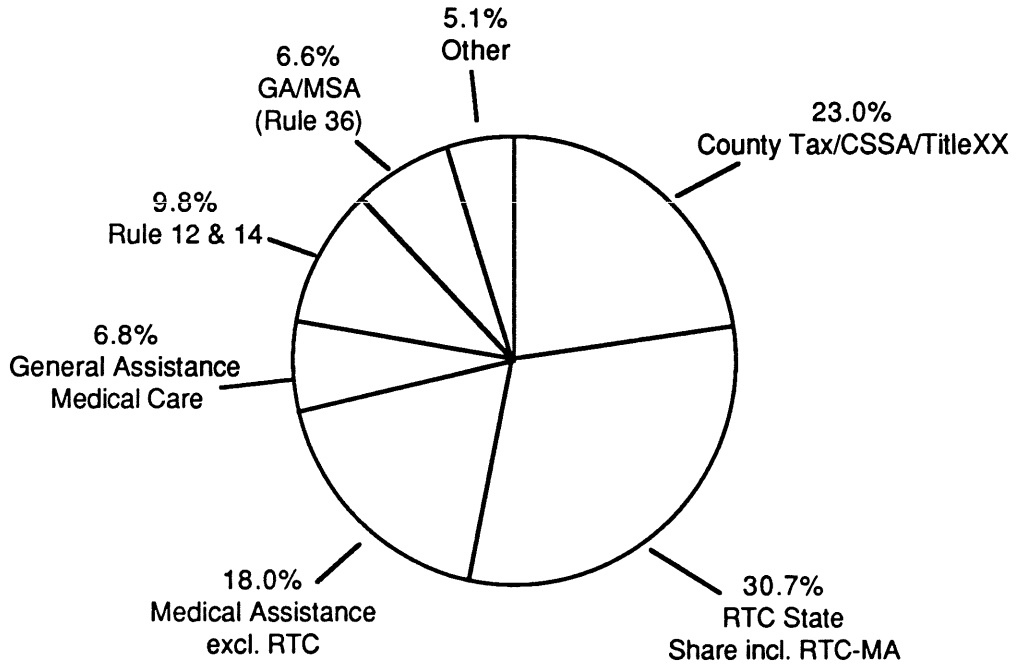
Table 7

FISCAL 1991
DHS Funding Sources
Adult Mental Health Services



Federal, State and County Funding

Table 8



Funding by Program Category

Feb 1991

E. Financial and Statistical Trends

1. Trends in RTC, Rule 12, Rule 14, Medical Assistance, and General Assistance Medical Care Clients and Expenditures

The primary state funding sources for mental health services for adults with serious and persistent mental illness are the state appropriations for RTCs, State Mental Health Grants (including Rule 12 and Rule 14), and state payments through Medical Assistance (MA) and General Assistance Medical Care (GAMC). Table 9 shows expenditure trends for these three major appropriations for the last seven years. MA/GAMC outpatient expenditures have experienced the largest percentage growth - 174%, while the RTC funds have experienced the largest dollar growth - an increase of over $33 million.

The basic trend, especially for MA/GAMC, is toward more focus on outpatient/community services, as opposed to inpatient services. However, the change is very gradual and most of the dollars are still expended for inpatient services. **At the current rate of change, inpatient expenditures from these funding sources will continue to far exceed outpatient expenditures far into the next century.**

Tables 10 and 11 compare client data to expenditure data for RTCs and Rule 12/14 programs. It is noteworthy that RTC costs have increased 89% over the past seven years, while RTC average client numbers have increased only 6%. At the same time, state grants for community programs have increased 129%, while Rule 36/CSP clients have increased 113%.

Tables 12 and 13 compare SSI eligible client and expenditure data for MA/GAMC inpatient v. outpatient. As discussed earlier, the MA/GAMC data system does not identify serious and persistent mental illness separately, but it does collect data separately for clients who are also eligible for Supplemental Security Income (SSI). These tables include data only for MA clients who are also eligible for SSI in order to focus on a group that approximates serious and persistent mental illness.

Seven-Year Comparison
Key Expenditures for Mental Health Services - Adults

Key Expenditures	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	
Rule 12 (Residential Rule 36)	$7,453,500	$8,526,900	$9,192,100	$9,934,000	$10,894,000	$11,144,000	$11,445,000	
Rule 14 (Community Supp. Programs)	$2,780,000	$3,028,792	$3,704,363	$4,983,000	$7,396,000	$8,502,962	$11,140,000	
Mental Health Special Projects	$0	$0	$0	$40,000	$960,000	$500,000	$847,000	
Total State Grants Community MH	$10,233,500	$11,555,692	$12,896,463	$14,957,000	$19,250,000	$20,146,962	$23,432,000	
RTC Adult MH state share excl. MA	$28,683,460	$30,131,683	$34,429,112	$41,795,030	$48,090,620	$50,021,844	$53,616,050	
Medical Assistance for RTC-MH	$8,708,569	$8,418,173	$8,938,709	$8,606,973	$10,235,022	$16,026,192	$17,177,718	
RTC Adult Total excl. co. and priv.	$37,392,029	$38,549,856	$43,367,821	$50,402,003	$58,325,642	$66,048,036	$70,793,767	
MA/GAMC Inpatient excl. RTCs	$17,433,677	$21,680,812	$25,071,598	$25,889,092	$28,094,424	$31,933,015	$33,272,652	
MA/GAMC Outpatient	$8,433,287	$11,249,606	$13,090,929	$14,413,114	$16,592,584	$20,135,298	$23,142,377	
Percent Change		FY 85 to FY 86	FY 86 to FY 87	FY 87 to FY 88	FY 88 to FY 89	FY 89 to FY 90	FY 90 to FY 91	FY 85 to FY 91
Rule 12 (Residential Rule 36)		14.4%	7.8%	8.1%	9.7%	2.3%	2.7%	53.6%
Rule 14 (Community Supp. Programs)		8.9%	22.3%	34.5%	48.4%	15.0%	31.0%	300.7%
Mental Health Special Projects		Not applicable	Not applicable	Not applicable	Not applicable	(47.9%)	69.4%	Not applicable
Total State Grants Community MH		12.9%	11.6%	16.0%	28.7%	4.7%	16.3%	129.0%
RTC Adult MH state share excl. MA		5.0%	14.3%	21.4%	15.1%	4.0%	7.2%	86.9%
Medical Assistance for RTC-MH		(3.3%)	6.2%	(3.7%)	18.9%	56.6%	7.2%	97.3%
RTC Adult Total excl. co. and priv.		3.1%	12.5%	16.2%	15.7%	13.2%	7.2%	89.3%
MA/GAMC Inpatient excl. RTCs		24.4%	15.6%	3.3%	8.5%	13.7%	4.2%	90.9%
MA/GAMC Outpatient		33.4%	16.4%	10.1%	15.1%	21.4%	14.9%	174.4%

RTC includes Security Hospital, but does not include state nursing homes.

Reliable cross-year data not available for CSSA or GA/MSA expenditures for MH. Available data indicates no significant change in state CSSA or GA/MSA for MH between 1982 and 1991.

Estimated projections are used for FY 90-91 MA/GAMC and FY 91 RTC. MA/GAMC includes state, federal and county shares.

SEVEN-YEAR COMPARISON
RULE 14, RULE 36 AND RTCS

TABLE 10

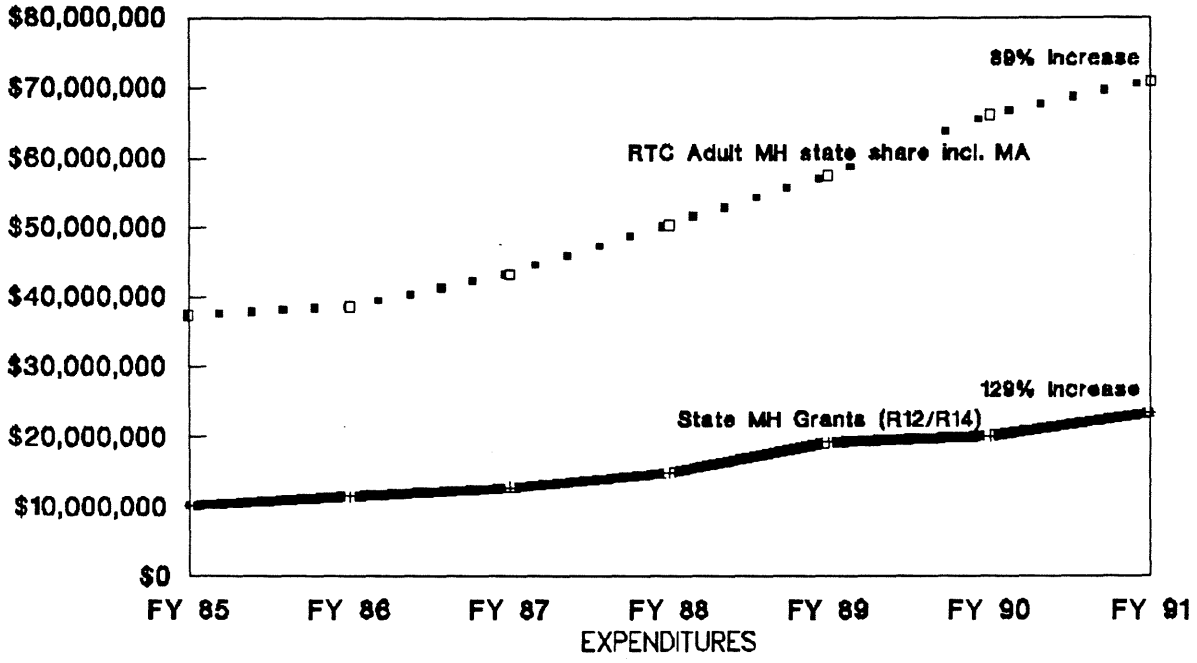
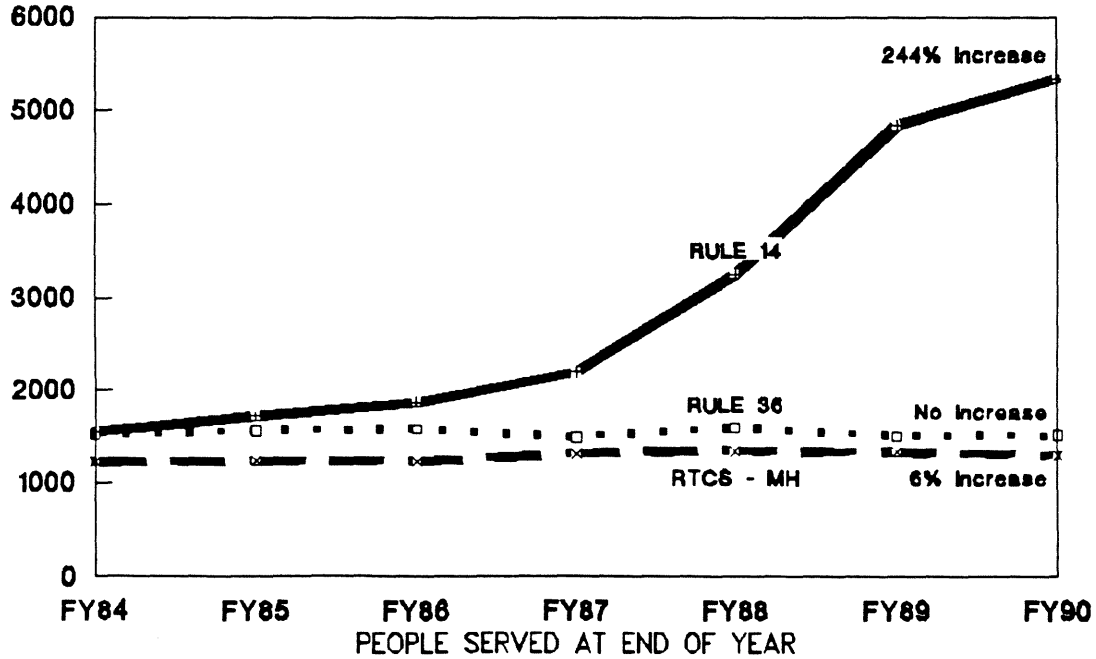
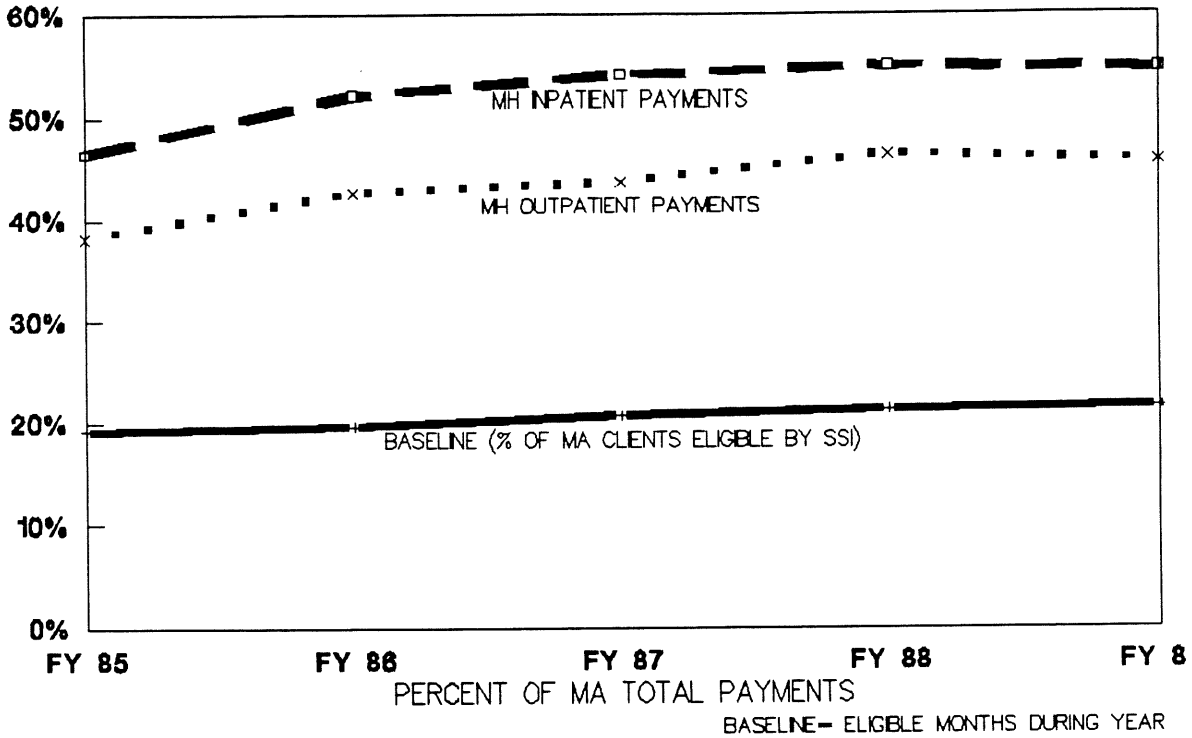


TABLE 11

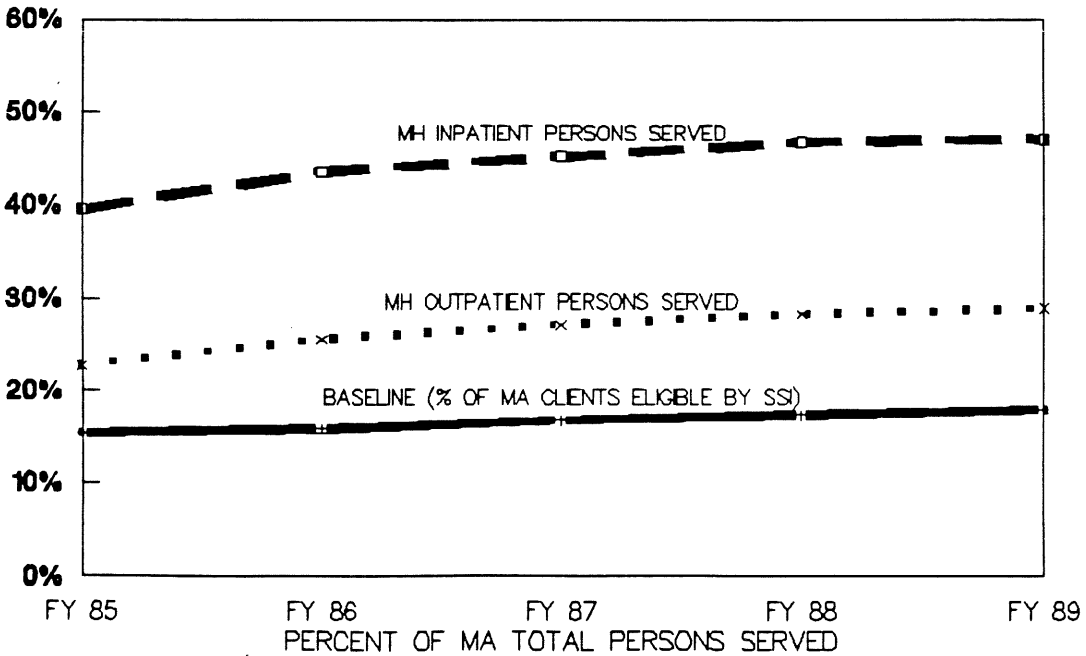


MEDICAL ASSISTANCE FOR ADULT MH SERVICE
INPATIENT VS OUTPATIENT
SSI ELIGIBLES PERCENT OF MA TOTAL
TABLE 12



BASELINE- ELIGIBLE MONTHS DURING YEAR

TABLE 13



DATA PROVIDED BY REPORTS & STATISTICS DIVISION

2. Trends in County Funding

As indicated earlier, the term "county funds" is usually used to refer to all county discretionary funds, including county taxes, state social service block grants under CSSA and federal social service block grants (formerly "Title XX"). Over the last seven years, total state and federal block grants for social services for all populations have remained almost unchanged, with no allowance for inflation, while total county tax funding for social services has increased from $152 million in 1985 to $267 million in 1990. This has resulted in an overall increase in "county funds" of 47% across six years.

