1992 Mental Health Report

To The Legislature

Department of Human Services
Mental Health Division

Pursuant to MS245.461, sd 3; MS245.487, subd 4; MS 245.4873, subd 2; MS 245.4861 & 1991 Laws, Ch 292, Art 6, sec 57, sd 1

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February, 1992

Table of Requirements

This report meets the legislative requirements shown in the table below.

Requirement	Citation	Pages
Implementation of adult mental health services	§245.461, subd. 3	2 - 16 30 - 31
Adult residential treatment funding	§245.73	13 - 16
Implementation of children's mental health services	§245.487, subd. 4	17 - 26 30 - 31
State coordination of children's mental health services	§245.4873, subd. 2	19 - 22
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Executive Summary

The Comprehensive Adult Mental Health Act and the Comprehensive Children's Mental Health Act establish goals for two mental health service delivery systems, one for adults and one for children. Through the Acts, the Legislature assigns specific duties and responsibilities to the Commissioner of Human Services and to county boards. These duties are aimed at moving the two service systems toward greater unification, accountability, and comprehensiveness.

The Department of Human Services carries out its responsibilities by supervising development and coordination of local systems through a variety of processes, including promulgation and enforcement of rules, review of county plans, awarding program grants, demonstration projects, and special initiatives. Counties carry out their responsibilities by planning and directly managing service delivery at the local level. This report summarizes the current status of the adult and children's systems. It focuses on accomplishments pertaining to the major issues in each of these systems during 1991. The report also summarizes the administrative actions taken by the Department to enhance the unity and accountability of these systems.

ISSUES IN THE ADULT SYSTEM

The major issues in 1991 for the adult system were these:

- Can we increase the use of more appropriate, less costly, and less restrictive settings of care?
- In this environment of budget reductions, can we find new ways to fund programs without loss of service?
- Can state rules regulating service delivery be brought up to date with legislation and with current trends toward fewer procedural requirements and more outcome-oriented requirements?

KEY ACCOMPLISHMENTS IN THE ADULT SYSTEM

Anoka Alternatives Project The Anoka Alternatives Project is an example of how more appropriate and less restrictive service programs can be developed for clients. This project has been successful in moving more than 100 "difficult to treat" regional treatment center patients into community-based programs. It demonstrates that with adequate community support services available in counties, including housing support services and subsidies, use of the more costly and restrictive institutional settings can be reduced.

MA Funding Use of federal Medical Assistance for services such as Rule 74 case management was increased in 1991. This is part of a large percentage increase over recent years in federal, state, and local funding for community nonresidential services.

Rules The Department opened all rules governing adult mental health services to reexamination in 1991. Each rule will be brought into line with current legislation and will be reoriented as much as possible away from process-related requirements to outcome-based requirements.

ISSUES IN THE CHILDREN'S SYSTEM

The major issues for the children's system in 1991 were the following:

- Is development and delivery of services proceeding as desired?
- Can the various state agencies governing children's programs be organized to bring about greater coordination--i.e., fewer conflicting or duplicative policies and procedures?
- Can local mechanisms of coordination be implemented?

KEY ACCOMPLISHMENTS IN THE CHILDREN'S SYSTEM

Service Delivery The Department added professional home-based treatment for children and their families to those services covered by Medical Assistance, and issued grants to 53 counties for provision of family community support services. These additions to the range of services available around the state will begin to help fill some of the "gaps" experienced by children and families in need of care.

State Coordination The longstanding problem of various state agencies funding and regulating programs for children, without adequate coordination, was addressed in 1991 by the State Interagency Coordinating Council (SICC). This council is composed of representatives from the state departments of human services, health, education, state planning, and corrections. In 1991 the Departments of Human Services and Education published two manuals for service providers, which help to establish a common language base among agencies. The Council also supported the Department in developing several multi-agency requests for proposals (RFPs).

Department staff completed the preliminary stages of a study of the feasibility of integrating children's mental health funding. As required by the 1991 Legislature, a task force is being established to continue work on this study with the Department, and to develop final recommendations for the 1993 Legislature.

Local Coordination Local coordination of service delivery to children and their families has been improved through establishment of Local Coordinating Councils (LCCs) in the counties. The LCCs are composed of representatives of mental health, social services, education, health, corrections, and vocational agencies, as well as consumers and providers. Each LCC is responsible for developing interagency agreements with providers to coordinate delivery of services.

ADMINISTRATIVE CHANGES

The Department made several internal organizational changes in 1991, and several changes in the way in which it interacts with counties, service providers, and other local stakeholders, to bring about greater unity and accountability in the adult and children's systems.

Organizational changes included assigning a single Assistant Commissioner to manage the Mental Health Division, the Residential Program Management Division, and the nine regional treatment centers of the Department; appointing an experienced manager and clinician to the role of Director of the Mental Health Division; and improving collaboration among Departmental divisions that administer mental health funds. The Department also made some changes in its resource base, including developing a recommendation for recapitalization for only one regional treatment center, and shifting federal dollars to crisis services.

Unity and accountability of the service systems was improved by establishing several new approaches to interaction between the Department and local stakeholders. These include meetings to foster direct communication, emphasizing technical assistance over punitive reactions to deficient local plans, and engaging local stakeholders in writing and revising rules based on program outcomes rather than detailed procedural requirements.

Introduction

This document comprises several reports meeting requirements of Minnesota Statutes (see Table of Requirements). Part I reports on implementation of the *adult* mental health services system as defined in the Comprehensive Adult Mental Health Act (with 1991 amendments). Part II reports on implementation of the *children's* mental health services system as defined in the Comprehensive Children's Mental Health Act, and contains the annual report of the State Interagency Coordinating Council. Part III provides brief reports on special initiatives undertaken by the Department.

The information provided here is intended to convey progress toward implementation of the Mental Health Acts. Persons wanting more detailed information, or information on mental health programs not discussed in this report, should contact the Department of Human Services, Mental Health Division, 444 Lafayette Road, St. Paul, MN, 55155-3828, (612)-296-4497. More detail on mental health services funding, and on the recommendations of the Department for additional programs and resources, is available in *Mental Health Report to the Legislature 1991*.

It is important to point out that the Department of Human Services is not the only agency involved in implementation of the Mental Health Acts. Each county responds to the requirements of the Acts in its own way, primarily through its contracts with service provider organizations. Mental health advocacy groups and advisory groups help to shape policy and procedures governing delivery of services. Consumers and families participate in many of these groups. The Legislature controls appropriations of state funds that support implementation. This report addresses only those accomplishments made within the programs and projects formally authorized by the Legislature for administration or supervision by the Department.

Statistical information, tables, and graphs presented in this report are produced from data collected by the Mental Health Division of the Department, either directly from service providers and counties, or from databases operated by other divisions of the Department, such as the Medical Assistance Claims System.

I.

Implementation of the Comprehensive Adult Mental Health Act

The Comprehensive Adult Mental Health Act outlines the features of a unified, accountable, comprehensive system of services to adults. It assigns duties and responsibilities to the various organizational components of that system, particularly the Department of Human Services and county boards. The Department carries out its responsibilities through the administration and supervision of various programs, projects, and initiatives, many of these involving grants to counties in support of service development and delivery. This report primarily addresses these efforts.