Unfortunately, reliable reporting systems have not been in place to track the mental health share of these expenditures in a consistent manner. In 1987, it was estimated that 20%, or about $50 million, of 1985 county funds was for adult and children's mental health services.

County plan data for 1990 indicates that counties are now budgeting about 24%, or about $89 million, of their total county funds for adult and children's mental health services. This would indicate an increase of 74% over six years. However, due to inconsistent reporting methods, it is not clear how much of this increase is due to changes in reporting methods, e.g., counting children's mental health under the mental health category instead of under the children's category.

The Comprehensive Mental Health Act, M.S. 245.48, requires counties to continue to spend for mental health services an amount equal to the total expenditures for services to persons with mental illness in the county's approved 1987 Community Social Services Act plan. This requirement relates only to county funds. This means that counties receiving new state or federal categorical funds for existing county expenditures must redirect their county funds towards expanded mental health services. Table 14 provides maintenance of effort figures by county, indicating that most counties are reporting much higher commitment of county funds for mental health services than the minimum required by law.

Note that the 1987 base established in law relates to a combined total for adult and children's mental health. Reliable figures are not available which would separate the 1987 base into children's and adult amounts.

The Mental Health Acts passed in 1987 and 1989 (for children) changed and clarified basic definition of target populations and mental health services. Since these have occurred since counties prepared their 1987 plans, the validity of 1987 plan data for the maintenance of effort requirement is questionable. There may be a need to establish a new base, perhaps the 1990 plans.

TABLE 14

MENTAL HEALTH PLAN MAINTENANCE OF EFFORT

COUNTY		1987 CSSA PLAN MAINTENANCE OF EFFORT**	1990 MH PLAN CSSA/TXX/CTY TAX EXPENDITURES	PERCENT INCREASE
AITKIN	*	$145,150	$157,231	8%
ANOKA		$1,910,376	$2,657,363	39%
BECKER		$344,200	$441,172	28%
BELTRAMI		$370,850	$397,350	7%
BENTON		$311,101	$494,329	59%
BIG STONE		$90,692	$101,179	12%
BLUE EARTH		$637,089	$712,735	12%
BROWN		$306,120	$498,527	63%
CARLTON		$307,684	$340,264	11%
CARVER		$581,777	$791,134	36%
CASS		$165,800	$335,543	102%
CHIPPEWA		$248,269	$339,541	37%
CHISAGO		$219,956	$383,799	74%
CLAY		$486,290	$752,477	55%
CLEARWATER		$92,083	$124,122	35%
COOK		$29,882	$115,289	286%
COTTONWOOD		$171,588	$294,942	72%
CROW WING	*	$300,982	$1,012,903	237%
DAKOTA		$2,470,163	$3,110,153	26%
DODGE		$130,242	$188,508	45%
DOUGLAS		$142,263	$269,500	89%
FILLMORE		$155,306	$213,681	38%
FMW		$523,361	$706,921	35%
FREEBORN		$573,100	$652,681	14%
GOODHUE		$469,143	$883,276	88%
GRANT		$61,210	$89,020	45%
HENNEPIN		$20,611,220	$34,011,422	65%
HOUSTON		$169,019	$225,065	33%
HUBBARD		$110,000	$209,424	90%
ISANTI		$235,326	$486,653	107%
ITASCA		$452,122	$576,334	27%
JACKSON		$119,651	$119,651	0%
KANABEC		$80,370	$211,927	164%
KANDIYOHI		$955,586	$1,082,413	13%
KITTSON		$54,741	$54,741	0%
KOOCHICHING		$313,930	$514,094	64%
LAC QUI PARLE		$73,681	$84,343	14%
LAKE		$118,106	$118,210	0%
LAKE OF WOODS		$28,194	$32,160	14%
LE SUEUR		$187,231	$292,382	56%
MCLEOD		$205,155	$458,875	124%
MAHNOMEN		$50,470	$82,517	63%
MARSHALL		$111,801	$173,198	55%
MEEKER		$226,436	$303,729	34%
MILLE LACS		$180,636	$303,500	68%
MORRISON		$330,870	$360,842	9%
MOWER		$839,601	$839,601	0%
NICOLLET		$270,258	$521,791	93%
NOBLES		$370,063	$391,687	6%
NORMAN		$141,567	$144,415	2%
OLMSTED		$1,262,603	$1,262,603	0%
OTTER TAIL		$323,496	$792,903	145%
PENNINGTON		$136,221	$203,683	50%
PINE		$342,013	$342,013	0%
PIPESTONE		$106,565	$175,138	64%
POLK		$492,700	$701,223	42%
POPE		$107,400	$127,700	19%
RAMSEY	*	$7,235,139	$11,160,242	54%
RED LAKE		$27,084	$37,424	38%
REDWOOD		$248,757	$318,664	28%
REGION VIII		$632,938	$691,587	9%
RENVILLE		$383,000	$402,418	5%
RICE		$420,294	$592,195	41%
ROCK		$105,750	$115,556	9%
ROSEAU		$74,150	$86,215	16%
SAINT LOUIS		$2,611,000	$4,156,205	59%
SCOTT		$447,501	$626,390	40%
SHERBURNE		$384,545	$761,016	98%
SIBLEY	*	$187,400	$188,711	1%
STEARNS		$900,796	$1,410,953	57%
STEELE		$388,035	$499,393	29%
STEVENS		$59,409	$126,133	112%
SWIFT		$213,100	$273,513	28%
TODD		$171,987	$306,026	78%
TRAVERSE		$77,940	$77,940	0%
WABASHA		$207,910	$212,467	2%
WADENA		$83,470	$85,500	2%
WASECA		$176,476	$223,830	27%
WASHINGTON		$1,312,863	$2,874,143	119%
WILKIN		$139,064	$171,685	23%
WINONA		$323,702	$768,164	137%
WRIGHT		$495,276	$930,168	88%
YELLOW MEDICINE		$145,845	$272,260	87%
TOTAL		$57,705,140	$88,636,675	54%

NOTE: ** This column shows the amount counties budgeted for mental health services in their 1987 CSSA Plans. This figure shows county discretionary funds only, excluding state and federal dedicated funds

* Indicates that the Children's Mental Health Plan has not been approved as of February 6, 1991.

F. Fiscal Incentives and Comparative Costs

Minnesota's complex funding system has raised concerns as to whether the funding system "drives" clients towards inappropriate services. This concern was especially valid five years ago, when there was little dedicated funding for community mental health services. As a result, community support programs were simply non-existent in most counties.

DHS's proposed version of the original Comprehensive Mental Health Act in 1987 included a consolidation of funding from ten different funding sources. Variations of a "Mental Health Fund" passed both the House and Senate, but were ultimately voted down in the legislative conference committee. A key concern on the part of advocates and counties related to the probable loss of the entitlement feature associated with some of the funds to be included. The entire fund would have been allocated to counties on a formula basis, with little ability to vary funding based on changes in total need per county. The option of putting all mental health funding on an entitlement basis was considered, but was determined to be budgetarily and politically impossible.

Although no progress has been made in the area of consolidation of existing funds, significant progress has occurred as far as increased funding for community alternatives. For example, since 1987:

> Rule 14 funding for adult community support services has increased by over $7 million per year, thus enabling services to be provided for consumers in all 87 counties. (Since Rule 14 and RTC funding are both 90% state share, the issue here is not one of fiscal disparity in percentage terms, but more an issue of the total dollars available and the resulting service capacity.)
>
> General Assistance Medical Care coverage has been expanded by over $1 million per year to include outpatient mental health services and day treatment. (Before 1988, GAMC did not include mental health outpatient services, only inpatient.)
>
> Medical Assistance has been expanded to include case management for persons with serious and persistent mental illness. Current expenditures are about $1.5 million per year, with total expenditures eventually expected to rise to $5 million per year (including about $3.8 million for adults and $1.2 million for children).

Table 15 estimates comparative costs per person per day for different settings. However, please refer back to the discussion earlier in this chapter regarding differences among clients in different settings. Although there are overlaps, the most

disabled clients tend to be placed in RTCs, and the least disabled served in non-residential community support programs. Community support programs have demonstrated they can serve very disabled clients; however, available cost data averages in all clients served in each setting.

EST. FY 91 TOTAL COST PER ADULT PER DAY

	Residential Setting			
Service Programs	RTC	Rule 36 IMD	Rule 36 Non-IMD	Supported Housing
RTC	$197.49	$.00	$.00	$.00
Case Management	$3.08	$3.08	$3.08	$3.08
Room and Board	$.00	$25.60	$22.50	$21.00
Rule 36 Program	$.00	$25.18	$52.03	$.00
Day Treatment	$.00	$12.13	$12.13	$20.00
CSP excl. Day Trtmt.	$.00	$5.51	$5.51	$30.00
Outpatient MH	$.00	$2.24	$2.24	$2.24
Pharmacy	$.00	$2.71	$2.71	$2.71
Periodic Hospitalization	$.00	$2.96	$2.96	$2.96
Non-MH Medical Services	$.00	$2.76	$2.76	$2.76
Total	$200.57	$82.17	$105.92	$84.75

EST. FY 91 COUNTY SHARE PER ADULT PER DAY

	Residential Setting			
Service Programs	RTC	Rule 36 IMD	Rule 36 Non-IMD	Supported Housing
RTC	$19.75	$.00	$.00	$.00
Case Management	$1.02	$1.02	$.62	$.62
Room and Board	$.00	$.00	$.00	$.00
Rule 36 Program	$.00	$6.30	$13.01	$.00
Day Treatment	$.00	$4.00	$2.43	$4.00
CSP excl. Day Trtmt.	$.00	$1.82	$1.82	$6.00
Outpatient MH	$.00	$.74	$.45	$.45
Pharmacy	$.00	$.27	$.14	$.14
Periodic Hospitalization	$.00	$.30	$.15	$.15
Non-MH Medical Services	$.00	$.28	$.14	$.14
Total	$20.77	$14.71	$18.74	$11.48

Actual county share varies depending on availability of pilot projects and on individual client needs and eligibility.

G. Fiscal Recommendations Including Maximizing Medical Assistance

The Department's fiscal recommendations are contained in the Governor's budget to be submitted to the Legislature Feb. 20, 1991. Since the budget process is occurring later than other years, it is not possible to include specific fiscal recommendations in time for this report.

The major program outlines of the Department's fiscal recommendations are described in a section describing the Adult Mental Health Housing Initiative, in Chapter II.F.

The following issues and options were considered in developing the Department's fiscal recommendations:

1. Case Management Funding

In 1987, the Legislature authorized Medical Assistance for case management for persons with serious and persistent mental illness. The total annual cost projected for adults was $3.8 million. Current billings are only about $1.5 million per year. It appears that additional legislative authorization is not necessary for adult case management. The Department has several efforts underway to determine why county billing is so much lower than expected:

> Department staff have been meeting with a Case Management Implementation Committee, including county representatives, to examine assumptions upon which Rule 74 reimbursement is based.
>
> As a result of the work of the implementation committee, the Department conducted a survey of all counties to obtain counties' actual costs for providing case management, to review client eligibility data, and to review components of staff time for case management
>
> During February, 1990, the Department will complete its analysis of the comments and data received to determine what kinds of changes need to be made to maximize these funds, and thus to improve the service delivery. At this point, it appears that significant improvement could occur through improved training of counties, and greater county focus on billable services. However, there may also be some need to revise Rule 74.

2. Institutions for Mental Disease (IMD) Downsizing

About 950 adults are now placed in Rule 36 facilities larger than 16 beds per facility. Under federal law, these facilities are

classified as IMDs, making residents age 21-65 ineligible for all Medical Assistance services. This law particularly affects medical services needed by the residents outside the facility. Provision of these services costs the state more than twice as much under General Assistance Medical Care because there is no federal share for GAMC.

About 200 adults with mental illness are placed in non-Rule 36 nursing facilities classified as IMDs (This number is in addition to the group now being relocated under the Nursing Home Alternatives project due to OBRA-87.) The state incurs the same additional GAMC costs for ancillary services for these persons as for the Rule 36 IMD group described above. In addition, the state pays extra state funds under MSA for nursing facility costs which would otherwise be eligible for federal participation under MA, were these residents not living in an IMD.

Appropriate alternatives to IMDs, such as smaller facilities or supported housing arrangements, usually cost more per client. However, because these alternatives are probably more effective in meeting client needs and allow collection of federal financial participation, it is possible the long-term cost of alternatives may be lower. Current fiscal projections indicate that, at least for the coming biennium, the additional federal funds gained by downsizing IMDs will be offset by the additional cost of appropriate alternatives.

The downsizing process will be very difficult, requiring a major commitment of state staff involvement with counties, providers, clients and others. Facilities with about 25 beds or less can feasibly be downsized to 16 bed facilities. Larger facilities will probably need to be totally replaced or converted to other uses. Individual client needs will need to guide the process of relocation and development of alternative services. The inherent difficulties involved will limit the number of facilities that can be downsized each year.

3. Medical Assistance Rehabilitative Services

Minnesota's community support (Rule 14) and residential (Rule 36) programs now use state funds to provide a substantial amount of services which could be eligible for federal reimbursement. The following conditions must be met in order to receive the federal funds: only clients residing in non-IMDs (facilities of less than 16 beds) are eligible, the state must choose this as a statewide MA service, the services must meet the federal criteria for "rehabilitative services", and other general federal MA requirements must be met.

General federal requirements relating to all MA services include an "entitlement" aspect. Once a state chooses to provide a

service, it must make the service available to all eligible residents who need the service.

The Department considered a number of options to insure that an expansion of MA rehabilitative services would not contribute to the state's budget deficit. For Rule 36 programs, it appears feasible to use current state Rule 12 funds as the match for federal MA funds; since the number of programs is stable and is limited by licensure and the Rule 12 grant approval process, it is possible to guarantee that the non-federal share will never exceed the currently available Rule 12 funds. Therefore, the state could gain at least $1 million per year in new federal funds with no risk of additional state financial liability.

The picture is not as clear for Rule 14 programs. Many Rule 14 programs already receive MA rehabilitative service funds through their day treatment components. It is unclear how many other CSP components would meet federal requirements without substantial change. It is possible that some of the changes needed might require CSPs to lose some of the positive aspects of their non-medical approach. Since Rule 14 programs are growing, not licensed and more subject to change than Rule 12/36 programs, it may not be possible to make the same guarantee that expansion of MA rehabilitative services for CSPs would not add to the budget deficit.

4. Housing Subsidies

Chapter II.F. of this report describes cooperative efforts undertaken with the Minnesota Housing Finance Agency and the federal Housing and Urban Development agency to increase funds available for housing for adults with serious and persistent mental illness. It appears there is a clear need for a state housing subsidy program to help people who are on waiting lists for federal subsidies, or who do not qualify for other programs.

About 800 adults with mental illness are homeless or living in shelters. As indicated earlier in this report, about 300 adults with mental illness are in the Regional Treatment Centers and ready for discharge, but are unable to obtain appropriate community housing and services. About 1,000 to 2,000 adults with mental illness are placed in non-Rule 36 negotiated rate facilities (non-certified boarding care and board and lodging) paid by GA/MSA. Many of these people are in these facilities because GA/MSA pays more for negotiated rates than for independent living, and use of negotiated rate facilities is their only alternative for affordable housing.

A state housing subsidy program could provide more appropriate alternatives to many of these people. In cases where people move

from other state-subsidized settings, e.g. RTCs or board and lodging facilities, savings in other state programs may be possible. A state housing subsidy program would also maximize federal funds by ensuring that adults with serious and persistent mental illness were on the appropriate waiting lists for federally funded housing. In addition, a low-income person in supported housing can qualify for federal food stamps, while these are not available for those in institutions.

H. State Administrative Costs

The most recent national data available (1987) indicates that Minnesota's per capita spending for state mental health agency administrative costs was the lowest for all 50 states. (The national data regarding administrative costs is not separated by adult v. children's mental health.) Even after adding in increases approved by the Legislature since 1987, Minnesota's current state administrative costs still rank among the lowest ten states nationally (in comparison to other states' 1987 data.)

V. IMPLEMENTATION OF THE COMPREHENSIVE CHILDREN'S MENTAL HEALTH ACT

This chapter has been prepared to comply with Minnesota Statutes, section 245.487.

The Minnesota Comprehensive Children's Mental Health Act, passed in 1989, requires the development and implementation of an array of appropriate, accessible mental health services to meet the needs of children with emotional disturbance and their families by 1992.
The legislation calls for accomplishment of three primary goals:

- the creation of a comprehensive array of mental health services throughout the State so that children and families receive services appropriate to their individual need;

- the establishment of mechanisms at the state, local and individual levels for coordination among agencies serving children with mental health needs and their families; and

- the establishment of advisory and coordinating councils at the state and local levels to assure input from parents, providers, and advocates in the development of comprehensive mental health services.

Services are to be available in each county by the dates listed:

- 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 support of foster care 1/1/92

Although services were to be phased in, the Act directed counties 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.

The Comprehensive Children's Mental Health Act established three child target populations eligible to receive mental health services:

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

2. Children with emotional disturbance, as defined in statute (for Outpatient Services, Acute Care Hospital Services, and Residential Treatment Services).

3. Children with severe emotional disturbance (for Screening, Professional Home-Based Family Treatment, Case Management Services, Family Community Support Services, Day Treatment, and Therapeutic Support of Foster Care).

In order to be eligible for the services listed in 3., the child must meet the definition of emotional disturbance and one of the following:

1. Recent admission or risk of admission to an inpatient or residential treatment program due to an emotional disturbance; or

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

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

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

4. Significantly impaired home, school or community functioning as a result of emotional disturbance that has lasted at least one year or which has a substantial risk of lasting one year.

Issues of state-level coordination are addressed by the state interagency coordinating committee, as required by Minnesota Statutes 245.4873. The annual report of that committee is included in Chapter VII of this report.

By January 1, 1990, counties were required to have established local coordinating councils, comprised of representatives from the local systems serving children with emotional disturbance. These councils are to meet at least quarterly to develop recommendations addressing coordination of services and funding

issues. The councils are required to report annually to the Commissioner regarding unmet service needs, service priorities, and strategies to further the development of coordinated local systems of services. According to biennial children's mental health plans, local coordinating councils have been established as required. However, lack of state staff to provide consultation to these groups has left counties concerned that their functioning is less than optimal.

The Department has approved children's mental health plans in all but four counties and continues to work with these remaining counties to develop plans which comply with the Comprehensive Children's Mental Health Act. Funding issues remain the major stumbling block to approval of these plans. The Department is currently working with counties to draft legislation which revises the planning process to meet legislative mandates in a more concise and effective manner. (See Chapter IX for a fuller discussion of the plan simplification process.)

Although the 1989 Legislature passed the Comprehensive Children's Mental Health Act, it appropriated only $2.2 million in new funding for three of the twelve mandated services. (The 1990 Legislature subsequently cut this amount to $1.3 million.) The Legislature also funded only two staff positions for children's mental health within the Department, including replacement of an existing position temporarily funded through federal grant funds. A lack of staff, combined with the lengthy review process for county children's mental health plans, has severely limited the efforts to develop service guidelines and to provide the necessary technical assistance to counties in implementing the Act. Without service funding, standard setting and technical assistance, counties cannot be expected to have implemented all services by the required dates. Therefore, the Department will propose extension of the implementation time-lines during the 1991 legislative session.

The Department anticipates that approximately $11 million would be needed during the next biennium to meet the demands of children with emotional disturbance and their families based on a phased-in plan which projects full service use by 1995. Funding for these services (including a sufficient complement of staff at the state level) remains a top priority for the Mental Health Division, State Mental Health Advisory Council, and Children's Subcommittee. (See Chapter VI for a complete discussion of children's funding issues.)

A. Early Identification and Intervention Efforts

Minnesota Statutes, section 245.487, subdivision 4, requires collaborative interdepartmental efforts to ensure early identification and intervention (EI/I) for children with, or at risk of developing, an emotional disturbance.

As a preliminary step in the development of an EI/I system, the Mental Health Division, in cooperation with the Minnesota Department of Education, sponsored a multi-agency planning effort to design a system of EI/I services. The goal of such a system would be identifying children needing or at risk of needing, mental health services, and offering prevention and treatment to each child identified as needing mental health services.

Recommendations of the advisory group, established to assist in planning for EI/I services, as reported last year and progress to date include:

1. The need to identify currently existing resources for early identification and intervention within the State and nationally.

   During the past year, the group has identified current resources to enhance service access and utilization of existing services within the mental health, health, education, and corrections systems.

2. The need to build mental health capacity within and across systems, through access to child mental health professionals.

   The group has continued working on methods for building capacity into existing service systems through identification of key points of entry to which mental health education and training efforts can be targeted. In collaboration with the Minnesota Department of Health, the Department will conduct a series of regional child mental health awareness training for professionals from a variety of systems serving children and families in the spring of 1991. The goal of these sessions will be heightened awareness of the mental health issues faced by children, resulting in more effective identification and earlier intervention for children in need of services.

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

   Having drafted a mission statement for EI/I which addresses the need for a shared commitment by multiple systems to early identification and intervention for all children, the group recommended pursuit of state-level collaborative strategies, policies, and funding to develop these services.

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

Additional statutory language is being proposed to highlight the need for Local Coordinating Councils to address early identification/intervention efforts.

B. Family Community Support Services

During the past year, the Department has worked in collaboration with counties, service providers, families, and advocates to design and implement family community support services. This array of services is designed to help each child with severe emotional disturbance to remain with the child's family in the community by improving the child's functioning within home and school settings and improving the child's ability to handle basic activities and to participate in leisure and recreational activities.

Family community support services include:

- client outreach;
- medication monitoring;
- assistance in developing independent living skills and parenting skills necessary to address the needs of the child with severe emotional disturbance;
- assistance with leisure and recreation;
- crisis assistance, including crisis placement and respite care;
- professional home-based family treatment;
- foster care with therapeutic supports;
- day treatment; and
- assistance in obtaining respite care, special needs day care, and financial resources.

The Department has solicited proposals from counties to develop family community support services. Counties must demonstrate their capabilities to plan, develop and implement a comprehensive service delivery system which is based on interagency collaboration and coordination among service systems. Proposals must reflect the extent to which counties have maximized funding resources by leveraging other dollars and in-kind contributions to be used in the development of the services. A portion of the funding made available may be used to provide "wrap-around services", those services needed by a particular child which are not otherwise provided by any agency.

Grants will be awarded in February, 1991, for the fifteen-month period from April 1, 1991 to June 30, 1992, contingent upon legislative appropriation for the period July 1, 1991 through June 30, 1992. Funding is expected to be awarded based on the greater of $10,000 per county or $1.00 per child per year, depending on the number of counties applying for the grants.

C. Case Management

Case management services are activities that are coordinated with family community support services and designed to help the child with severe emotional disturbance and the child's family obtain needed mental health, social, educational, health, vocational, recreational, and related services.

The Department has worked this past year with families, advocates, service providers, and counties to begin planning case management services for children with severe emotional disturbance. Currently, service models and funding strategies are being developed. Three case management models stressing interagency coordination and collaboration and focusing on the individual needs of the child and family are being examined:

1. A model in which a single case manager accepts the responsibility for bringing together all providers of service to the child and family, and assesses the child's and family strengths and needs in the development of an individualized family community support plan.

2. An individualized case management team model in which a multi-agency team, including the child and family, assumes case management responsibilities. A lead case manager is assigned, and the team decides which members assume various responsibilities on behalf of the child and family.

3. A flexible system based upon the individual needs of the child and family. The local agency chooses the single case manager model or the case management team model, based upon relevant factors including individual service needs, number of persons and agencies involved with the child and family, and intensity of needed services.

Due to limited state staff available to work on the development of case management services and the fact that existing national service models are not readily adaptable to Minnesota's service structure and mandate, the Department will propose a delay in implementation of these services from July 1991 to July 1992.

D. Rule 5 Residential Treatment Services

Rule 5 is the licensing rule governing residential facilities providing services to more than 10 children and adolescents with "emotional handicaps". The mandate for counties to make such services available is found in MS 245.4882, subd. 1. Definition of these services is found in MS.245.4871, subd. 32. The rule

itself was promulgated in 1971 and is recognized as needing revision. Division staff have recently begun the revision process, which is anticipated to take approximately two years.

The forty-one facilities currently licensed under Rule 5 admitted approximately 1,684 children with mental illness, emotional disturbance, or "unknown" diagnoses in FY 1989, according to data reported to the Department. Of these admissions, 759 were court-ordered. No data is currently available on the number of children placed in Rule 5 facilities who could have been appropriately served by community-based mental health services, had such services been available in their home communities. (A discussion of screening issues for residential placement of children can be found in Chapter VIII.)

Three of the 41 facilities are crisis shelters (one did not report admissions) and two are units at Regional Treatment Centers (Willmar and Brainerd.)

Counties estimated having spent $20,213,933 on Rule 5 services for 1,416 children in Calendar Year 1988, and project those expenditures will rise to $22,223,495 for 1,577 in 1990 and to $22,257,824 for 1,589 children in 1991. Of the Calendar Year 1988 estimated expenditures, $2,934,352 was reimbursed by federal Title IV-E funds. The remainder of the expenditures is believed to have come from county funds, which include funding through CSSA.

The Department is evaluating statutory changes which would permit Medical Assistance reimbursement for services provided in Rule 5 facilities which meet federal guidelines, along with methods to assure that reimbursement mechanisms are fiscally neutral with respect to incentives for out-of-home placement. A discussion of Rule 5 funding issues can be found in Chapter VI.

E. Children's Demonstration Projects

During the past year, the Division has continued to work closely with the eight Children's Mental Health Demonstration Projects which serve children with severe emotional disturbance. (Funding for these projects comes from the federal Alcohol, Drug, and Mental Health Block Grant.) These projects continue to collaborate in the development of services and to address many of the system and funding barriers which, in the past, have prohibited development and implementation of coordinated mental health services.

Most of the eight projects have progressed to the point of collaborative service development and delivery. The following is an example of how collaboration is effectively occurring.

The Joining Forces Project of Itasca County is a school/ community human services/corrections partnership serving children experiencing emotional disturbance and their families. Northland Mental Health Center, Itasca County Social Services, and the Northeast Educational District have collaboratively developed an intervention program based in the schools. Three staff provide prevention, early identification, and linkages for mental health and chemical dependency services. A therapeutic day treatment program serves 9 - 11 year olds. Service decisions are based upon an intensive needs assessment involving multi-disciplinary staff. Three full-time mental health coordinators and a part-time project coordinator are housed in the schools and district office.

The general experience of the demonstration projects supports the need for collaboration with the schools as vital to the successful implementation of the Comprehensive Children's Mental Health Act. Four of the eight projects have developed day treatment programs that are jointly funded, staffed and operated. Collaborative ventures assist teachers and administrators in obtaining needed mental health expertise, while also assisting mental health and social service departments in providing mental health services as an integral part of the regular school day.

Federal funding will continue to be available for these projects only until February of 1992. It is hoped that alternative sources of funding will be available to support the continued work of these counties as leaders in the implementation of the Comprehensive Children's Mental Health Act.

F . Child and Adolescent Service System Grant (CASSP)

During 1990, the Department was successful in obtaining a $101,000 grant from the National Institute of Mental Health for federal fiscal year 1991.

This grant will enable the Department to hire an unclassified mental health consultant to develop curriculum and to conduct training at state and local levels which address strategies for multiple system collaboration and service coordination. These training activities will enhance the ability of the local systems of care to design and fund services which are comprehensive and coordinated across all systems serving children with emotional disturbance and their families.

Receipt of this grant also enables Minnesota to participate in the CASSP network of states which provides access to information regarding service development, policies, and funding strategies for children with severe emotional disturbance and their families across the nation.

VI. FUNDING AND STATISTICAL REVIEW OF CHILDREN'S MENTAL HEALTH SERVICES

This chapter has been prepared to comply with Minnesota Statutes, section 245.463.

A. Prevalence Estimates for Children with Emotional Disturbance

The National Institute of Mental Health (NIMH) is currently conducting an epidemiological study of households to estimate the prevalence of emotional disturbance among children. The NIMH conducted a similar survey for adults in the early 1980s which is summarized in the adult section of this report. However, a number of studies already completed allow estimates of the prevalence rate. Gould et al in 1981 reviewed the studies and provided the estimates below in Table 16. These are the estimates currently used by NIMH.

TABLE 16

EMOTIONAL DISTURBANCE PREVALENCE AMONG CHILDREN

TYPE OF EMOTIONAL DISORDER	PERCENT	NUMBER OF CHILDREN
SEVERE EMOTIONAL DISTURBANCE	5.0%	57,017
EMOTIONAL PROBLEM THAT LIMITS CAPACITY TO FUNCTION	11.8%	134,560
HIGH RISK GROUP FOR EMOTIONAL DISTURBANCE	15-20%	171,050-228,067

As summarized in the Division's document, **Children and Youth at Risk of Emotional Disturbance**, the Wilder Foundation's 1987 Ramsey county survey found that 32% of low income parents and 19% of middle or high income parents felt their children needed help with mental health problems during the previous year. Eighteen percent of low income parents and 10% of middle or high income parents sought professional help for their children.

The Minnesota Department of Education's survey of 90,000 children in grades 6,9, and 12 during the 1988-89 school year found that one in nine (11%) students reported a suicide attempt. Fourteen percent indicated that they had sometime sought treatment for personal, emotional or behavioral problems. Of those who had made a suicide attempt, only 43% had received professional treatment.

The Department of Health reports that in 1987 suicide was the second leading cause of death among children/adolescents 10-19 years of age. Sixty-five Minnesota children ages 10-19 committed suicide during 1987. The Minnesota Center for Health Statistics report that the vast majority (82%) of suicides during the period of 1980-1986 among 15-19 year olds were males. However the rate for females increased during that period.

B. Numbers of Children Served

Given the recent passage of the Comprehensive Children's Mental Health Act, reporting on the use of new children's services is just being implemented in the Community Mental Health Reporting System. However, the number of children planned to be served in 1990 and 1991 was provided in county mental health plans. Because these are new types of service and this was the first children's mental health plan, the projected numbers in Table 17 should be used with caution.

TABLE 17

CHILDREN'S DATA FROM COUNTY MH PLANS
CLIENT NUMBERS

SERVICE	PROJECTED 1990	PROJECTED 1991
EARLY ID & INTERVENTION	5,301	6,273
EMERGENCY SERVICES	14,772	15,423
SCREENING	2,052	2,242
PRE-PETITION SCREENING	185	213
OUTPATIENT EXCLUDING MA	15,075	15,794
CASE MANAGEMENT	2,524	3,372
DAY TREATMENT	1,358	1,714
HOME-BASED TX	1,933	2,478
THER. SUPP. FOSTER CARE	594	729
FAMILY COMMUNITY SUPPORT SERVICES	2,852	3,768
RULE 5- RESIDENTIAL (INCL. SHELTER)	1,577	1,589
RTC	198	199
ACUTE HOSPITAL (EXCLUDING MA)	290	322

Table 17, above, indicates the number of children planned to be served during 1990 and 1991 by county agencies. However, Table 18 provides the number of children reported to be served during FY 1990 through the Community Mental Health Reporting System (CMHRS), the Reimbursement Division for Regional Treatment

Centers, and the Reports and Statistics Division for Medical Assistance reimbursed acute care inpatient treatment and all mental health services (for FY 1989). There appears to be a difference in the number actually served and those planned to be served. Part of this difference may be due to the new additional children's services which have not been reported in the past in the CMHRS and Medical Assistance systems.

TABLE 18
CHILDREN WITH AN EMOTIONAL DISTURBANCE
SERVED BY PUBLIC FUNDING DURING FY 1990

TYPE OF SERVICE	ANY EMOTIONAL DISTURBANCE
OUTPATIENT	18,000
RULE 5 (EXCLUDING SHELTER PLACEMENTS)	1,500
ACUTE HOSPITAL**	800
CASE MANAGEMENT	950
DAY TREATMENT	1,000
RTC *	134
ANY MH SERVICE (UNDUPLICATED)* **	**19,000**

NOTE: The figures from this table are based primarily on data from the Community Mental Health Reporting System (CMHRS) for the FY 1990 period. For the services of Case Management, Outpatient and Day Treatment the CMHRS data was supplemented by data for clients who received Medical Assistance reimbursed treatment but were not included in CMHRS. In CMHRS there is not an unique statewide client ID number. Therefore, some minor duplication in the estimates may exist.

* Numbers for RTCs covered calendar year 1989 were reported by the Reimbursements Division which does RTC billings.

** The acute hospital totals are based on FY 1989 GAMC and Medicaid services provided for a primary diagnosis of mental illness.

*** The RTC and Acute Hospital figures were not used in calculating the unduplicated total. It is assumed these clients would receive some additional services and, therefore, would not change the unduplicated total.

C. Description of Funding Sources

Table 19 provides a funding flow chart for children's mental health service funding administered or supervised by DHS. Because the county is the local mental health authority responsible for provision of a comprehensive array of mental health services, most funds flow through the counties. The major

exceptions are Medical Assistance, which is paid directly to providers due to federal requirements and RTC funding.