Because of the variety of organizations, programs, and funding mechanisms involved in providing services to adults with mental illness, the "system" of care, both at the state and local levels, tends to fragment. To the client, a fragmented system means having to travel to various locations to get what you need, and when getting there having to repeat administrative or assessment procedures. The system never seems to learn about you and improve in its response. From the perspectives of the service provider and administrative organizations, a fragmented system means watching clients "slip through the cracks," experiencing problems in matching clients to the most appropriate services, and suffering inefficiencies in the use of resources. Efforts to *unify* the system are efforts to solve these kinds of problems.

> ***"...severe mental illness is no respecter of persons...[these] disorders affect people of all ages, races, and walks of life."***
>
> ***"The underlying vision of community mental health is of mentally ill people living freely as an integrated and accepted part of the community...As long as mentally ill people are shunned and feared, they will not be truly integrated..."***
>
> ***"The settings in which mental illness is treated range from drop-in centers to major psychiatric hospitals."***
>
> ***"The diverse interventions and services needed by people with severe mental disorders are often provided by different agencies or persons, working under different administrative direction, and supported by different funding streams and levels of government."***
>
> ***"Knowing how best to care for those consumed by mental illness is possible only from a base of knowledge generated through research and from tested ways to put that knowledge into systematic practice."***
>
> -- from ***Caring for People with Severe Mental Disorders,*** National Institute of Mental Health, National Advisory Mental Health Council.

Injecting *accountability* into the system means establishing procedures that ensure funding sources, and the general public, that the services being provided are effective and do not put clients at risk or violate their rights. Monitoring procedures provide the administrative agencies with information about service delivery. These agencies then employ procedures for evaluating and redirecting parts of the system that fall short of performance expectations.

A *comprehensive* system is one that has the range of services necessary to meet all the needs of the population. These services must also be accessible. Under priorities established in the Act, each local system must provide a defined array of coordinated services (see Figure 1). Services assigned highest priority are: a) emergency services; b) services to adults with serious and persistent mental illness, including case management and community support services; c) services to adults with acute mental illness.

Although reaching maturity in provision of some of the required services, local adult systems of care are still undergoing significant development and, with recent budget reductions, major economic adjustments. During 1991, the main areas for continued development of the adult services system were these:

- Increasing the use of less costly and less restrictive settings of care.
- In a time of budget reductions, finding new ways to fund programs without loss of service or service quality.
- Revising state rules regulating service delivery, in order to bring them up to date with legislation and current trends toward fewer procedural, and more outcome-based, requirements.

Figure 1

Adult Mental Health Programs and Services

- ***Emergency Services***
- ***Case Management***
- ***Community Support Services***
- ***Day Treatment***
- ***Residential Treatment (Rule 36)***
- ***Outpatient Treatment***
- ***Community Education and Prevention***
- ***Regional Treatment Center Inpatient Treatment***
- ***Acute Care Hospital Inpatient Treatment***

The adult report addresses these issues by describing what has been accomplished during the last year in key programs and services, and through special projects. Key programs and services include: emergency services; case management; community support services, including employability, housing services, and services to homeless persons. Special projects carried out by the Department in 1991 are: the Anoka Alternatives Project, designed to assist Anoka RTC patients move into the community with support services; implementation of the federal Nursing Home Reform Act (OBRA);

downsizing of institutions for mental disease (IMDs); writing of an emergency Rule 74 for case management; and reexamination of several existing state rules reducing unnecessary mandates.

Prevalence of Adult Mental Illness

The prevalence of adult mental illness in Minnesota provides a basis for assessing the level of need for services, and their level of utilization.

According to studies conducted by the National Institute of Mental Health (NIMH) in the early 1980s, during any one month period an estimated 12.6% of the adult population has a mental illness disorder. Among the more severe disorders, an estimated 0.7% 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 of the state in 1990 (See Table 1). Table 1 also shows estimates of lifetime prevalence (mental illness at any time in one's life) based on NIMH studies. These estimates exclude persons residing in nursing homes and state-operated RTCs at the time of the survey. It is important to keep in mind that not all cases of mental illness are chronic, or longterm, and that definitions for categories of mental illness at the national level might not coincide with state definitions.

Prevalence of the disorders in Table 1 appear to vary by sex and age. Schizophrenia appears to occur equally among men and women, while women have a higher occurrence of affective disorders. Higher rates for most disorders are found among younger respondents, especially for those under 45. Affective disorders tend to decrease in prevalence after age 65.

Several national studies have produced estimates of rates of approximately 0.5% to 1.0% of the adult population having a disabling mental illness. However, none of these studies was targeted at estimating serious mental illness. In 1989, the National Center for Health Statistics, working with NIMH, conducted a nationwide random telephone survey to estimate the number of adults with severely disabling mental illness. While the results of the entire survey are not yet published, a pretest on a random sample found that approximately 1.0% of the adult population met national criteria for severely disabling mental illness. **Applying the 1% to Minnesota's adult population means that about 32,000 adults with a severely disabling mental illness are living in the state. This can be regarded as a reasonable estimate of the number of adults with serious and persistent mental illness.**

Table 1

Prevalence of Mental Illness Among Adults in Minnesota (estimated)

Disorders	1 Month Prevalence	Lifetime Prevalence
Any mental illness	398,817	699,513
Schizophrenia	22,157	47,478
Affective disorder	161,426	262,713

Although the prevalence of adult mental illness can be estimated, mental health service

use does not necessarily follow occurrence. For a variety of reasons, some persons with mental illness do not seek mental health care, or they may seek care from physicians or other non-mental health professionals.

Service Need and Numbers Served

Many of the state's estimated 32,000 adults with serious and persistent mental illness (SPMI) are in need of services from the public sector--that is, services provided directly by state and county human services agencies or by their contracted and grantee providers, and paid for by public funds. Table 2 contains rounded estimates of the number of adults who received public sector mental health services in state fiscal year (SFY) 1991.

The figures in Table 2 are based primarily on data reported by counties and their providers through the Community Mental Health Reporting System (CMHRS). For case management, day treatment, and outpatient treatment, the figures also include clients who received services reimbursed through Medical Assistance but not reported through the CMHRS. The acute care hospital SPMI figure is estimated from 1987 data analysis showing that 74% of Medical Assistance inpatient billings are for clients with diagnoses of a serious and persistent nature. Case management figures are slightly lower than figures published in the *Mental Health Report to the Legislature 1991*, because of improvements made in provider reporting systems that better differentiate Rule 74 case management from general case management.

Some questions about service need have to do with the needs of clients, those persons already in the service system. Clients move from one type of service or program to another, or can sometimes be transferred from more costly or restrictive settings such as hospitals to community settings, with no loss in treatment effectiveness.

In an effort to estimate the level of service need among adult clients, the Department contracted for a survey in the RTCs in 1989 and in community support programs and residential programs in 1990. The Department conducted a similar survey of RTCs in 1991.

Table 2

Number of Adults With Mental Illness Served by Public Funding During SFY 1991

Type of Service	With SPMI *	With Any Mental Illness
Outpatient	13,000	53,000
Rule 74 Case Management	8,300	11,000
Community Support and Day Treatment	10,100	11,400
RTC Inpatient	3,350	3,350
Acute Care Hospital	3,900	5,300
Rule 36 Residential	2,600	2,800
Any MH Service **	19,000	64,300

* Serious and persistent mental illness.
** Unduplicated totals.