The following is a brief description of the major DHS funding sources for children's mental health services:

Federal Mental Health Block Grant funds (about $674,000 for children's mental health for FY 91) are targeted to underserved populations, including eight demonstration projects for children's mental health and ten projects serving American Indians. (See Chapter VI for more information about the children's demonstration projects and Chapter XI regarding the Indian programs.) No local match is required for the American Indian projects. The demonstration projects are funded on a three-year basis with an expectation that local or other funding must be arranged to pay for an increasing share of the project each year.

Community Social Services Act (CSSA) funds include, for FY 91, approximately $45 million from the Federal Social Services Block Grant (formerly Title XX), approximately $51 million from state CSSA funds and about $270 million in county tax funds. For 1990, counties planned to spend about 10%, or $37 million, of these "generic" funds for children's mental health services. These, the most flexible funds available to counties, are used whenever other funds are inadequate to meet client needs.

Since children's costs in RTCs are almost completely reimbursed from Medical Assistance, insurance, and other funds, the RTC state appropriation is used for operating capital until the other funds are collected. In FY 90, Medical Assistance paid about $4 million for children's services in RTCs. The state share (42%) for these Medical Assistance payments was about $1.7 million.

Medical Assistance (MA) covers inpatient services, outpatient services, day treatment and case management within very specific limits for eligible children. MA includes 53% federal funding and is subject to federal requirements. State law previously required counties to pay 10% of the non-federal share of MA; however, the county share is scheduled to be eliminated after January 1991. In FY 89, MA paid about $14 million for children's mental health services (other than RTCs).

The Children's Health Plan (CHP) is a new program which began covering outpatient mental health services on July 1, 1990. CHP is a totally state-funded program for low-income children who do not qualify for MA. Until January 1991, CHP included only children under 9 years of age. Ages 9-17 were added January 1, 1991. Although CHP is not subject to the

same federal rules as MA, CHP coverage for outpatient mental health services is similar to MA (with the exception of an annual cap of $1,000 per child for mental health services and limits on the types of services covered.)

State grants to counties for family community support services are scheduled to begin April 1991 at an annual level of $1.2 million. These grants will fund county costs for new family community support services required by the Comprehensive Children's Mental Health Act. No local match is required, but counties must maintain their previous spending for mental health services.

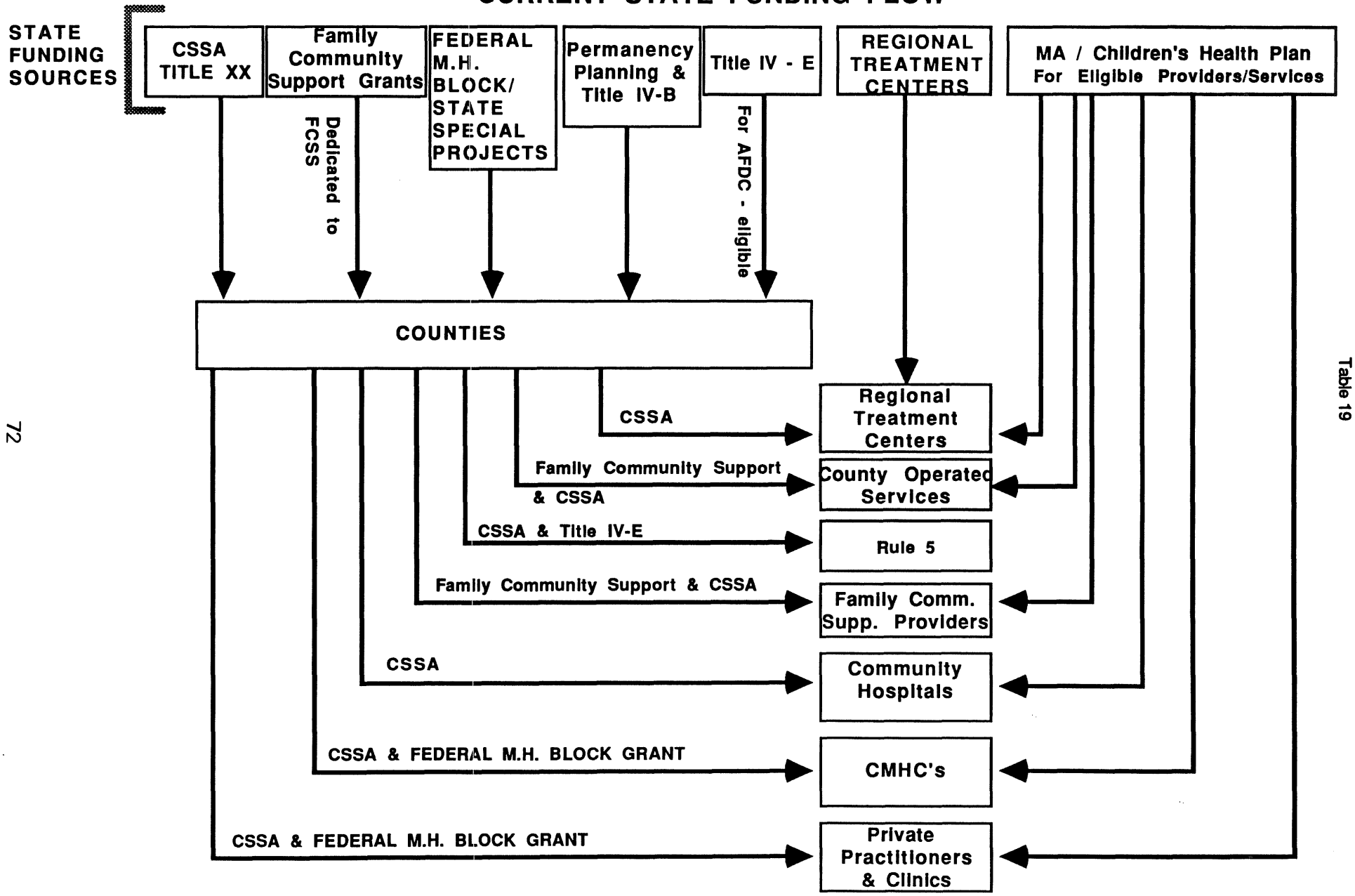
Table 20 illustrates total estimated FY 91 DHS expenditures for children's mental health services, by service category, including county matching funds for state grants. The largest expenditure is in the residential category. **Total expenditures include 23.8% inpatient, 37.3% community residential (including therapeutic support of foster care), 38.7% community non-residential (outpatient) and .2% for state administration.**

Table 21 indicates funding source by level of government, while Table 22 shows the same funds by program. **The single largest funding source for children's mental health services is county funds.**

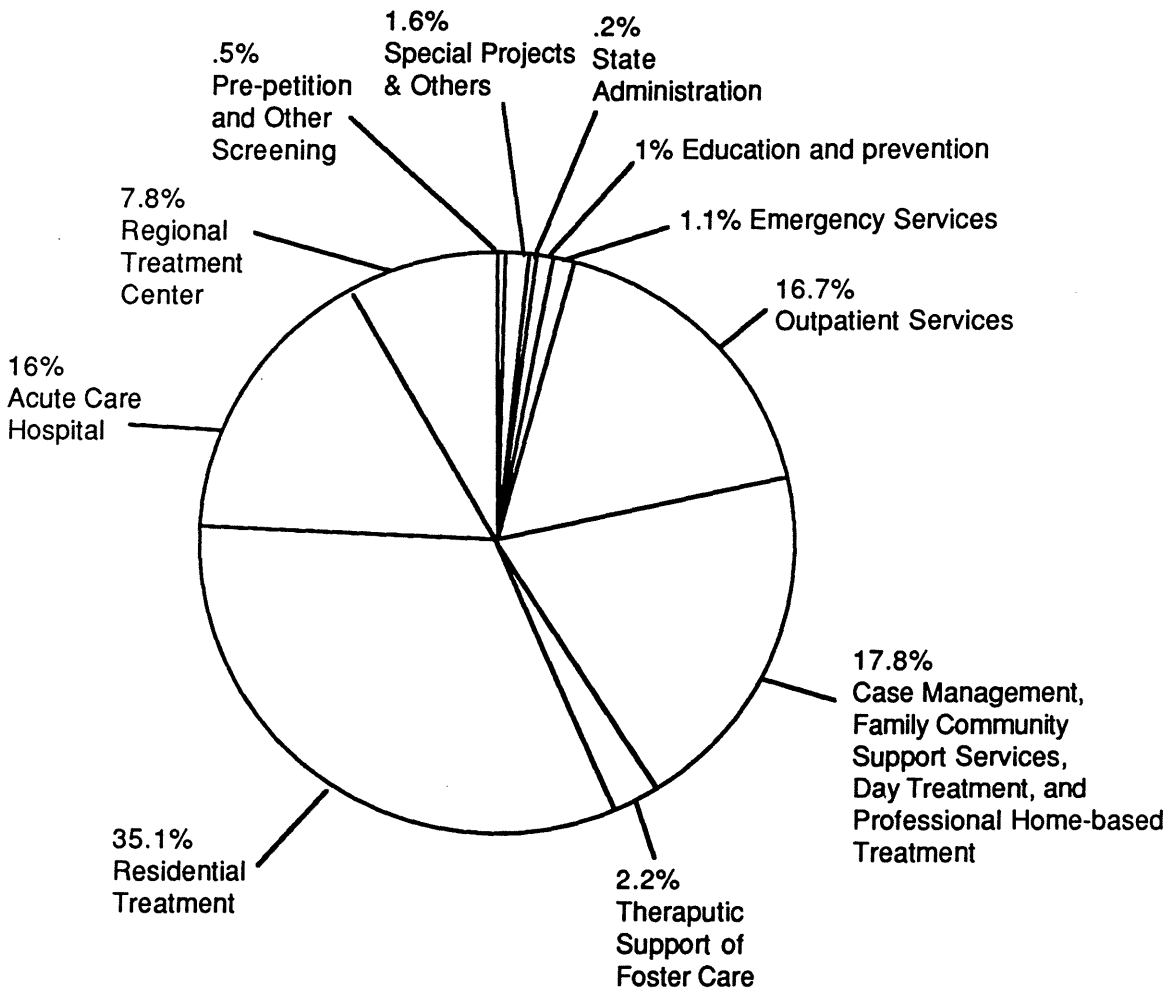
Table 23 compares adult and children's state, county and federal shares. **Note that the state share for adult mental health services averages 57%, but the state share for children's mental health services is only 23%.**

CHILDREN'S MENTAL HEALTH SERVICES

CURRENT STATE FUNDING FLOW



FISCAL 1991
Estimated DHS Expenditures
Children's Mental Health Services



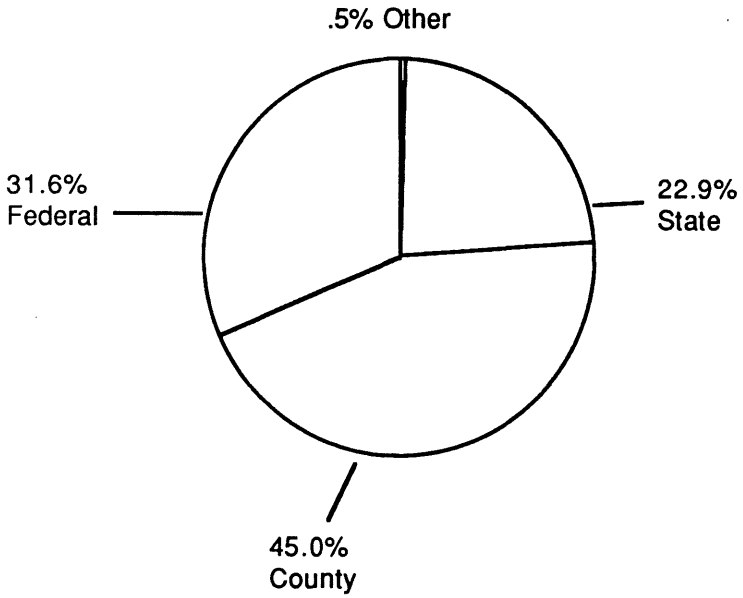
TOTAL: $63,100,000

In addition to the above, MH services are also funded by the Departments of Education, Corrections, Jobs and Training, plus private insurance and private pay.

This table does not include Income Maintenance payments for living expenses.

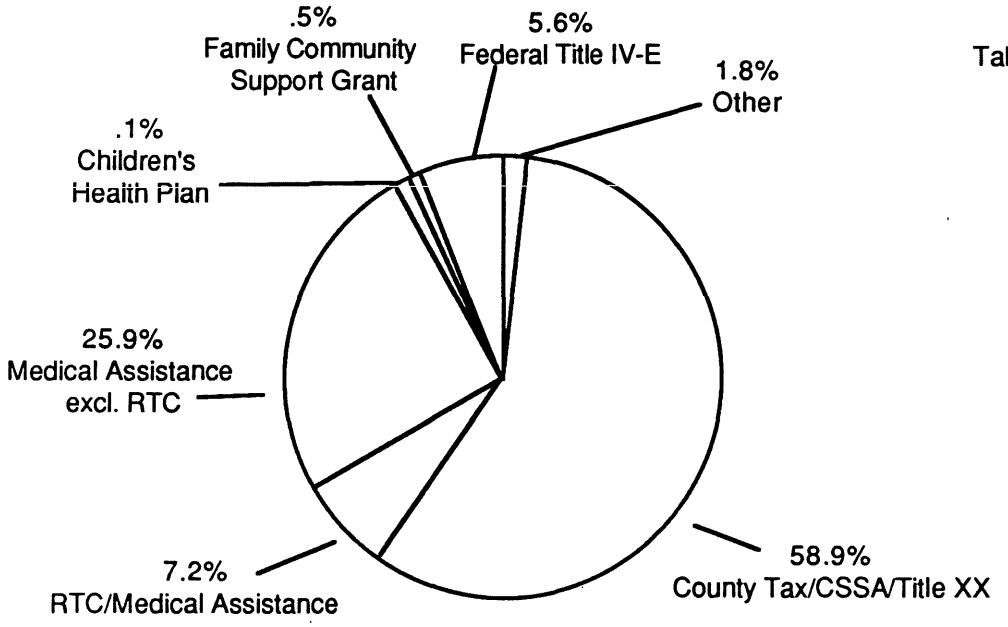
Table 21

FISCAL 1991
DHS Funding Sources
Children's Mental Health Services



Federal, State and County Funding

Table 22

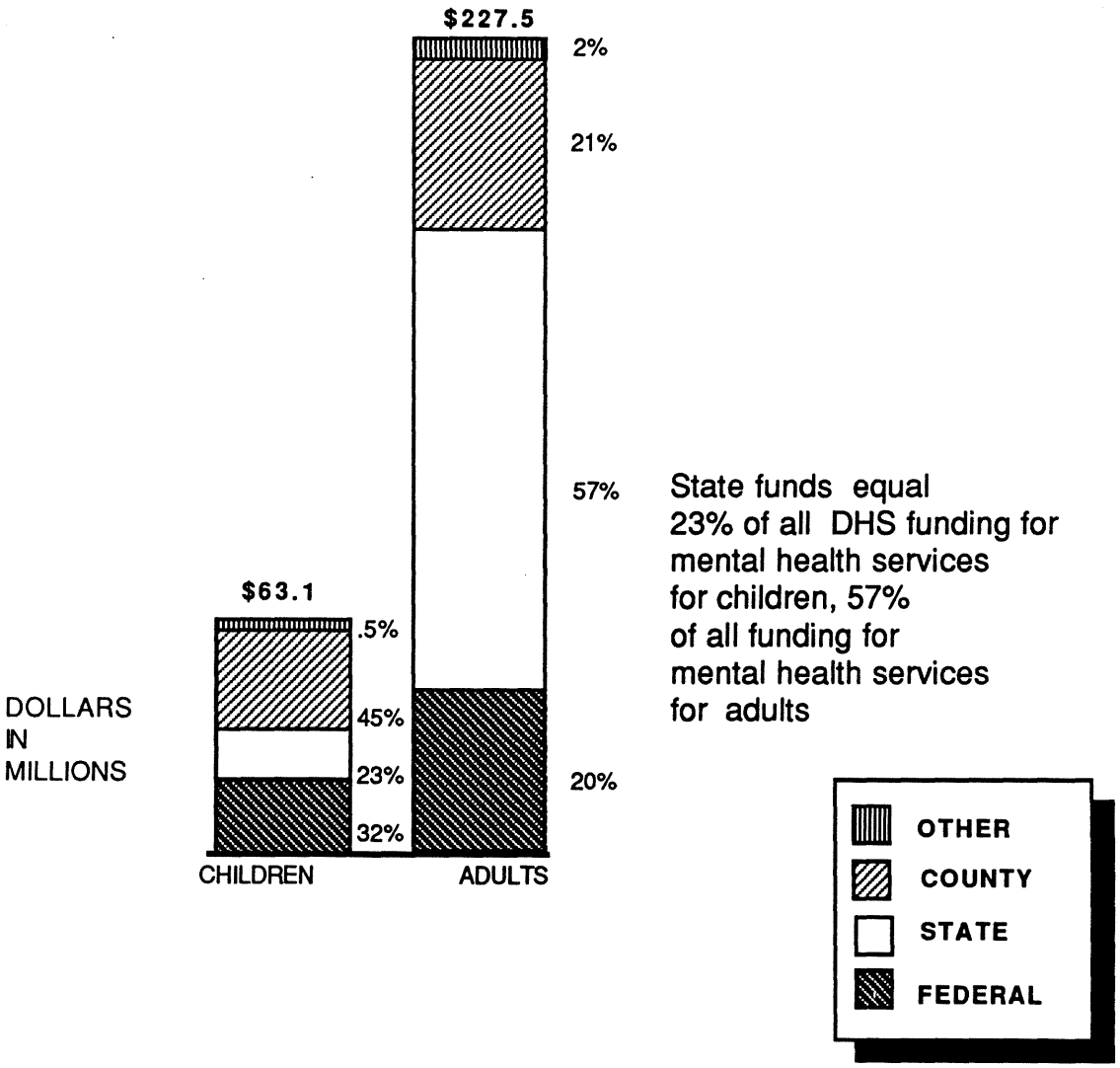


Funding by Program Category

Feb 1991

FEDERAL, STATE AND COUNTY FUNDING SOURCES: MENTAL HEALTH SERVICES FOR CHILDREN AND ADULTS

(ESTIMATED; FISCAL 1991)



Feb 1991

D. Financial and Statistical Trends

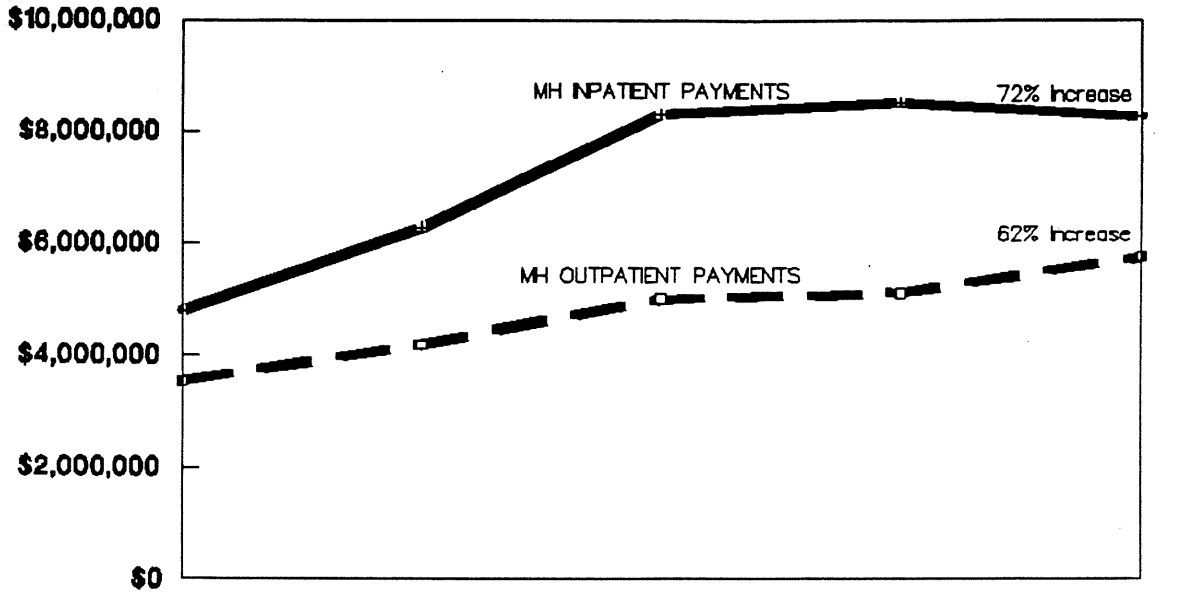
1. Trends in Medical Assistance Clients and Expenditures

Medical Assistance is the only major funding source for children's mental health services which can provide reliable multi-year data regarding clients and expenditures. Tables 24 and 25 show client and expenditure trends for this funding source for the last five years.

MA inpatient expenditures for children's mental health increased significantly between FY 85 and FY 87, but now appear to have leveled off. MA outpatient expenditures for children's mental health have increased steadily and are now increasing faster than inpatient expenditures.

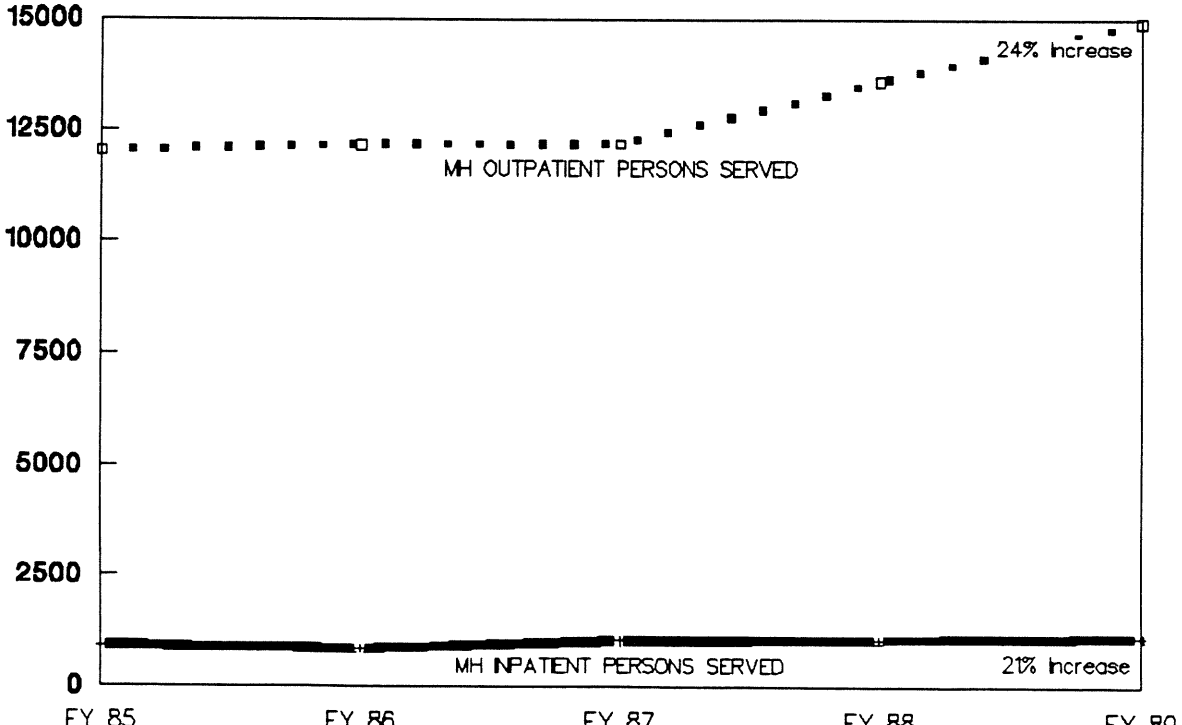
MEDICAL ASSISTANCE FOR CHILDREN'S MH SERVICE INPATIENT VS OUTPATIENT

TABLE 24



NET PAYMENTS INCL. FED., STATE AND LOCAL SHARES

TABLE 25



CHILDREN (0–18) SERVED DURING THE FISCAL YEAR

Adjusts for HMO data based on client eligibility.
RTC use was not included in analyses.

2. Trends in County Funding

As indicated in the chapter on adult funding, available data indicates that counties have increased their funding for adult and children's mental health services (combined) by 74% over the past six years. Unfortunately, reliable reporting systems have not been in place to track these expenditures in a consistent manner. It is not clear how much of this increase is due to changes in reporting methods, e.g., counting children's mental health under the mental health category instead of under the children's category.

On the whole, it appears that most counties have been very supportive of providing mental health services, especially children's mental health. The chapter on adult funding which includes maintenance of effort figures by county indicates that most counties are reporting much higher commitment of county funds for mental health services than the minimum required by law.

E. Fiscal Incentives and Comparative Costs

Minnesota's complex funding system has raised concerns as to whether the funding system "drives" clients towards inappropriate services. This concern seems especially valid for children's mental health services. Funding disparities for different services seem to be greater for children's mental health than for adult mental health. Table 26 shows average state, county and federal shares for key children's mental health services. **Note particularly the large disparity between county share for RTC services (6%), compared to county share for case management and community support services (68%), or county share for community residential treatment (62%).** As a result, family community support services are currently non-existent in many counties.

Some progress has occurred as far as increased funding for community alternatives. For example, since 1987:

* Medical Assistance has been expanded to include case management for persons with serious and persistent mental illness. Current expenditures for children are only about $60,000 per year, but total expenditures are eventually expected to rise to $1.2 million per year.

* New funding for family community support services for children with severe emotional disturbance is expected to begin April 1991 at a rate of $1.2 million per year.

* The 1989 Legislature approved expansion of Medical Assistance for professional home-based treatment for children with severe emotional disturbance. This service is

now expected to begin in 1992, with total expenditures eventually expected to rise to $7 million per year.

Very little reliable information is available regarding the comparative cost per child in different settings. The following is a summary:

* A 1990 study conducted by a work group of executive and legislative staff found an average per diem of $109 for Rule 5 community residential treatment.

* The "official" FY 91 per day rates for RTC adolescent mental health programs are $218.40 for Brainerd and $190.60 for Willmar. However, these rates are based on average calculations for the entire mental health program at each facility. Since the children's programs are a relatively small part of each facility, the rates primarily reflect the cost of the adult programs. Actual per day costs for the children's units are probably higher.

* The average Medical Assistance payment for children's psychiatric hospitalization in calendar year 1989 was $337 per day.

* In 1988, DHS surveyed the few programs providing the new services required by the Comprehensive Children's Mental Health Act. The fiscal note indicated the following estimated per day per child costs for the Act:

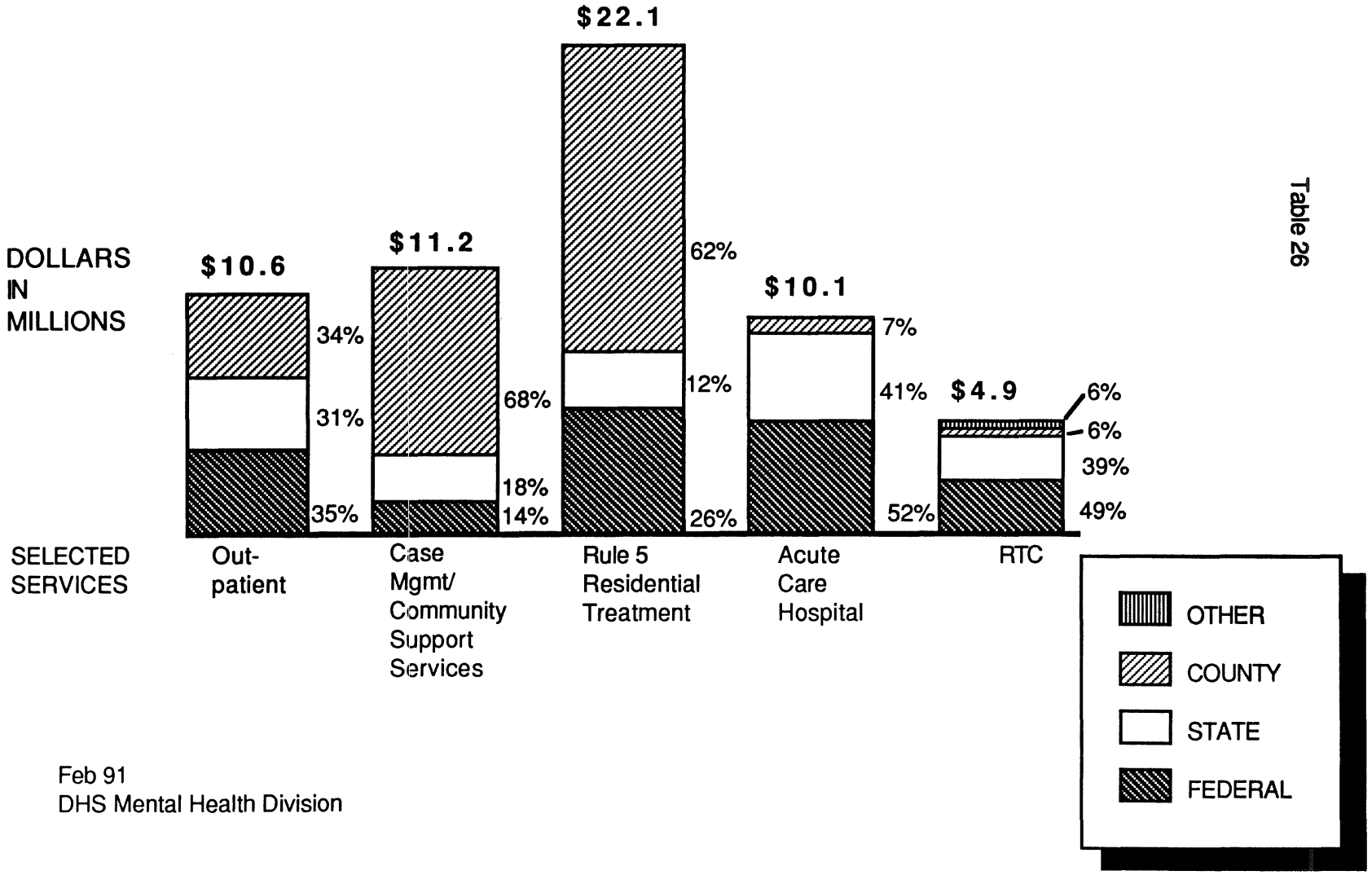
    * $6 for family community support services
    * $3 for case management
    * $14 for professional home-based family treatment
    * $14 for therapeutic support of foster care

The major missing piece is an estimate of the total package of services which a child might need in the community as an alternative to institutionalization. It is assumed that most children with severe emotional disturbance would receive at least 2 or 3 of the community services listed above, plus a number of outpatient "ancillary" services (physician, psychologist, etc.)

For adults with serious and persistent mental illness, special analyses have been done to identify the true costs of serving an adult with serious and persistent mental illness in a community program. (The data is shown in Table 15 of this report.) No comparable analyses have been done for children, partly because a similar group (e.g., children in IMDs) has not been identified in MA records, and partly because of insufficient staff time for children's mental health analyses.

FEDERAL, STATE AND COUNTY SHARES OF FUNDING FOR SELECTED CHILDREN'S MENTAL HEALTH SERVICES

(ESTIMATED; FISCAL 1991)



Feb 91
DHS Mental Health Division

Table 26

F. Fiscal Recommendations Including Maximizing Medical Assistance

When the Comprehensive Children's Mental Health Act was proposed to the 1989 Legislature, DHS prepared a fiscal note estimating the cost of full implementation for all services required in the Act. Each new service was scheduled to be phased in over a period averaging about four years. Since that time, some delays have occurred, some funds appropriated in 1989 have been rescinded and assumptions regarding MA eligibility have changed. Table 29 shows an updated estimate of the total cost of full implementation. Table 28 shows funding which has already been approved and is now part of the state's budget base. Table 27 shows the additional new funding needed.

Tables 27-29 are marked "DHS version" to differentiate them from similar tables in the legislative report of the State Advisory Council on Mental Health. The Advisory Council projects a need for more money in F.Y. 92-93, assuming that services can be developed faster than projected by DHS. For F.Y. 94-95, the Advisory Council projects a need for less new state funding than projected by DHS, on the assumptions that the development of community alternatives will reduce residential treatment costs and that new federal funds will be obtained for the remaining residential treatment costs.

The Department's specific fiscal recommendations are contained in the Governor's budget to be submitted to the Legislature February 20, 1991. Since the budget process is occurring later than other years, it is not possible to include specific fiscal recommendations in time for this report.