In both RTC surveys, RTC staff indicated that approximately 25% of the non-forensic mental health clients could be housed and treated in the community. In the community survey,

only 3% of clients were rated by community program staff as needing more intensive treatment such as RTC, forensic hospital, or a nursing home. Among the community programs there appears to be a demand for even less restrictive housing and treatment. Staff at the more intensive residential programs (Category I Rule 36) indicated that 37% of their residents could live in mainstream housing with support services. In the less intensive residential treatment (Category II Rule 36), staff put 22.5% of residents into this group. These studies suggest that the services system can and should accommodate a more rapid transfer of clients into less costly and restrictive community settings.

Emergency Services

Provision of locally available mental health emergency services is the highest priority of the Adult Mental Health Act. Preliminary findings of a Department survey on emergency services indicate that these services are being provided as prescribed in the Act. In all counties, emergency services includes assessment, crisis intervention, and appropriate case disposition, as well as access to a mental health professional.

Rule 74, governing case management to adults with serious and persistent mental illness, was modified in 1991 to require that a case manager who has reason to believe that a client might need or use emergency services must provide the client the information necessary to access the services. The case manager must also obtain information about the client's use of the services, and inform all persons who need to know of this use.

Case Management

The Comprehensive Adult Mental Health Act requires that county boards make case management services available to all adults with serious and persistent mental illness residing in the county. Provision of the service is required in all cases where the adult requests or consents to receive the service.

The model of case management employed in Minnesota is often referred to as "targeted case management." In this model, the case manager's role is advocacy, assisting clients to gain access to a broad array of mental health and other services, including medical, social, educational, and vocational. As implemented by Rule 74, it sets forth qualifications for staff and requires monthly contact with clients and ongoing monitoring of service activity and client well-being. Coordination of service delivery is a key component of case management activity, along with development of a functional assessment and community support plan for each client. Minnesota now has about 175 Rule 74 case managers.

Several enhancements were made to the Adult Mental Health Act in 1991 that are intended to increase the flexibility of case managers and to provide incentives for delivering the service. These enhancements will be implemented through revision of Rule 74. Through a reexamination of the theoretical basis and practicality of the rule, the following changes were drafted by the Department in 1991, and were made part of an emergency rule effective December 27, 1991.

- A reasonable maximum caseload limit was set at 40 clients to each FTE case manager.

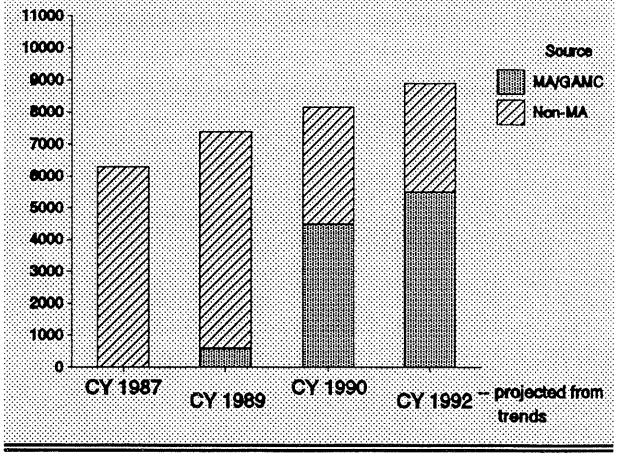
- Medical Assistance reimbursement was expanded to include case manager in-county travel time, within the six-hours per client per month limitation on services.

To help ensure service quality around the state, the Department developed a method for onsite monitoring of case management. A pilot of the method suggested several problems in the way case management is being delivered. In many counties, and in a high proportion of cases statewide: a) intake procedures do not clearly establish when a case is opened for case management, b) client diagnostic records do not indicate whether the client meets the criteria for serious and persistent mental illness, and c) functional assessments are not completed on a timely basis. Findings from the monitoring effort helped to bring about some of the changes in emergency Rule 74 and to establish priorities for further program development.

Data reported to the Department by providers of case management suggest that enrollment is leveling off after initial sharp increases. The slowdown of enrollment suggests that counties might be reaching their limit of eligible clients, or the limits of the county's capacity to provide the service (e.g, caseload size). However, the improved ability of providers to report this service more precisely could also account for the leveling pattern--i.e., non-Rule 74 clients were included in some early reports.

Because Medical Assistance (MA) funding is important to the success of the case management model, the Mental Health Division monitors billings to this source. Figure 2 shows that the number of clients for whom case management is billed to MA is increasing along with the overall number of case management clients. The *proportion* of clients served through MA, relative to all case management clients, is also increasing. The increase in MA billings is in part due to technical assistance efforts made by the Department, including the automation of the billing procedure in most counties.

Figure 2
Number of Adults With SPMI Receiving Case Management (by pay source)



Hours of service billed to MA is another indicator monitored by the Department. The statewide percentage of Rule 74 case management hours billed to MA was 56% for calendar year 1990.

Need for case management, when defined in terms of hours of service per client, is not being met around the state. Average hours of service per adult with SPMI increased from 6.5 hours per year in 1989 to 13 hours per year in 1990; however, the Department still regards this level of service as minimal at best and expects continued increase in 1992. A survey conducted in June of 1990 showed that the average ratio of clients to case managers was 46:1. This high ratio would account for inability to make an adequate number of contacts per client, and was the reason for limiting caseload ratios to 40:1 in

emergency Rule 74.

The major problems in implementing sufficient levels of case management appear to be lack of provider flexibility due to regulation, and inadequate incentives. The requirements established in law and rule are intended to ensure quality of service; however, these same safeguards are felt in some cases to "tie the hands" of providers. Further, the reimbursements available through MA are felt by some providers to be inadequate incentive for increasing the level of service. Changes to Rule 74 have been, and will continue to be, designed to overcome these problems.

Community Support Services

The Comprehensive Adult Mental Health Act requires that county boards make sufficient community support services available to meet the needs of adults with serious and persistent mental illness who are residents of the county. These services must be designed to help clients live and function effectively in the community. As a result, these services should reduce the need for, and use of, more costly and restrictive placements into hospital and residential programs.

A complete community support services program (CSP) includes all the services shown in Figure 3. All 87 counties now make most of these services available to their residents. Many counties, however, do not yet provide the complete array of services. The Department employs a fulltime staff person to assist counties in developing and operating community support programs.

At the end of 1991, about 25% of the state's estimated 32,000 adults with serious and persistent mental illness were receiving community support services. Data reported to the Department by counties and providers show approximately 7800 of these adults receiving community support services in SFY 1991, and about 3600 receiving day treatment. The total for community support and day treatment combined (and unduplicated) was about 10,100, a 19% increase over SFY 1990 figures.

The amount of state funds granted to counties for provision of community support services totaled $10,958,000 in SFY 1991. Appropriate use of these funds is defined in Rule 14. A local 10% match is required for receipt of the state funds.

Figure 3

A Complete Program of Community Support Services (with case management)

- client outreach
  - crisis assistance
- psychosocial rehabilitation
  - housing support services
- medication monitoring
  - assistance in independent living skills
- help in applying for government benefits
  - development of employability and work-related opportunities
- day treatment

Several changes in the way community support services are administered were made during 1991.

- A draft of Rule 15, which will establish state standards for community support programs, was completed.

- The Rule 14 grant application process was streamlined and integrated with county mental health plans.

- Several demonstration projects were extended, which are aimed at converting former Rule 12 (residential treatment) funds for use in providing community support services. Over 70 persons have received services through these projects.

- A method for determining the effectiveness of community support programs, on a statewide basis, was developed by the Department. This method will undergo field tests in 1992.

This year will see more efforts to make community support services more culturally sensitive. A further goal is expansion of the housing support and employability services.

Employability Services

Under an interagency cooperative agreement with the Department of Rehabilitation Services (DRS), the Department established four new employability pilot projects in 1991 for adults with serious and persistent mental illness. Beginning in January, 1992, these projects will serve 6 counties and approximately 100 adults, by providing single-site, competitive employment. Each project will undergo rigorous evaluation by the Department, with assistance from the Stout Vocational Rehabilitation Institute at the University of Wisconsin-Stout. The purpose of the evaluations will be to establish the degree of effectiveness of the services provided by the projects.

A total of $220,000 in state funds has been committed to the demonstration projects, $120,000 of which comes from the Department of Human Services.

Additionally, as part of its review of 87 county mental health plans in 1991, the Department examined the extent to which counties plan to meet legal requirements for the provision of supported employment services. The Department provided technical assistance materials to counties to help them implement and coordinate these services.

Housing Initiative

The 1991 Legislature approved the Department's request for a housing initiative that would address one of the most critical needs of persons with serious and persistent mental illness: stable, affordable, and safe housing in settings that maximize community integration and opportunities for acceptance.

The initiative consists of the four components shown in Table 3. The downsizing of IMDs (institutions of mental diseases) would capture new federal funding (Medical Assistance) for residents.

Although the four components of the housing initiative will not get underway officially until 1992, several projects administered by the Department in 1991 will provide a base from which to launch the new efforts. These are housing support pilot projects, the Anoka Alternatives Project, and the Rule 12 Alternative Demonstration Project.

The housing support pilot projects are discussed in the next section. The housing

initiative will expand upon the "good ideas" that have emerged from these projects, providing grant funds to support them in additional counties.

Table 3

Components and Funding of the Housing Initiative

Component	State Funding
Expansion of housing support projects to additional counties	$ 500,000
Development and implementation of a pilot housing subsidy program	1,000,000
Downsizing and converting of several Rule 12/36 IMDs	750,000
Conversion of Rule 12 residential program funding into housing support funding	***

*** Depends on number of counties and facilities participating

The Anoka Alternative Project, also discussed in more detail below, has been successful in developing the kinds of flexible, individualized supports and creative subsidies that allow former residents of regional treatment centers to maintain themselves in community housing. Knowledge gained from this project will be used in the housing initiative.

The Rule 12 Alternative Demonstration, discussed above in the community support services section, has provided former residents of Rule 36 facilities with housing support services and with a temporary housing subsidy that allows them to still qualify for a federal Section 8 certificate. The Department continues to monitor the outcomes of this project for information on how best to design subsidies. The Department has also worked with the Minnesota Housing Finance Agency (MHFA) to develop guidelines for their current housing subsidy program.

Housing Support Development

Since 1988, the Legislature has allocated funds for the development and implementation of housing support pilot projects. The purpose of these projects is to provide supportive services to adults with serious and persistent mental illness, which allow them to live in safe, stable, and affordable housing of their choice. The choice of housing is made from those living environments available to the general public. Examples of housing support services include help in locating housing, crisis assistance, landlord and roommate mediation, help in filling out forms, and transportation.

Eleven pilot projects are now funded in the state. In SFY 1991, 693 adults received services from these projects, at an average cost of $789 per person. The total amount of grants awarded by the Department for that year was $549,000.

The housing support pilot projects have demonstrated that increasing supportive services enables adults with serious and persistent mental illness to obtain and maintain safe and affordable housing of their choice. Minnesota does have the physical capacity to house all persons with mental illness in the state who are homeless, and the Mental Health Division will continue to work

with all appropriate agencies to ensure that those with serious and persistent mental illness have the financial capacity to access this housing. The Department was successful in receiving funding from the State Legislature for housing subsidies, and for an expansion of housing support services.

Mental Health Services to Homeless Persons

Research estimates that about 18% of homeless persons in Minnesota are adults with serious and persistent mental illness, most of whom are outside the reach of conventional mental health services. For the last five years, the Department has made special efforts to extend mental health services to this population. Grants have been provided to counties in which concentrations of homeless persons are known to exist, and these counties have been successful in identifying individuals in need of services and in delivering these services to them.

Examples of successful programs include those listed in Figure 4. The goals of these programs vary from site to site, but in general are aimed at providing mental health services to homeless persons, and at engaging entire local mental health systems in the provision of these services.

In SFY 1991, $705,000--federal ($359,000) and state ($346,000)--were expended on homeless projects in seven counties. More than 2,300 homeless persons received services through these projects. The funds also supported training of staff in 53 shelters, and of 57 staff in other mental health organizations.

Funding from the federal source has been inconsistent over the lifetime of this effort. With growing numbers of homeless persons in our society, the Department recognizes the need to continue existing programs and to expand the effort to counties with large concentrations of homeless and little or no services reaching them. Higher and more stable levels of state funding will be sought in 1992.

Figure 4

Successful Programs for Homeless Persons

- ***In Duluth, a HUD home was purchased and converted into a transitional home for homeless persons with serious and persistent mental illness.***
- ***In Moorhead, a drop-in center was created and subsequently expanded to provide outreach services in the community.***
- ***In Hennepin County, a new Salvation Army facility was developed, containing special homeless beds for persons with serious and persistent mental illness.***

OBRA Preadmission Screening (PAS) and Annual Resident Review (ARR)

The federal Nursing Home Reform Act requires states to screen all nursing facility (NF) admissions of persons suspected of having mental illness. The purpose of the screening is to evaluate the appropriateness of admission. Persons residing in NFs prior to implementation of the preadmission screening process must be evaluated as part of an annual review of residents to determine if they have mental illness. Residents determined to have mental illness must then be re-evaluated each year.

All 87 counties in Minnesota have implemented the PASARR process as of the end

of 1991. Approximately 1700 PAS evaluations and over 5000 ARR evaluations were made during the last year. Department staff provided twenty training sessions for county and facility personnel throughout the state, as well as ongoing technical assistance. In 1992, the Department will conduct more regional training sessions to keep pace with new federal regulations.

Figure 5

Specialized Mental Health Services For Relocated Nursing Facility Residents

- *housing support*
- *housing subsidies*
- *enhanced community support services*
- *friendly visitor services*
- *transportation assistance*
- *enhanced day treatment*
- *day care*

In 1989, the Department estimated that 300 persons in Minnesota were inappropriately residing in nursing facilities (NFs) due to mental illness. These persons would be better served in community mental health programs. All of these residents were to be relocated by June 30, 1992. However, data from actual reviews of individual residents revealed that 143 NF residents, not the estimated 300, were subject to relocation. As of December 31, 1991, 92 of these residents had already been relocated. Specialized mental health services are also being provided to those long-term NF residents who, under federal law, have the option of remaining in the facility.