UPDATED FISCAL NOTE

Table 27

1989 CHILDREN'S COMPREHENSIVE MENTAL HEALTH ACT, INCL. 1990 AMENDMENTS

DHS VERSION

	A. TOTAL NEW COST EXCLUDING BASE INCLUDES STATE AND COUNTY SHARE				
	FY91	FY92	FY93	FY94	FY95
EARLY IDENTIFICATION					
AND INTERVENTION (EPSDT)	0	0	15,000	0	15,000
OUTPATIENT					
OUTPATIENT-CHILD'S HEALTH PLAN	0	368,556	833,267	999,920	1,183,239
CASE MANAGEMENT-(MA/SPMI)	0	0	0	0	0
CASE MANAGEMENT-(MA/SED)	0	0	0	0	0
CASE MANAGEMENT-(NON-MA)	0	0	2,297,816	3,353,387	3,521,057
CASE MANAGEMENT SUB-TOTAL	0	0	2,297,816	3,353,387	3,521,057
PROFESSIONAL HOME-BASED(MA)	0	0	0	0	0
PROFESSIONAL HOME-BASED(NON-MA)	0	0	4,000,000	5,500,000	7,000,000
PROFESSIONAL HOME-BASED SUB-TOTAL	0	0	4,000,000	5,500,000	7,000,000
THER. SUPPORT FOR FOSTER CARE:					
REGULAR MA	0	0	0	0	0
NON-MA	0	0	576,700	1,835,000	1,926,750
THER. SUPPORT / FOSTER CARE SUB-TOTAL	0	0	576,700	1,835,000	1,926,750
DAY TREATMENT-(MA)	0	0	0	0	0
DAY TREATMENT-(NON-MA)	0	0	257,148	584,159	625,367
DAY TREATMENT SUB-TOTAL	0	0	257,148	584,159	625,367
OTHER FAMILY COMMUNITY					
SUPPORT SERVICES-(MA-REHAB)	0	0	0	0	0
OTHER FAMILY COMMUNITY					0
SUPPORT SERVICES-(NON-MA)	0	0	1,880,848	3,749,478	3,984,952
OTHER FCSS SUB-TOTAL	0	0	1,880,848	3,749,478	3,984,952
SCREENING-COUNTY(CSSA)*	0	0	0	0	0
SCREENING-MA*	0	0	0	0	0
SUB-TOTAL (MA-REHAB)	0	0	0	0	0
SUB-TOTAL (MA)	0	0	15,000	0	15,000
SUB-TOTAL (NON-MA)	0	368,556	9,845,780	16,021,945	18,241,365
STATE ADMINISTRATION	0	350,000	375,000	398,750	423,688
TOTAL	$0	$718,556	$10,235,780	$16,420,695	$18,680,052

UPDATED FISCAL NOTE

Table 28

1989 CHILDREN'S COMPREHENSIVE MENTAL HEALTH ACT, INCL. 1990 AMENDMENTS

DHS VERSION

	B. APPROVED BUDGET BASE/FORECAST INCLUDES STATE, FED. AND CTY SHARE				
	FY91	FY92	FY93	FY94	FY95
EARLY IDENTIFICATION					
AND INTERVENTION (EPSDT)	30,000	0	0	0	0
OUTPATIENT					
OUTPATIENT-CHILD'S HEALTH PLAN	69,368	368,556	833,267	833,267	833,267
CASE MANAGEMENT-(MA/SPMI)	$60,572	$176,315	$330,371	$484,544	$635,964
CASE MANAGEMENT-(MA/SED)	0	0	0	0	0
CASE MANAGEMENT-(NON-MA)	0	0	0	0	0
CASE MANAGEMENT SUB-TOTAL	60,572	176,315	330,371	484,544	635,964
PROFESSIONAL HOME-BASED(MA)	$0	$2,000,000	$4,000,000	$5,500,000	$7,000,000
PROFESSIONAL HOME-BASED(NON-MA)	$0	$0	$0	$0	$0
PROFESSIONAL HOME-BASED SUB-TOTAL	0	2,000,000	4,000,000	5,500,000	7,000,000
THER. SUPPORT FOR FOSTER CARE:					
REGULAR MA	$0	$0	$576,700	$1,835,000	$1,926,750
NON-MA	$0	0	0	0	0
THER. SUPPORT / FOSTER CARE SUB-TOTAL	0	0	576,700	1,835,000	1,926,750
DAY TREATMENT-(MA)	18,000	72,000	213,064	353,211	370,871
DAY TREATMENT-(NON-MA)	60,000	240,000	240,000	240,000	240,000
DAY TREATMENT SUB-TOTAL	78,000	312,000	453,064	593,211	610,871
OTHER FAMILY COMMUNITY					
SUPPORT SERVICES-(MA-REHAB)	$0	$0	$0	$0	$0
OTHER FAMILY COMMUNITY					
SUPPORT SERVICES-(NON-MA)	240,000	960,000	960,000	960,000	960,000
OTHER FCSS SUB-TOTAL	240,000	960,000	960,000	960,000	960,000
SCREENING-COUNTY(CSSA)*	($47,828)	$0	$0	0	0
SCREENING-MA*	($23,915)	$0	$0	0	0
SUB-TOTAL (MA-REHAB)	0	0	0	0	0
SUB-TOTAL (MA)	84,657	2,248,315	5,120,134	8,172,755	9,933,585
SUB-TOTAL (NON-MA)	321,540	1,568,556	2,033,267	2,033,267	2,033,267
STATE ADMINISTRATION	$100,000	$100,000	$100,000	$100,000	$100,000
TOTAL	$506,197	$3,916,871	$7,253,401	$10,306,022	$12,066,852

UPDATED FISCAL NOTE

Table 29

1989 CHILDREN'S COMPREHENSIVE MENTAL HEALTH ACT, INCL. 1990 AMENDMENTS

DHS VERSION

	C. TOTAL NEW COST COMPARED TO FY 89 INCLUDES STATE, FED. AND CTY SHARE				
	FY91	FY92	FY93	FY94	FY95
EARLY IDENTIFICATION					
AND INTERVENTION (EPSDT)	30,000	$0	$30,000	0	30,000
OUTPATIENT					
OUTPATIENT-CHILD'S HEALTH PLAN	69,368	737,112	1,666,534	1,833,187	2,016,506
CASE MANAGEMENT-(MA/SPMI)	$60,572	$176,315	$330,371	$484,544	$635,964
CASE MANAGEMENT-(MA/SED)	0	0	0	0	0
CASE MANAGEMENT-(NON-MA)	0	0	2,297,816	3,353,387	3,521,057
CASE MANAGEMENT SUB-TOTAL	60,572	176,315	2,628,187	3,837,931	4,157,020
PROFESSIONAL HOME-BASED(MA)	$0	$2,000,000	$4,000,000	$5,500,000	$7,000,000
PROFESSIONAL HOME-BASED(NON-MA)	$0	$0	$4,000,000	$5,500,000	$7,000,000
PROFESSIONAL HOME-BASED SUB-TOTAL	0	2,000,000	8,000,000	11,000,000	14,000,000
THER. SUPPORT FOR FOSTER CARE:					
REGULAR MA	$0	$0	$576,700	$1,835,000	$1,926,750
NON-MA	$0	0	576,700	1,835,000	$1,926,750
THER. SUPPORT / FOSTER CARE SUB-TOTAL	0	0	1,153,400	3,670,000	3,853,500
DAY TREATMENT-(MA)	18,000	72,000	213,064	353,211	370,871
DAY TREATMENT-(NON-MA)	60,000	240,000	497,148	824,159	865,367
DAY TREATMENT SUB-TOTAL	78,000	312,000	710,212	1,177,370	1,236,238
OTHER FAMILY COMMUNITY					
SUPPORT SERVICES-(MA-REHAB)	$0	$0	$0	$0	$0
OTHER FAMILY COMMUNITY					
SUPPORT SERVICES-(NON-MA)	240,000	960,000	2,840,848	4,709,478	4,944,952
OTHER FCSS SUB-TOTAL	240,000	960,000	2,840,848	4,709,478	4,944,952
SCREENING-COUNTY(CSSA)*	($47,828)	$0	$0	0	0
SCREENING-MA*	($23,915)	$0	$0	0	0
SUB-TOTAL (MA-REHAB)	0	0	0	0	0
SUB-TOTAL (MA)	84,657	2,248,315	5,150,134	8,172,755	9,963,585
SUB-TOTAL (NON-MA)	321,540	1,937,112	11,879,047	18,055,212	20,274,632
STATE ADMINISTRATION	$100,000	$450,000	$475,000	$498,750	$523,688
TOTAL	$506,197	$4,635,427	$17,504,181	$26,726,716	$30,761,904

1. Case Management Funding

In 1988, the Department promulgated Rule 74, relating to case management for both adults and children with serious and persistent mental illness. The fiscal note for Rule 74 assumed that counties would provide case management to about 1,000 children with serious and persistent mental illness, and that about 500 of those children would be funded through Medical Assistance (MA). The Rule 74 fiscal note was based on earlier budget projections presented to the Legislature in 1987 for the Comprehensive Mental Health Act. In 1987, the Legislature approved case management for persons with serious and persistent mental illness as a new service under MA, effective January 1989. The original budget projected that MA would pay $4.8 million (state, federal and county shares) for this service in 1989, with about 25% of that total, or $1.2 million, being for children.

In 1989, the Legislature passed the Comprehensive Children's Mental Health Act, including a statewide mandate for case management for children with severe emotional disturbance (SED), effective July, 1991. The Department estimated that twice as many children would qualify as having SED, compared to the earlier "serious and persistent mental illness" criterion. However, since the effective date for the expanded eligibility did not occur until the next biennium, the 1989 Session did not appropriate any funding relating to the new mandate, nor did it amend MA coverage for the service.

Therefore, at this time, MA can legally pay for children's case management only for children meeting the criteria for "serious and persistent mental illness." The administrative systems have been in place for counties to charge MA for this service since January 1, 1989. However, actual billings have been far less than expected, especially for children. Total MA payments for calendar 1989 for children's case management were only $29,743 for 76 children statewide.

Limited, more recent, data indicates that counties are now billing MA for over 200 children. (1990 expenditure data is not yet available because many counties have not yet billed for services provided in 1990.) The client count may now be approaching 50% of the initial projection for children with serious and persistent mental illness. However, hours per client appear to be averaging only about 1 hour per month, compared to the initially budgeted 3.6 hours per client per month.

The Department has several efforts underway to determine why county billing is so much lower than expected. Most of these efforts are focussed on adult case management, but have relevance to children as well:

* Department staff have been meeting with a Case Management Implementation Committee, including county representatives, to examine assumptions upon which Rule 74 reimbursement is based.

* As a result of the work of the implementation committee, the Department conducted a survey of all counties to obtain counties' actual costs for providing case management, to review client eligibility data, and to review components of staff time for case management

* During February, 1990, the Department will complete its analysis of the comments and data received to determine what kinds of changes need to be made to maximize these funds, and thus to improve the service delivery. At this point, it appears that significant improvement could occur through improved training of counties, and greater county focus on billable services. However, there may also be some need to revise Rule 74.

Expansion of MA case management to children with severe emotional disturbance would require a statutory change and new funding.

2. Medical Assistance Rehabilitative Services

Some of the services proposed to be included in Minnesota's new family community support services could be eligible for federal reimbursement. However, data from counties indicates that only 30% of the children needing this service qualify for Medical Assistance. For this 30%, it appears that only about 50% of the services provided would meet federal criteria. Applying a 53% match to that means that only about 8% of total family community support costs might be subject to federal reimbursement.

3. Children's Integrated Mental Health Fund

The Comprehensive Children's Mental Health Act includes four major new services (family community support, case management, professional home-based family treatment and therapeutic support for foster care) which will require state grant funding for non-MA eligible children and non-MA eligible services. A Children's Integrated Mental Health Fund could address all four of these services and lay the groundwork for integration of other children's mental health funds in the future.

4. Medical Assistance Coverage of Professional Home-Based Services

The 1989 Legislature approved funding to begin Medical

Assistance-reimbursed Professional Home-based Family Treatment Services for children with severe emotional disturbance in January, 1991. Due to limited numbers of staff in both the Mental Health and Health Care Divisions, it now appears that the earliest possible start date for Medical Assistance payments for this new service will be April, 1992.

5. Equalization of county share of children's services in Regional Treatment Centers and expansion of Medical Assistance to cover children's Rule 5 residential treatment

As indicated earlier, a great disparity exists between the county share for RTCs and county share for community residential treatment costs. One option being considered would require counties to pay approximately 47% (the non-federal share) of the cost for both RTC and community residential treatment. Initially, this would be a significant increase in county cost for RTC services. However, as Medical Assistance was implemented for community residential treatment, counties would begin to obtain significant savings which could be redirected towards development of more community-based, low-cost alternatives.

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

This chapter has been prepared to comply with Minnesota Statues, section 245.4873

Minnesota Statutes direct 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". They also require representatives of key state agencies involved in mental health service provision to children, and a representative of the Minnesota District Court Judges Association's Juvenile Committee, to meet at least quarterly to:

- o educate each agency about the policies, procedures, funding, and services for children with emotional disturbance in agencies represented;
- o develop mechanisms for interagency coordination on behalf of children with emotional disturbance;
- o identify programmatic, policy or procedural barriers that interfere with delivery of mental health services for children;
- o recommend policy and procedural changes needed to facilitate the development and effective delivery of mental health services for children;
- o identify mechanisms for better use of federal and state funding in the delivery of mental health services for children; and
- o report on policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system.

The report, to be submitted to the Legislature and the State Mental Health Advisory Council, is to include information from each agency represented on:

- o the number of children in each department's system who require mental health services;
- o the number of children in each system who receive mental health services;
- o funding mechanisms within each system;

o coordination methods to provide more effective, appropriate services for children; and

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

Committee membership includes:

Department of Commerce, Chuck Ferguson, Policy Analyst

Department of Corrections, Richard Quick, Executive Officer, Juvenile Release

Department of Education, Wayne Erickson, Manager, Unique Learner Needs Section

Department of Health, Ruth Curwen Carlson, Principal Planner, Maternal and Child Health Division

Department of Human Services, Rob Sawyer, Supervisor, Family Based Services Section, Children's Services Division, and Jerri Sudderth, Director, Mental Health Division.

Minnesota District Judges Association, The Honorable J.B. Gunderson

State Planning Agency, Ann Jaede, Acting Director, Program Planning

Additional participants have included:

Bonnie Bray and Sam Richardson, Unique Learner Needs Section, Department of Education

Jan Gibson Talbot, Supervisor, Children's Mental Health Unit, Mental Health Division, Department of Human Services

A. Committee Activities

The State Interagency Coordinating Committee, meeting approximately monthly, undertook a project to obtain data on the provision of services to children with emotional disturbance. Phase I of the project involved identification of the various funding sources currently available for mental health services, funding amounts, and the number of children being served.

Phase II will look at the administrative regulations and requirements attached to each funding source, the eligibility groups able to access funding and the processes for accessing each funding source. Its purpose is to identify current gaps in

funding and duplication of services/expenditures within and across agencies to develop a holistic picture of children's mental health expenditures among various agencies serving children.

Phase III will look at the children being served across agencies. It will also examine the various data collection methods currently being used and attempt to determine how much overlap exists among data collection systems.

Phase I data is provided in Tables 30 to 32. By using, the same matrix in each of the tables, available data highlight the degree to which funding is **not** being duplicated for services by the various agencies. In particular, the matrix separates clinical services from instructional and educationally-related services provided with funds from the state Department of Education and local school districts. For example, both education and human services systems pay for services to children in residential treatment. However, educational funding is utilized for specialized instruction, while human services funding provides treatment and room and board.

Unfortunately, the lack of data from the same calendar or fiscal year precludes inclusion of these amounts in any one table or totalling the numbers between tables. It should also be noted that the numbers reported, while unduplicated within service categories, likely include duplication between services. Therefore, it is not yet possible to provide an accurate total of the number of children served during the years cited.

B. Data and Agency Descriptions

Department of Health

Activities addressing mental health needs of children are part of a full range of program activities provided by the Department of Health. No funding is appropriated specifically for children's mental health, nor can dollar amounts spent or numbers of children served be determined. However, a number of activities address children with mental health needs. These include:

- o training of those responsible for conducting Early and Periodic Diagnosis, Screening, and Treatment (EPSDT), Early and Periodic Screening (EPS), and Early Childhood Screening (ECS).

- o training of local public health nursing staff who work directly with families in their homes, providing education, counseling and support to parents and families. Nursing Child Assessment Satellite Training is provided to public health and other professionals who conduct home visits with

infants and toddlers and their parents. These visits help assess interactions between parents and their children and to promote and guide early intervention and referral as needed.

o provision of case management, information and referral, advocacy, resource management, and consultation on the health, education, and psychosocial needs of children with special health needs through Developmental Learning Clinics. These Services for Children with Handicaps (SCH) clinics offer evaluations and treatment recommendations for children who have or are suspected to have a variety of problems, including behavioral or psychological problems, interfering with normal development.

Very few mental health services are covered for payment by the SCH program. Psychology charges are reimbursed when the psychologist is part of an interdisciplinary team treating a child for an SCH-eligible condition. SCH also covers Developmental Assessment evaluations which include testing for children under age three.

Department of Corrections

Data for state fiscal year 1991 shown in Table 30 is based on estimates that approximately 10 percent of juvenile residents of state correctional facilities (Red Wing and Sauk Center) meet the statutory criteria for emotional disturbance. Funds for services for these children are appropriated by the State Legislature.

Table 32 shows the estimated number of children with emotional disturbance served at state correctional facilities. The outpatient services shown are contracted sex offender services slated to begin in FY 1991.

County corrections budgets do not contain funds for mental health services for children, except for court-ordered psychological or psychiatric evaluations. Instead, reimbursement for services needed by children within the correctional system come from county social service funds.

Department of Education

As seen in Table 30, the largest portion of educational expenditures for children with emotional disturbance provides specialized instruction, specially designed intervention, and related or support services to meet the unique cognitive, affective, or psychomotor needs of pupils. Services may include consultation, indirect services, or direct services ranging from less than an hour to a full day in duration. Direct instruction is provided to a child placed in a residential facility.

Educationally-related services are specially designed services not provided by regular or special education to meet the unique needs of the pupil to benefit from that child's educational program. These services may involve psychological, social work or medical services for diagnostic purposes. Specially designed intervention includes consultation and indirect services.

Table 32 indicates the number of children with emotional disturbance served during the 1989 school year.