The Department awarded grants to fifteen counties totaling $2,130,000 for this relocation effort.

Based on findings from the ARR process and because of changing federal regulations, in September, 1991, the Department submitted a revised plan to HCFA for relocating the remaining eligible residents, which would extend the deadline to December 31, 1992. Approval of the new plan has not yet been received.

Anoka Alternatives Project

The Anoka Alternatives Project was implemented in 1990 to increase the rate of discharge from the Anoka Metro Regional Treatment Center (AMRTC). The goal of the project is to develop alternative community services programs in the metro counties, and then to discharge into these programs those AMRTC residents who are ready for community living. The alternative services are to be flexible, individualized, mental health and supportive services, such as housing support and subsidies, enhanced inhome community support services, medications, home care and family supports.

Discharges through this project number well over 100 as of the end of 1991, exceeding projections. Data collected on these persons subsequent to discharge suggest that this group is representative of RTC residents in general in terms of diagnosis, functioning, and level of care needs, and that alternative services apparently provide the needed care at much less cost. Furthermore, rates of readmission for this group are lower than for other discharged patients.

The Anoka Alternatives Project's initial legislative authorization of $500,000 for SFY

1991 was decreased to $300,000 per year for SFY 1992 and SFY 1993, with the understanding that the Department might supplement the $300,000 with additional mental health funds. The Department has increased the SFY 1992 total to $370,000 and the SFY 1993 total to $430,000, as a result of lower than expected use of OBRA funding.

The Anoka Alternatives project has demonstrated that, with enhanced alternative services, many long-term and difficult to treat residents of regional treatment centers can be discharged to the community and successfully maintained there. Many of these persons are able to live in their own homes rather than in residential facilities. The success of the project argues strongly for expansion of the community based treatment and services system, and for creative, individualized approaches to service development.

IMD Downsizing

Federal regulations define an institution for mental diseases (IMD) as any facility with more than 16 beds, serving primarily people with mental illness. All IMD residents under 65 years of age are ineligible for Medical Assistance reimbursement for services, including doctor visits, dental care, and drugs.

Since 1988, the Department has been directly involved in efforts to reduce the number of beds in facilities currently classified as IMDs. The purpose of these reductions is to gain Medical Assistance reimbursement for services to residents of the facilities, and to improve the quality of these services.

As of the end of 1991, 11 adult residential treatment facilities (Rule 36) have been downsized, with a total reduction of 60 beds.

In addition to Rule 36 facilities, several nursing facilities will have to change their mix of residents in order to be undeclared as IMDs. Individuals who choose to leave these facilities will have access to new funding to meet their needs in the least restrictive community setting.

A new fulltime staff person was added to the Department's Mental Health Division in 1991 for the purpose of implementing the IMD downsizing and conversion process.

Regional Treatment Centers

Because noninstitutional treatment of mental illness offers more individual freedoms, is less costly, and is no less effective for many clients than institutional treatment, inappropriate use of Regional Treatment Center inpatient programs is a continuing point of concern for the state. Much of the thrust of the Adult Mental Health Act is toward development of community based alternatives, such as CSPs.

Table 4 shows the psychiatric bed capacities and average daily populations for the six RTCs serving adults with mental illness. Table 5 shows utilization levels for SFY 1991.

The statewide occupancy rate for December, 1991, was about 91%. (December is typically a low occupancy month.) The average number of days spent in RTC inpatient treatment per patient in SFY 1991 was about 130 days. (This is a *sum* of days for the year, not an average length of stay.)

Table 4

RTC Staffed MI Beds and Average Daily MI Population for December, 1991

Facility	Number Staffed MI Beds	Average Daily Population
Anoka	247	239
Brainerd	80	75
Fergus Falls	115	100
Moose Lake	210	187
St. Peter	176	159
St. Peter Security	236	218
Willmar	273	240
TOTALS	1337	1218

Table 5

RTC Utilization in SFY 1991

Facility	Number Adult Patients	Adult Patient-Days
Anoka	532	82,726
Brainerd	365	31,444
Fergus Falls	355	39,243
Moose Lake	416	69,618
St. Peter	895	140,352
Willmar	807	83,925
TOTALS	* 3350	447,308

* adjusted slightly for duplication

Rule Revision

During 1991 the Department reexamined four rules governing delivery of adult mental health services (see Figure 6). This reexamination process is preliminary to revision of the rules, which will be for several purposes:

- To make the rule more consistent with the Comprehensive Adult Mental Health Act.
- To eliminate any unnecessary mandates.
- To reorient mandates from process requirements to outcome-based performance requirements.

Promulgation of Rule 29 revisions is expected in 1992. Final revisions of Rule 14 and Rule 15 have been completed, but will be reexamined for outcome-based performance requirements. Rule 14 will be integrated with Rule 78.

Revision of Rule 36 is near completion. The revision addresses concerns raised by the Legislative Audit Commission (December 1989) relating to staff ratios, training, and qualifications. In addition, the proposed rule strengthens sections relating to client rights. The projected effective date for the newly revised Rule 36 is January 1993.

Rule 74 will be rewritten in 1992 to incorporate outcome-based performance indicators and will be integrated with Rule 77.

Figure 6

Department Rules Undergoing Reexamination

- **Rule 14/15, establishing requirements for community support services programs and standards of quality and performance for these programs.**
- **Rule 36, establishing standards of quality for state licensure of adult residential treatment programs.**
- **Rule 74, defining case management services to adults with serious and persistent mental illness and the requirements for Medical Assistance reimbursement.**
- **Rule 29, establishing standards for third-party reimbursement of services provided by community mental health centers and clinics.**

Funding and Costs Summary

Table 6 shows how funds supervised or administered by the Department have been distributed among the major types of adult mental health programs. Fiscal year 1991 dollars are compared to fiscal year 1987 dollars to demonstrate how funding has changed in recent years.

In 1987, funding for adult programs totaled approximately $150,277,000. Community nonresidential services comprised 27% of this total, community residential 18%, and community inpatient 18%. State-operated inpatient (RTC) funding comprised the remaining 37% of total adult funding. In 1991, the total funding for adult programs climbed by about 50% to $227,524,000. The community nonresidential share rose to nearly 32%, while community residential dropped slightly to 13%. The RTC share rose slightly to 38.5%.

Table 6

Distribution of Funding* Among Adult Programs *(dollars in thousands)

Program	FY 1987 Dollars	FY 1991 Dollars	% Change
Community Nonresidential	$41,054	$72,066	76%
Community Residential	26,272	30,002	14%
Community Inpatient	26,641	36,451	37%
subtotal	93,967	138,519	47%
State-Operated Inpatient (RTC)	55,670	87,652	57%
State Prevention/Admin	640	1,354	112%
TOTALS	$150,277	$227,524	51%

* Funds supervised or administered by the Department.

A large increase in funding from 1987 to 1991 occurred in community nonresidential services. This reflects increases in Rule 14 funding of community support programs, and increased use of Medical Assistance for case management and day treatment. However, the

dollar increase for RTC mental health was slightly larger than the nonresidential increase.

Table 7 compares estimated daily costs of adult service programs, depending on the client's residential setting. The least expensive settings are the larger Rule 36 residential treatment facilities (IMDs) and supported housing (community support programs); however, it must be kept in mind that the differences in client needs among these settings have effects on costs.

Table 7

Estimated Daily Costs of Adult Services By Residential Setting, 1991

Program or Service	Setting			
	RTC	Rule 36 (IMD)	Rule 36 (non-IMD)	Supported Housing
RTC	$197.50	0	0	0
Case Mgmt	3.10	3.10	3.10	3.10
Room and Board	0	25.60	22.50	21.00
Rule 36 Program	0	25.20	52.00	0
Day Trmt	0	12.10	12.10	20.00
CSP *	0	5.50	5.50	30.00
Outpat Trmt	0	2.20	2.20	2.20
Pharmacy	0	2.70	2.70	2.70
Periodic Hospitalization	0	3.00	3.00	3.00
Non-MH Medical Services	0	2.80	2.80	2.80
State Admin	**	0.35	0.35	0.35
TOTALS	$200.60	$82.00	$105.90	$84.80

* Community support program excluding day treatment.
** State administration for RTCs is included in the RTC per diem.

II.

Implementation of the Comprehensive Children's Mental Health Act

The Minnesota Comprehensive Children's Mental Health Act defines three basic requirements for development of the children's mental health system.

- Development and delivery of services.
- Coordination of policy making, funding, and administrative procedures among state agencies.
- Local coordination of service development and delivery.

Although children (under age 18) have been recipients of mental health services for years, the appropriateness and availability of these services has been questionable at best. The Children's Mental Health Act defines an appropriate and complete array of children's mental health services (see Figure 7) and requires development and delivery of these services in each county. Required dates of implementation vary from service to service.

Coordination of policy making, funding, and administrative procedures among state agencies is to take the form of quarterly meetings of representatives of the state departments of human services, health, education, state planning, and corrections. The State Subcommittee on Children's Mental Health, which advises the Department of Human Services, also provides a coordinating function at the state policy level.

At the local level, each county board must establish a Local Coordinating Council (LCC) composed of representatives from mental health, social services, education, health, corrections, and vocational agencies. County boards must also establish local advisory councils, composed of advocates, consumers, providers, and parents, that provide recommendations for the children's system.

Figure 7

Children's Mental Health Services to be Available in Each County

- **Emergency services**
- **Education and Prevention**
- **Early Identification and Intervention**
- **Outpatient**
- **Case Management**
- **Family Community Support**
- **Day Treatment**
- **Therapeutic Foster Care**
- **Professional Home-Based Family Treatment**
- **Benefits Assistance**
- **Screening for Inpatient and Residential Treatment**
- **Residential Treatment**
- **Acute Care Hospital Inpatient Treatment**

Prevalence of Emotional Disturbance in Children

Table 8 provides estimates of the prevalence of emotional disturbance among Minnesota

children. These numbers are based on rates determined in 1981, which are currently in use by the National Institute of Mental Health (NIMH). For children with severe emotional disturbance, the rate is 5.0% of the child population; for children with a limiting emotional disturbance, the rate is 11.8%; for children at high risk for emotional disturbance, 15-20%.

Table 8

Prevalence of Emotional Disturbance Among Minnesota Children (estimated)

Type of Disorder	Number of Children
Severe emotional disturbance	57,000
Emotional problem that limits functioning	134,000
High-risk group for emotional disturbance	171,000 to 228,000

Service Need and Numbers Served

Not all of the state's estimated 57,000 children with severe emotional disturbance (SED) are in need of services from the public sector--that is, services provided directly by state and county human services agencies or by their contracted and grantee providers, and paid for by public funds. Table 9 shows the estimated number of children in need of each service, while Table 10 contains rounded estimates of the number of children with SED who actually received public sector mental health services in state fiscal year (SFY) 1991.

Table 9

Estimated Number of Children in Need of Publicly Funded Mental Health Services

Service	Number of Children
Outpatient	20,000
Home-Based Treatment	2,800
Day Treatment	2,800
Family Community Support	2,800
Case Management	5,100
Therapeutic Foster Care	1,100
Residential Treatment	150
Inpatient Hospital	1,000
Est. Unduplicated Total	24,000

* Estimates of need are primarily based on Robert M. Friedman's study titled "Service Capacity in a balanced System of Services for Seriously Emotionally Disturbed Children," adjusted for Minnesota's population, service system design, and annual turnover rate.

The figures in Table 10 are based primarily on data reported by counties and their providers through the Community Mental Health Reporting System (CMHRS). For case management, day treatment, and outpatient treatment, the figures also include clients who received services reimbursed through Medical Assistance but not reported through the CMHRS. Client counts for some services are not yet available since they have only recently been implemented.

Table 10

Number of Children With Emotional Disturbance Served by Public Funding During SFY 1991

Type of Service	With SED *	With Any Emot. Disturb.
Outpatient	2,000	17,700
Home-Based Treatment	NA	NA
Day Treatment	400	770
Family Community Support	NA	NA
Rule 74 Case Management	320	1000
Therapeutic Foster Care	NA	NA
Residential Treatment	850	1500
Inpatient Hospital - Acute Care	700	700
Inpatient Hospital - RTC	175	175
Any MH Service **	2,900	19,000

* Severe emotional disturbance.
** Unduplicated totals.

In comparing Table 9 (need) with Table 10 (numbers served), several services appear problematic. The numbers of children with any emotional disturbance, which includes children with SED, who received day treatment and case management in 1991 are well below numbers in need of these services. The number who received residential treatment exceeds the number in need by tenfold. The need estimate for residential treatment is based in part on availability of less restrictive alternatives.

Changes to Administrative Structures and Rules

Both state and county human services agencies have made changes to children's mental health administrative structures and procedures. These are changes apart from establishment of interagency councils, which are discussed in detail below.

The Department established a new unit within its Mental Health Division to supervise statewide development of children's services systems. Although 1991-92 funding fell short of what is needed to carry out all the unit's responsibilities, the unit did grow by 2 positions.

The Department promulgated Emergency Rule 78 in December, 1991, which governs grant applications, approvals, and allocations for family community support services and case management to children with severe emotional disturbance and their families. The rule will be employed for the first time in April, 1992, in awarding Children's Community-Based Mental Health Grants to counties.

Emergency Rule 77, governing case management to children with severe emotional disturbance, was also promulgated in December, 1991. This rule sets program standards and clarifies requirements of the Children's Mental Health Act. Children with serious and persistent mental illness were also added to Emergency Rule 74 (see Adult Report). The Department will promulgate a permanent case management rule for children by January, 1993. The process of developing this rule will include an intensive look at outcomes-based regulations.

Rule 5 had not been revised for 20 years prior to 1991. In an effort to bring the rule more into line with current practice standards and current law, the Department made major revisions in 1991. Changes are so extensive and complex that the Department is requesting an extension of the original promulgation date from July, 1992 to January, 1993.