Department of Human Services

Table 30 provides expenditures for children's mental health services in calendar year 1988, as provided by counties in their 1990-1991 biennial Children's Mental Health Plans. Table 31 shows the number of children for whom Medical Assistance paid for mental health services and the dollar amount of payment by provider type in State Fiscal Year 1989. This latter table includes estimates for children whose Medical Assistance coverage is provided through health maintenance organizations.

Table 32 indicates the number of children for whom each service was provided, according to county biennial mental health plans. (In future years, this data will be available through the Community Mental Health Reporting System and will be more current than that provided in the mental health plans. A discussion of this data system is found in Chapter X.)

Department of Jobs and Training

The Department of Jobs and Training administers federal and state funds targeted to serving low income adolescents at risk of dropping out of school. Approximately 28.5 % of the 6,711 adolescents provided services through the federal Summer Youth Employment and Training Program are identified as having physical, emotional, or mental handicaps. A total of $8,121,119 was expended in the summer of 1990 through this federal program. During the same period, $2,850,000 of state funds was spent on similar services for 3,466 adolescents through the Minnesota Youth Program, of which 26.5 % were identified as having physical, emotional or mental handicaps.

Because the targeting of services is accomplished at the service delivery (local) area, information on the actual number of adolescents with emotional disturbance served and the exact breakdown of services provided are not known on the state level. Pre-employment services provided in the summer programs include independent living skills training, counseling, and case management as well as other services.

TABLE 30

SERVICES FOR CHILDREN WITH EMOTIONAL DISTURBANCE
FEDERAL, STATE, AND LOCAL FUNDING

	HUMAN SERVICES	SPECIAL EDUCATION	CORRECTIONS
SERVICES	CY 1988 FUNDING*	1989 FUNDING	FY 1991 PROJECTION
Special Instruction		$40,328,141	
Education/Prev.	$297,142		
Emergency Services	$647,213		
Screening	$61,825		$41,500
Early ID, Intervention	$121,770	$1,456,744	
Outpatient Services:			
Clinical Svcs	$3,595,059		$75,000
Related Svcs		$1,942,325	
Case Management	$854,682	$2,913,487	
FCSS:			
Day Treatment-			
Clinical Svcs.	$2,323,340		
Instruction		$1,942,325	
Home Based Tx	$872,185		
Tx. Foster Care	$417,090		
Other FCSS	$498,008		
Residential/RTC:			
Clinical Svcs.**	$20,213,933		$730,000
Instruction		$4,680,078	
In-patient Acute Care Services	$251,215		
State Admin.	$99,000	$80,000	
Total	$30,252,462	$53,343,100	$846,500

*These amounts do not include Medical Assistance reimbursements for services to children with emotional disturbance. Totals are taken from county biennial children's mental health plans.

**includes room and board costs

TABLE 31

FY 1989 MEDICAID AND GAMC PAYMENTS FOR MI DIAGNOSES

CLIENTS AGES 0-18

FY89-# OF CLIENTS	GAMC-MED	GAMC-GA	GAMC TOTAL	MA SSI/MSA	MA AFDC	MA MA-NEEDY	MA TOTAL	TOTAL
GENERAL HOSPITAL(INPATIENT)	4	4	9	74	566	446	1,086	1,095
MENTAL HEALTH CENTER	1	6	7	82	3,817	1,134	5,033	5,040
HOSPITAL OUTPATIENT	8	3	11	125	2,122	750	2,996	3,007
PHYSICIAN/PSYCHIATRIST	13	11	24	229	3,473	1,452	5,154	5,178
PSYCHOLOGIST	0	0	0	155	4,104	1,385	5,644	5,644
REGIONAL TREATMENT CENTERS	0	0	0	7	41	155	203	203
OTHER	0	0	0	1	13	6	20	20
PUBLIC HEALTH	0	0	0	3	122	18	143	143
REHABILITATION	0	1	1	6	84	20	110	111
TOTAL	26	26	52	681	14,343	5,365	20,389	20,441
UNDUPLICATED TOTAL	**21**	**16**	**37**	**496**	**11,662**	**4,040**	**16,077**	**16,202**

FY89-NET PAYMENTS	GAMC-MED	GAMC-GA	GAMC TOTAL	MA SSI/MSA	MA AFDC	MA MA-NEEDY	MA TOTAL	TOTAL
GENERAL HOSPITAL(INPATIENT)	$12,208	$21,723	$33,931	$445,126	$3,889,171	$3,210,784	$7,545,081	$7,579,012
MENTAL HEALTH CENTER	$150	$532	$682	$37,509	$1,175,720	$320,189	$1,533,418	$1,534,100
HOSPITAL OUTPATIENT	$2,232	$164	$2,396	$29,943	$631,480	$200,088	$861,510	$863,907
PHYSICIAN/PSYCHIATRIST	$2,041	$4,910	$6,951	$55,599	$808,106	$473,734	$1,337,439	$1,344,389
PSYCHOLOGIST	$0	$0	$0	$77,574	$1,892,644	$584,815	$2,555,033	$2,555,033
REGIONAL TREATMENT CENTERS	$0	$0	$0	$103,842	$494,210	$3,016,247	$3,614,299	$3,614,299
OTHER	$0	$0	$0	$123	$955	$346	$1,424	$1,424
PUBLIC HEALTH	$0	$0	$0	$378	$9,889	$2,303	$12,570	$12,570
REHABILITATION	$0	$110	$110	$3,104	$82,395	$22,351	$107,849	$107,959
TOTAL	$16,631	$27,439	$44,070	$753,198	$8,984,570	$7,830,855	$17,568,623	$17,612,693

NOTE: THESE DATA WERE BASED ON SERVICE DATA FOR MI DIAGNOSES BEGUN DURING THE FISCAL YEAR. THE DATA WERE SUPPLIED BY THE REPORTS AND STATISTICS DIVISION. THE FIGURES ARE BASED ON DIRECTLY REIMBURSED SERVICES, EXCLUDING HMOS. THE DATA WERE ADJUSTED TO INCLUDE ESTIMATES FOR HMO UTILIZATION BY FACTORING IN THE INCREASE IN ELIGIBLE MONTHS DUE TO INCLUDING HMOS.

TABLE 32

SERVICES FOR CHILDREN WITH EMOTIONAL DISTURBANCE
CLIENTS SERVED

	HUMAN SERVICES*	EDUCATION	CORRECTIONS
SERVICES	CY 1988 CLIENTS	1989 CLIENTS	1991 PROJECTIONS
Special Instruction		9,391	
Education/Prev.			
Emergency Services	12,902		
Screening	377		425
Early ID, Intervention	1,758	339	
Outpatient Services- Clinical Svcs	16,236		10
Related Svcs		453	
Case Management	943	679	
FCSS:			
Day Treatment Clinical Svcs.	1,237		
Instruction		452	
Home Based Tx	512		
Tx. Foster Care	169		
Other FCSS	220		
Residential/RTC Clinical Svcs.**	1,590		45
Instruction		674	
In-patient Acute Care Services	167		
State Admin.			
TOTAL		11,988	480

* These totals are unduplicated within services not across services. They also do not include children for whom services were provided by Medical Assistance. Totals are provided by counties in biennial county children's mental health plans.

** Includes Room and Board.

C. Progress on 1990 Recommendations

In its 1990 Report to the Legislature, the Committee included recommendations for enhancing and improving the delivery of services to children with emotional disturbance. Those recommendations which addressed the functioning of the state agencies represented on the committee and the progress made in their implementation are as follows:

1. State agencies should collaboratively develop training needed for multi-system service providers, such as physicians, educations, 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.

Prior to receipt of the National Institute of Mental Health (NIMH) grant, described in Chapter V, a task force of representatives of state agencies developed a work plan for provision of training. The materials developed by that group were the basis of the proposal submitted to NIMH. In addition, the Department of Human Services' contract with the Department of Health for training providers of EPSDT services has been expanded to include awareness of issues related to emotional disturbance. A series of day-long training on the topic will be provided in the Spring of 1991. The Department of Education will also be involved in providing a portion of the training. Division staff also worked with Department of Education staff in the latter Department's revision of the handbook covering emotional/behavioral disorders for special education.

2. 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.

No specific activities have been undertaken in this area. However, the Mental Health Division continues to distribute **Children and Youth at Risk of Emotional Disturbance: Risk Factors and Symptoms**, the booklet developed and widely disseminated in January, 1990. Copies have been provided to a wide range of groups, including educators, health care professionals, and interested individuals.

3. 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 definitions and eligibility criteria for children with emotional disturbance.

The Department of Education has studied and recommended, in consultation with staff from other agencies, a rule on statewide eligibility for services to children with emotional/behavioral disorders (E/BD) for ages birth through 21. The proposed rule, to be considered for approval during the 1991 Legislative Session, attempts to achieve compatibility, to the extent feasible, with criteria used by other Departments.

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

The Department of Education's recently released document, **Challenge 2000: Success for All Learners**, urges the establishment of "comprehensive and accessible community parent resource centers statewide". The recommendation included in this document calls for centers to be located in all neighborhoods and communities statewide to give parents ready access to needed resources and to health and social service professionals. Members of the State Interagency Coordinating Committee contributed to the content and recommendations of that document.

5. 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.

Staff from the Mental Health Division are now participating on this Committee.

6. 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 [compartmentalization of funding]. If funding streams must remain discrete for federal purposes, state agencies should provide models for collaborative use of funds by local agencies.

The Department of Human Services has proposed to the 1991 Legislature statutory changes which would permit integration of what would otherwise be separate funding streams for various mental health services for children. The primary objective of the proposal is to maximize county's flexibility in the use of these resources to meet locally-identified needs. If adopted by the Legislature, the proposal would permit phased-in development of an integrated children's mental health fund, beginning with Family Community Support Services in 1992.

The Department's Request for Proposals (RFP) for development of

pilot Family Community Support Services, found in Instructional Bulletin #90-53D, also stresses the advantages of leveraging funds from other systems, such as schools and corrections, with the dollars available under this RFP in order to promote cooperative service development. In addition, **Challenge 2000**, mentioned earlier, urges the promotion of cost-effective service delivery through collaborative funding.

The Interagency Committee has responded to requests from the Children's Subcommittee of the State Mental Health Advisory Council and other groups to research and describe agency responsibility for ensuring provision of services to children. The purpose of these requests has been to assure that resources are utilized appropriately for the provision of services.

7. 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.

Staff from the Children's Mental Health Demonstration Projects have provided training to county staff and service providers on methods by which information may be shared within existing law. (See Chapter V for an overview of the projects.)

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

Discussion among participants on the Interagency Committee continues in order to determine the most effective approaches to interagency agreements.

VIII. CHILDREN'S SCREENING FOR INPATIENT AND RESIDENTIAL TREATMENT

> This chapter has been prepared to comply with Minnesota Statutes, section 245.4885, subdivision 1.

Minnesota Statutes require county boards to:

> ...screen all children admitted for treatment of severe 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; and
> (4) provides a length of stay as short as possible consistent with the individual child's need....

The required screening must comply with current Permanency Planning statutes. The law provides for approval of an alternate review process if the county board demonstrates that a comparable process has been established by the county board.

The same statute requires the establishment of a task force to study mechanisms for screening for children 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....

Required to report to the Legislature in 1990 on how existing mechanisms could be changed to accomplish the goals of screening described in statute, the task force submitted its initial conclusions and preliminary recommendations as part of the Division's 1990 Report to the Legislature. One recommendation of the group was additional study of screening issues and screening mechanisms to address current inconsistencies and to identify successful models from which to build an effective and coordinated screening system for children.

Therefore, the task force continued to meet through 1990 to examine the particular needs of children with respect to screening mechanisms. Final recommendations, which include modifications of the original recommendations, were developed:

1. Screening mechanisms, which are a part of screening required for all out-of-home placements of children under the Permanency Planning Act, should include both diagnostic and functional assessments of the child by a mental health professional and should address services needed to maintain the child in the community.

2. Screening mechanisms for emergency inpatient hospitalization should be different from those for residential placement so that care providers are not required to initiate both a pre-certification process under Medical Assistance Rule 48 and a screening team process under MS 245.4885.

3. The absence of less restrictive, community-based alternatives should be included as an appropriate consideration for Medical Assistance pre-certification of admission to acute care inpatient hospitalization for children.

4. Screening should be required **before**, rather than after, admission, except for situations which require emergency admission to inpatient hospital units. In the latter instance, screening should be required within three working days.

5. Counties should assure in contracts for residential and acute care hospital inpatient care that providers adhere to admission, discharge, and continued stay criteria. (These contracts should not be required when reimbursement is under General Assistance Medical Care or Medical Assistance.)

6. Assurances of coordination in planning and continuity of care between service providers and appeal mechanisms should be included in service contracts between counties and providers.

7. Summary data should be collected by counties on screening recommendations. This data should include the degree to which these are followed in placements, as well as the reasons recommendations are not followed.

Following these recommendations, the Department has proposed statutory amendments to address the issues raised. Counties would be required to assure, in contracts for residential and acute care inpatient care, that providers adhere to admission, discharge, and continued stay criteria. Coordination in planning and continuity of care between service providers and appeal mechanisms would also be required in contracts under this legislative proposal.

Screening would be required before children are admitted, except for emergency admissions to acute care inpatient hospitals, when a three working day delay would be permitted. For care provided under General Assistance Medical Care and Medical Assistance in an acute care inpatient hospital, no additional screening beyond that already required under DHS Rule 48 would be necessary.

Screening under MS 245.4885 would require both diagnostic and functional assessments by mental health professionals and would be required to address needed community services. Finally, counties would be required to collect summary data on screening recommendations and the degree to which these are followed in placement decisions, as well as reasons for not following the screening recommendations.

In addition to the statutory amendments, a subgroup of the children's task force has worked with staff from the Mental Health and Audits Divisions to propose revisions to DHS Rule 48, which governs admission of children to acute care hospital services under Medical Assistance. Staff from the Hospital Reimbursements Unit of the Audits Division will utilize this material for possible revisions of Rule 48. This process is expected to be undertaken in the Spring of 1991.

IX. MENTAL HEALTH PLANNING SIMPLIFICATION

One of the traditional methods used to implement legislative policy in mental health has been a biennial plan developed by each county and approved by the state agency. Historically, this method dates back at least to the Community Social Services Act, inaugurated in 1979. With the passage of the Comprehensive Mental Health Act in 1987, that section of the plan pertaining to services for those with mental illness became a separate plan document. In 1989, the Comprehensive Children's Mental Health Act instituted an additional plan for services to children with an emotional disturbance.

By mid-1989, it had become evident that the planning burdens on both county and state staff had become enormous. The two mental health plans totaled close to two hundred pages. County staff felt their time was being spent in unnecessary paperwork. Virtually all of the staff in the Mental Health Division of the Department of Human Services were required to spend most of their time between August of 1989 and July of 1990 simply reviewing mental health plans and providing feedback to counties. The Community Social Services Plan was making similar demands on both county and state staff time.

In the Spring of 1990 and at the invitation of several Department Assistant Commissioners, a group of directors from the Minnesota Association of Social Services Administrators and state staff began to discuss how planning efforts could be simplified and streamlined. The group had several major goals:

- To reduce the paperwork of county plan requirements;

- To move from a focus on compliance to a focus on the planning process;

- To strengthen accountability at both the state and local levels; and

- To enlist the county social service directors themselves in the effort to make planning work for both the state and the counties.

After a brief series of meetings, the state agency and the county directors agreed on the following parameters:

1. Previously separate plans for Community Social Services, federal Title XX funds, Adult and Children's Mental Health, and Mental Illness Community Support Program (Rule 14) funds would be merged into a single plan for social services.

2. The department would evaluate the plan for approval-disapproval decisions, including:

- determining the adequacy of local planning, including the involvement of stakeholders;

- reviewing the appropriateness of local objectives, based on previously set state goals;

- reviewing the allocation of funds within program areas and for specific identified services;

- requiring county certification that identified legal mandates have been met.

3. Information requested through the plan would be only that which cannot be obtained through other means, such as the Community Mental Health Reporting System. Counties would no longer provide actual counts of clients and expenditures for prior years, projected client counts, or provider and staff qualification data available from the Licensing or County Monitoring Divisions.

4. The state agency would identify at least one goal for each program area. Counties would be responsible for developing measurable objectives for these goals. A county could identify other goals appropriate for their own particular county. Where other monitoring systems identify a specific problem in a county, the state agency would develop a specific goal for that county aimed at correcting the specific problem. Objectives would be expected to cover the two-year plan period.

5. Accomplishment of objectives would be determined through the Department's reporting and monitoring systems.

6. The "program areas" and "services" of the plan would correspond with the Budgeting Reporting and Accounting for Social Services (BRASS) system which went into effect on January 1, 1991.

7. No change would be made in the Department's authority to approve or disapprove plans or to apply sanctions for non-approved plans.

8. The Department would specifically identify a list of statutory requirements that counties must pledge to meet.

9. The Department would supply counties with information on incidence and prevalence where obtainable; counties would not be required to produce such information.