State-Level Coordination

The Children's Mental Health Act requires the commissioners of the departments of human services, education, health, state planning, and corrections, or their designees, to meet at least quarterly to develop mechanisms for interagency coordination. The State Interagency Coordinating Council (SICC) was formed in response to this requirement. The status and accomplishments of the SICC are covered in the next section.

In an effort to develop a holistic approach to providing children's mental health services, the Department has developed coordinated Requests for Proposals (RFPs) across state agencies. Two examples are described in Figure 8.

Figure 8

Two Examples of Multi-Agency RFPs

- **Counties and community mental health centers received an RFP for grants to support provision of family community support services. Grant recipients must demonstrate how they are collaborating with other agencies and counties in maximizing resources.**
- **Funds from the Departments of Human Services and Education will be made available to local coordinating councils to implement early identification and intervention services.**

Annual Report of the State Interagency Coordinating Council

Lack of coordination among state agencies that administer children's programs can result in conflicting or overly restrictive policies and procedures that negatively affect the ability of local agencies to deliver services.

The State Interagency Coordinating Council (SICC), formed in response to these issues, has several duties.

- Educate each agency about the policies, procedures, funding, and services for children with emotional disturbances of all agencies represented.
- Develop mechanisms for interagency coordination.
- Identify barriers to the delivery of mental health services to children.
- Recommend policy and procedural changes that will improve service delivery.
- Identify mechanisms for better use of federal and state funding in the delivery of mental health services for children.
- Prepare an annual report on the policy and procedural changes needed to implement a coordinated, effective, and cost-efficient children's mental health delivery system.

The Council has made substantial progress toward meeting its responsibilities as stated in the *1990 Mental Health Report to the Legislature*. Figure 9 is a summary of responsibilities.

The *1991 Mental Health Report to the Legislature* (Tables 30, 31, and 32) provides extensive information on: federal, state, and local funding of services for children with emotional disturbance; Medicaid and GAMC payments for MI diagnoses; and number of clients served in each department's system. Based upon the data and needs that were identified, and the recognition that Council agencies have clients in common, the SICC established a goal for 1991 to

write an interagency agreement for state agencies to assist the development and delivery of a unified, accountable, and comprehensive mental health service system in Minnesota.

Figure 9

Responsibilities of the SICC

- **State agencies should collaboratively develop training needed for multi-system service providers to help them clearly identify the target population for children's mental health services and to provide information on connecting with decision-makers who control access to services in other systems.**
- **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**
- **The Departments of Human Services and Education should cooperate in developing mental health community education programs and curricula to assist families and children in recognizing symptoms which may indicate the need for mental health services.**
- **Pooled funding and shared resources, rather than categorical funding, should be studied as a means to address the needs of the target population. If funding streams must remain discrete for federal purposes, state agencies should provide models for collaborative use of funds by local agencies.**
- **The Departments should develop interagency agreements to assure coordinated development of early identification and intervention services among systems serving children.**

To accomplish the task of establishing a joint agreement, the SICC worked to understand the issues, mission, priorities, and perspectives of each agency represented. The federal, state and local level rules, policies, guidelines, and definitions that establish their department mandates; target populations and eligibility requirements; budget and programmatic reporting cycles; and operational language were discussed.

Part of the process of reaching the joint agreement was to identify areas that are compatible among SICC agencies and any policy differences that exist. The next step will be to determine whether the differences are in terminology and intradepartmental rules, which can be changed, or in statutory mandates. The SICC is providing information for the preliminary report on the feasibility of establishing an integrated children's mental health fund. The Council will continue to work with the feasibility of integrated funding task force and to prepare its recommendations to the Legislature due in February, 1993.

The SICC has written a draft agreement which clarifies the mission and goals of the children's mental health interagency effort and identifies the individual and joint responsibilities of the state agencies represented. One of the goal areas in the agreement is the development of a single comprehensive plan for how the agencies will coordinate their activities to carry out the mission of the Act. A meeting will be conducted with the commissioners of the agencies at which time commitment to the policies of the Comprehensive Children's Mental Health Act will be reaffirmed and the goals of the agreement will be approved.

The Departments of Human Services and Education collaboratively developed and published two manuals for providers: *Developing Quality Services For Children and Youth Experiencing Emotional/Behavioral Disorders* and *Minnesota Identification And Eligibility For Children And Youth Experiencing Emotional Or Behavioral Disorders, 1991*. The manuals have been presented and distributed at statewide conferences sponsored annually by the following professional organizations: Association for Community Mental Health

Centers, Council for Children with Behavioral Disorders, State Directors of Special Education, Minnesota Mental Health Association, and the Human Resources Institute for County Commissioners. Local Advisory and Local Coordinating Councils have also received the materials.

A brochure entitled " The Mental Health Needs of Children and Youth" and a packet of information developed through an interagency effort by the Departments of Health, Human Services, and Education is being disseminated statewide to a wide range of professionals, advocates, and interested individuals.

An RFP for grants to govern funding for Children's Community-Based Mental Health Services has been distributed to counties and community mental health centers. These services are based on a service delivery system that is child-centered, family focused, community based, and recommends interagency collaboration. Counties will demonstrate how they are collaborating with other agencies by maximizing funding resources and leveraging other dollars and in-kind contributions to be used in the development of these services.

Finally, the Department of Human Services is initiating a new program of grants to Local Coordinating Councils to implement Early Identification and Intervention services. The program will include at least $400,000 in federal mental health block grant funds and $140,000 in funds from the Department of Education. The MHD is seeking matching funds from Children's Services, Departments of Corrections and Health, if available.

Children's Mental Health Funding

The Laws of Minnesota for 1991 require the Department to "convene a task force to study the feasibility of establishing an integrated children's mental health fund." This requirement overlaps with a requirement that the SICC report on how children's mental health services are currently funded. The task force is to report its recommendations to the Legislature in early 1993.

In 1991, the Department undertook preliminary work to provide the task force with information it would need to carry out its functions. The preliminary work included analysis of the following.

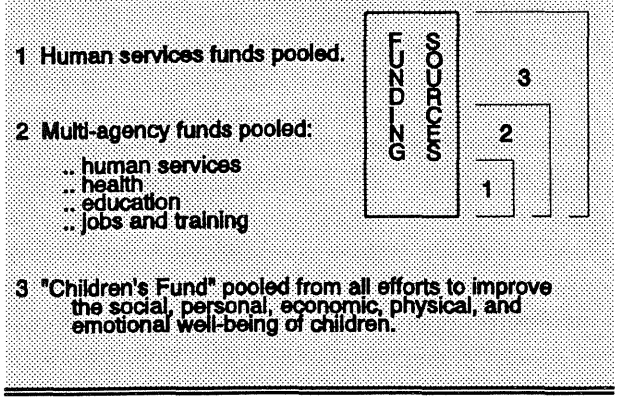
- The components of the current children's services system, and their interrelationships.
- Barriers to having an effective services system.
- Funding strategies that could result in removal of some of the barriers.

A key issue for the task force is to define what constitutes an integrated fund. Two basic concepts outlined by the Department are that of a "funding pool" and that of "agreed coverage." Agreed coverage means that those agencies paying for services reach formal agreement among one another on which services are paid by which agency. This removes overlap and confusion from the system.