Guidelines for the integrated social services plan were distributed to counties in January, 1991. As agreed, training for counties about the changes in planning requirements will be presented through a joint effort by state staff and county directors in the late winter and early spring.

As well as coordinating with the BRASS social service taxonomy, this plan integration project is correlated with other Department projects aimed at improving and rationalizing bureaucratic systems. These include the Social Service Mandate Project, the Community Social Services Program Performance Project, and the Fiscal Reporting Reform Project.

To fully implement the county-state agreement on plan simplification, the Department will propose amendments to current statute on plan requirements.

X. SPECIAL INITIATIVES

This chapter has been prepared to comply with Minnesota Statutes 245.4861 (Public/Academic Liaison Initiative).

A. Public-Academic Liaison Initiative

The Comprehensive Mental Health Act was amended in 1989 to include a Public-Academic Liaison Initiative (PALI) which is seen as essential to improving the quality of mental health services. The Department is charged with establishing an 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 have mental illness;

- 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 has been made for the Public Academic Liaison Initiative. Therefore, no new activities have been started directly as a result of the Initiative. However, many ongoing Division activities, as well as new activities funded by the NIMH Human Resource Development (HRD) capacity building grant facilitate the public/academic liaison function.

DHS's Institutional Review Board's 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 chosen to advocate for research within the regional treatment center system. 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.

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 students 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.

In July of 1990, the Minnesota Higher Education Coordinating Board (HECB) joined the Western Interstate Commission for Higher Education (WICHE). In addition to its role in higher education, WICHE also operates a mental health program. The WICHE Mental Health Program assists member states in four areas: 1) development of mental health decision support and data systems; 2) mental health human resource development; 3) rural mental health policy development; and 4) public/academic liaison development. Upon the HECB's admittance, WICHE extended an invitation for Minnesota to participate in the WICHE Mental Health Program. This invitation was extended even though the Division was unable to provide the annual dues of $15,000 required of states for this participation. More recently, however, WICHE has requested a phased-in dues schedule which is likely to preclude Division participation.

University faculty are routinely sought out to serve as representatives on a variety of advisory groups. Currently, faculty from higher education institutions sit on the following advisory and work groups: HRD Project; Compulsive Gambling; Education/Prevention/Research Subcommittee of the State Mental Health Advisory Council; and Early Identification/Intervention.

Dr. David Knoke, professor and chair of the University's Department of Sociology, prepared a grant application to the NIMH on 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 project, though approved by NIMH, was not funded. Dr. Knoke plans to resubmit the proposal during the next funding cycle.

The Division, in collaboration with the University of Minnesota Institute on Community Integration and Ramsey County Mental Health Services, applied for NIMH funds to develop and evaluate a consumer run housing support program. This proposal was also approved, but not funded.

The Division is currently working with Dr. Christopher Krogh and Dr. Sharon Satterfield, faculty at the University of Minnesota Medical School, Department of Family Practice and Community Health, to develop a proposal for a research project to study homeless persons with mental illness. The proposal should be submitted to the NIMH this year.

Dr. Robert Murphy, Chair of the Department of Applied Psychology at St. Cloud State University has developed a proposal to begin a bachelor's degree program in psychology with a strong practitioner's emphasis. Dr. Murphy discussed this program with Division staff, seeking input into types of practical training sites which may be available to students in the proposed program as well as the future prospects for employment for graduates of the program. The MAD lent its support to this proposal.

The HRD Project has begun a survey of Minnesota higher education academic programs in disciplines which frequently prepare persons to work in mental health services. Survey questionnaires were sent to over 160 faculty heads of degree programs in psychiatry, psychology, social work, nursing, counseling, occupational therapy, and special education. The survey will gather information on program capacity, enrollment demographics, curriculum content, student opportunities for practical experience, etc. The results of the survey will be used as a basis for PALI, outlining the current scope of higher education/service system collaboration and highlighting other needs and opportunities. The study will be completed by March, 1991.

DHS has obtained assistance from the State/University Collaboration Project (S/UCP), headquartered in Washington, D.C. This project is a joint effort of the Pew Memorial Trust and the American Psychiatric Association. The S/UCP offers in-depth consultative services to states wishing to develop or enhance existing state/university collaborations. The S/UCP also conducts regional workshops designed to assist in creating or expanding collaborative efforts between state mental health departments and departments of psychiatry. The HRD Project has coordinated assistance from S/UCP as part of its workplan.

The S/UCP held a two-day Mid-West Regional Workshop in St. Paul in June, 1990. Staff from DHS joined representatives from the University of Minnesota Department of Psychiatry and the Minnesota Association of Community Mental Health Programs in the workshop, which served to educate participants regarding the

benefits of such collaborative relationships as well as outlining characteristics of successful collaboration. At this workshop, S/UCP faculty announced that Minnesota's request for consultation had been accepted by the S/UCP Steering Committee.

Consultants from the State of Washington's Institute for Mental Illness Research and Training and the University of Washington Department of Psychiatry conducted the S/UCP consultation on January 11, 1991. Representatives from the Department, University of Minnesota, and other interested groups participated in the consultation. As a result of the consultation, the representatives from DHS and the University of Minnesota Department of Psychiatry reached an agreement to pursue the following collaborative activities:

- The Department of Psychiatry and DHS will work together to provide continuing medical education and outreach in an effort to reduce the isolation of psychiatrists practicing in public sector settings in Minnesota.

- The Department of Psychiatry and DHS will work together to review and simplify procedures necessary to secure approval for research projects conducted in state-operated facilities. Standards of scientific merit and the protection of the rights if human subjects will remain of primary concern in this process.

- DHS will use existing funds for psychiatric services to pursue a contract with the Department of Psychiatry to employ a Department of Psychiatry faculty person as a Research Coordinator at the Anoka-Metro Regional Treatment Center. The Research Coordinator will have additional responsibilities for outreach to psychiatrists working in community based mental health programs.

- The Department of Psychiatry agreed to consider the need to develop a public-community focus as it recruits to fill faculty positions.

While the S/UCP 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 last offered grants for the development of public/academic linkages in 1989. These grants are available only upon demonstration of established public-academic liaison activities and an ongoing state commitment to the process. Based on the recommendations of the Pew/APA consultation, the Department may apply for a PALI grant in a future funding cycle.

B. Indian Mental Health Projects

During 1990, the Division continued its support of Indian Mental Health projects, utilizing 25 percent of the Federal Alcohol, Drug Abuse, and Mental Health Block Grant funds. From January through September of 1990, the projects served a total of 2,721 Indian men, women and children.

Indian mental health projects, designed to provide mental health services in coordination with county community support services, utilize the services of traditional healers as well as services available through county community mental health centers. Indian mental health project staff are involved in county mental health advisory committees for adults and children and work with counties to offer the array of mandated mental health services in a culturally-competent manner.

The Division received ten applications for the continuation of Indian mental health projects for calendar year 1990, including five from Chippewa Tribes in the northern part of the State, three from the Sioux Communities in the southwestern part of the State and two from the urban communities of the metropolitan area. These applications were reviewed by a special committee in August of 1989, with recommendations to continue funding for all ten Indian mental health projects during 1990.

A total of $379,689 was awarded in 1990 to the following projects:

Bois Forte, located in the northernmost part of the State in St.Louis and Koochiching Counties, serves the Deer Creek and Vermillion Communities. Mental health services provided include education and prevention, outreach services, and transportation services for clients referred to the Range Mental Health Center in Virginia. The Range Mental Health Center provides consultation and additional support services. The project is supervised by a master's-level Indian social worker who also provides direct services such as individual and family counseling. Project outreach services are provided by two mental health workers who work directly with the schools and communities. The Bois Forte project received $58,421 for 1990.

Fond Du Lac, Cloquet, provides individual, family and group counseling, outreach, education/prevention, support and referral services. Services are provided by two Indian mental health professionals in collaboration with the Human Development Center in Duluth, as well as a traditional healer. The Fond Du Lac project received $70,365 during 1990.

Grand Portage, located near the Canadian border in Cook County, is very isolated, with community support services located about 35 miles away in Grand Marais, and residential services available in Duluth (110 miles away). Services provided by a wellness technician include client outreach, individual and family counseling, education and prevention, and consultation to the Cook County Community Support Program. The Grand Portage project received $35,410 for 1990.

The Indian Health Board, located in the heart of the urban Indian population in south Minneapolis, is a comprehensive health care clinic providing a range of services. Mental health services are provided by mental health professionals and paraprofessionals who provide outreach services. Services provided with $30,576 of project funds include outreach, education and prevention, psychosocial rehabilitation, and assistance in independent living skills.

Leech Lake, one of the state's three largest reservations, is located fourteen miles east of Bemidji. Mental health services are provided by two mental health workers. Services include outreach, education/prevention, case management, and advocacy services. This project is fortunate to have local access to the Indian Health Services Hospital for 24-hour emergency services. The project coordinates services with the Upper Mississippi Mental Health Center and also provides services to the Bemidji area. The Leech Lake project received $61,602 for 1990.

The Lower Sioux Community is a tiny community located in the southwestern part of the state in Morton. A mental health worker provides outreach and education/prevention services. The mental health services of Redwood and Yellow Medicine Counties are also utilized. The Lower Sioux Community received $14,228 for 1990.

Mille Lacs, in the north central part of the State, includes portions of the four counties of Aitkin, Mille Lacs, Pine and Kanabec. Mental health services provided under the grant include client outreach, individual and family counseling, and education/prevention provided by the project mental health professional, with additional consultation and coordination provided by the Northland Mental Health Center. This project also utilizes the services of a traditional healer. Mille Lacs received $47,996 for 1990.

Shakopee Mdewakanton Sioux Community is located in Scott County about 30 miles southwest of the metropolitan area. Mental health services provided by a mental health worker include outreach, education/prevention, and coordination

with Scott County and metro area clinics and hospitals for 24-hour emergency services. The Shakopee Mdewakanton Sioux Community received $11,457 for 1990.

The Upper Midwest American Indian Center project serves a significant Indian population and is the only Indian mental health program in the north Minneapolis area. The project's mental health advocate provides education/prevention and client outreach services, and coordination and linkage with the Hennepin County Community Support Program. The Upper Midwest American Indian Center received $28,105 for 1990.

The Upper Sioux Community project is also located in the southwestern part of the state in Yellow Medicine County. Mental health services provided by the mental health outreach worker include client outreach and education/prevention services. Coordination and linkages occur with the Western Human Development Center in Marshall. The mental health project of the Upper Sioux Community received $21,529 for 1990.

The Indian Mental Health Advisory Council, comprised of representatives from the reservations and urban communities of Minneapolis and Duluth, advises the Department regarding needed Indian mental health policy and service development. This Council meets quarterly.

The Indian Mental Health Advisory Council has also identified a high level of unmet mental health service need in Indian communities and an absence of state funding for Indian mental health service development and implementation. A majority of the Minnesota Chippewa Tribes, Sioux Communities, Minnesota Indian Affairs Council and urban Indian Organizations have passed resolutions supporting the Indian Mental Health Advisory Council's efforts to seek additional mental health funding during the 1991 Legislative Session.

The Council has also brought to the Department's attention the significant increased number of attempted and completed suicides among both the urban communities and reservations. The Indian mental health projects are currently attempting to address this problem through coordination with the schools and through outreach services designed to reduce the stigma of mental illness and to heighten community awareness and support of suicide prevention activities.

C. The Community Mental Health Reporting System

The Community Mental Health Reporting (CMHRS) was implemented on a test basis during 1989, and on a fully-operational basis in January, 1990. It provides the Division with the capability of

producing both routine semi-annual and annual reports and ad hoc reports.

The CMHRS 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 previous reporting systems. 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 semi-annual 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, 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 are being produced. The database is now available to DHS management for rapid response to ad hoc inquiries. Procedures for improving data quality and for providing additional technical support to the counties were added during the last year. The existence of CMHRS has been critical in eliminating burdensome monitoring aspects of the county planning process. (See Chapter IX for a discussion of the plan simplification process.)

The CMHRS now meets most of the Division's information requirements. More will be met in the future with expansion of the CMHRS. Other Divisions' information and data collection processes meet some data needs. These include extracts of the MA/GAMC claims from the Minnesota Medical Information System, data extracts from the RTC Reimbursement System and county monitoring of Rule 74 case management and improved county social services expenditure and revenue reporting to the Financial Management Division.

An adjunct to the CMHRS, the Mental Health Statistics Improvement Project (MHSIP) is funded by a three-year NIMH grant to help organizations providing mental health services develop improvements in their data systems. These improvements include installation of national data standards and use of these standards to serve local management decision-making.

Organizations working with the Department in this effort include county-operated and contracted community mental health centers and freestanding community support programs. System documentation has been collected from eight community mental health centers and from a software vendor who supplies a comprehensive data system to ten Community Support Programs (CSP) in Minnesota. Using this information, two contracts have been

let to support implementation work at two Community Mental Health Centers and a third contract developed for the CSP vendor. These contracts will support changes to local data systems. The result is expected to be more complete and comparable data for local decision-making and an enhanced ability of the Department to perform its supervisory role with respect to delivery of mental health services.

D. Anti-Stigma Campaign

Because stigma associated with mental illness affects not only persons with mental illness and their families, but also has an impact on the availability of services, the Division contracted with the Minnesota Department of Health, Division of Health Promotion to research, plan, develop, promote and implement a project about stigma and mental illness and to develop related media materials.

An advisory committee was selected to assist with the development of recommendations for the campaign. The committee included representatives from the Alliance for the Mentally Ill, the State Advisory Council, the Mental Health Association, consumers and family members. Literature was reviewed, experiences of other states and national organizations solicited, and consumer and family opinions about how stigma affects their lives gathered. The advisory committee discussed options and recommended development and distribution of a kit for counties and local advisory councils (LACs) to use in building coalitions and educating segments of their communities about mental illness.

Additional input was gathered from potential users of the kit, including LACs, county staff and other state experts about the target audiences for the proposed kit distribution, the overall message of the campaign, and identification of stigma-related concerns. They recommended that the materials reach a variety of groups within communities, asking that the kit include sections on organizing communities; mental illness and housing; employment; mental illness and community responsiveness; mental illness in the public eye; and resources.

After further research, a kit containing a collection of ideas and materials for promoting public awareness and community acceptance of mental illness and those who suffer from it was developed. The theme, **Understand mental illness. Every mind matters**, communicates the project's goals of increasing mental illness awareness and understanding, reducing misperceptions associated with mental illness, and improving community acceptance of persons with mental illness. The kit provides tips and tools for community use to create locally-directed public awareness and anti-stigma efforts.
Funding for development and production of the kit was provided by

a $100,000 state Mental Health Special Projects grant and resulted in distribution of approximately 500 kits to: community organizations including 28 Alliance for the Mentally Ill chapters, 18 Mental Health Association chapters, and 9 Educational Cooperative Service Units (215): consumers (5): family members (10); county social service agencies (105); mental health centers (42); and LACs (90). Additional kits were distributed to the media. An estimated 80 kits remain to be distributed on a "first come, first serve" basis.

DHS mailed an evaluation form to county agencies, LACs, advocacy groups and mental health centers a week after the initial mailing of 144 kits. Respondents included county social service agencies (35%), LACs (30%), community mental health centers (14%), Mental Health Association chapters (5%), and Alliance for the Mentally Ill chapters (20%). Twenty-eight percent indicated that few, if any, mental illness awareness activities had occurred in their community in the past year. Respondents were quite positive about the kit, with top ratings being given for the kit's quality, accuracy, comprehensiveness and usefulness. Respondents provided a number of examples of how the materials, information and ideas in the kit are being used, as well as a variety of comments, such as:

> "Best I've seen as it is very comprehensive and covers all aspects of stigma and how to overcome it";
>
> "Glad to see the Department giving grass roots organizations some help in our attempt to educate the general public about persons with mental illness. The materials are really fine. Thank you!"

Plans are in process to increase the utilization of the kits by obtaining designation of February 17-23, 1991 as Mental Illness Anti-Stigma Week. An outline for coordinating a statewide campaign has been developed. The focus would be on educating the general public about people with mental illness, asking Local Advisory Councils to select a particular issue and use the kit to plan events and/or activities for the particular week. Responses to the evaluations suggest this approach as a logical statewide extension of the direction that many Councils and advocacy groups are already taking.

XI. MENTAL HEALTH DIVISION GOALS

The 1987 and 1989 Comprehensive Mental Health Acts were based on the mission statements established by the 1986 and 1988 Legislatures. While progress has been made in implementing these Acts for adults and children, the goal of a unified, accountable, and comprehensive mental health system has not yet been met.

The reports included in this document show the Department's efforts during the past year to achieve that goal. The following Mental Health Division goals are the focus for efforts undertaken during FY 1991, as well as for emerging issues and initiatives.

Goal #1:

To plan for and promote development of high quality mental health services for children and adults.

Goal #2:

To assure that the quality of publicly funded mental health services meets the standards of the Comprehensive Mental Health Acts and best contemporary practices.

Goal #3:

To assist counties in the provision of high quality mental health services.

Goal #4:

To develop and manage resources for the provision of mental health services for children and adults.

Goal #5:

To monitor and evaluate the state's mental health service system for compliance with standards in law and rule.