Figure 10 represents the three most common concepts of a funding pool, each integrating a range of funding sources into a single, flexible source. Some of the funds that might be pooled are: Medical Assistance, Title XX social service, education and special education, chemical dependency, Title IV-E, funds for the developmentally disabled with dual diagnosis, community social services block grants, and community-based mental health grants.

The following three sections of this report incorporate some of the findings of the Department's preliminary study of the children's system.

Figure 10
Three Concepts of a "Pooled" Fund



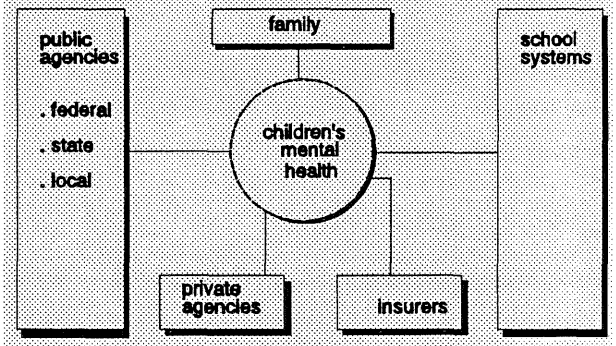
Components of the System

The children's mental health services system includes public and private agencies, planning and advisory groups, parents and other family members, schools, and insurers (see Figure 11). Public agencies include various agencies of federal, state, and local government. Private agencies are providers of service for the most part. All of these components of the system are concerned about the mental health of children and often must deal directly with the problems of those children experiencing emotional disturbance.

Parts of five state agencies are involved in the services system: 1) the Department of Human Services, 2) the Department of Education, 3) the Department of Corrections, 4) the Department of Health, 5) the Department of Jobs and Training. At the Department of Human Services, several divisions are involved, including the Mental Health Division which, in coordination with county human services departments, administers the public-pay side of the system.

The lines of connection in the diagram in Figure 11 are independent, meaning that each component, as formally structured, deals with children's mental health in its own way, making for an uncoordinated system. From the client's perspective, such a system leads to repetitive procedures and sometimes duplication of services, as well as scattered locations of service delivery. From the system perspective, conflicting policy can arise and actions taken by one component can have negative effects on the actions of another.

Figure 11
Components of the Children's Services System



Barriers to System Effectiveness

The Department's preliminary study of funding uncovered eight factors in the current system of service delivery that act as barriers to effectiveness. These are listed in Figure 12.

Current levels of funding for the children's mental health system fall far short of what is needed for full implementation of the Children's Mental Health Act. Where funding is not available, even eligible clients cannot receive services. For SFY 1993, the Department projects an unmet need of over $5,000,000 for services to public-pay clients. Services most in need of additional funding include: case

management, family community support services, day treatment, home-based family treatment, and therapeutic support for foster care.

Figure 12

Barriers to System Effectiveness

- **Funding not adequate**
- **Services not available**
- **Eligibility "gaps"**
- **Funding too inflexible**
- **System not coordinated**
- **Services not accessible**
- **Clients refuse service**
- **Cultural/linguistic problems**

Many of the mental health services needed by children and their families, including services mandated in the Children's Mental Health Act, are not available in many counties. Shortages of services are experienced in both metropolitan and outstate counties. Of critical concern are the nonavailability or underuse of case management and prevention/early intervention services.

Some clients have difficulty meeting the eligibility criteria for services. People with moderate incomes often cannot afford to pay for services themselves, and do not qualify for public assistance either. They are caught in the "gap" between.

Both private insurance and public assistance sources such as Medical Assistance limit the kinds of services covered, sometimes locking even those *with* resources out of needed services. As counties and providers run low on funds, doors to entire groups of clients can be closed.

Not only are funds inadequate, but the structure of the funding system, a collection of funding streams flowing from various sources to service providers, each with its own requirements for eligibility, often forces providers to match clients with a program or service that is not the optimal choice from a treatment standpoint. Nonlocal funding sources, such as Medical Assistance, are attractive to counties, but tend to pay for only the more restrictive and costly services, thereby providing financial incentives to treat clients in settings that are least desirable.

The systems of children's services, both state and local, are uncoordinated. The various components of the system, discussed above, typically do not communicate with one another in ways that ensure efficient and more effective service delivery. Although the Children's Mental Health Act established mechanisms of coordination, such as the State Interagency Coordinating Council and Local Coordinating Councils, the practicality of these mechanisms is yet to be demonstrated. Coordination efforts can consume so much time and resources that the primary work of those involved--service delivery, administration, etc.-- can suffer.

Even where services are available they are not always accessible. Clients without transportation can find it difficult, if not impossible, to get to the service setting. This problem might be more prevalent in rural areas, but even where public transportation is available, routes and schedules do not always meet clients' needs.

The child or the child's family has the right to refuse a service when offered, and evidence suggests that this is a common problem around the state. Some reasons for refusal include: a) lack of respect for what the system has to offer, b) fear of stigma, c) prior "bad experience" with the system, d) limits of parental schedules or energies, and e) desire to not open the family up

to observation.

Once in contact with the services system, some clients experience communication problems due to language differences, or cultural alienation. These problems often show up early in the continuum of care, in services like prevention, assessment, and early intervention, and can discourage clients from further use of the system.

Funding Strategies

The Department identified eight possible funding strategies to assist in dealing with the barriers of inadequate and inflexible funding. These strategies can be employed individually or in some combination. Some represent integrated funding strategies of the types shown in Figure 10. These strategies will be among many options to be studied and discussed during the coming year.

(1) Capitation is one approach to enhancing fund flexibility. The state would reimburse counties or providers a capitated amount for each eligible child.
(2) Multi-agency, categorical funds--such as child welfare, mental health, education, juvenile justice, public health--could be pooled into a single flexible pot from which counties or providers could draw.
(3) Expansion of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program under Medical Assistance promises to allow children across the multi-service system to receive mental health services.
(4) Use of the rehabilitation option in Medical Assistance would provide reimbursement for services outside the clinic.
(5) Expansion of mental health coverage among private insurers, HMOs, and company self-insurance groups can be brought about through changes in state law.
(6) Medical Assistance and Title IV-E can be used to a greater extent to cover costs of children's services.
(7) Reallocation of funds from other components to children's community mental health is an approach being used in other states.
(8) A medicaid waiver might permit flexibility of funding by allowing members of a target population to qualify for Medicaid as single-person families.

Local Coordination of Services

Two formal mechanisms now exist for coordinating services to children at the local level. Case management, a mental health service, is designed to coordinate at the level of the individual case. The case manager monitors the activity of each of his or her clients in the system and can intervene to ensure that needs are met without undue inconvenience or duplication.

The second coordinating mechanism is the Local Coordinating Council, required in each county by the Children's Comprehensive Mental Health Act. These councils are composed of representatives from mental health, social services, education, health, corrections, vocational services, juvenile court, law enforcement, and Indian Reservation Authority (where a reservation exists within a county). The LCC must meet at least quarterly to develop recommendations to improve coordination and funding of services to children with severe emotional disturbance.

In 1991, the Local Coordinating Councils were asked to complete a survey to provide information to the Department on: a) their activities, b) local planning priorities, c) barriers to coordinating services, and d) complications to providing collaborative mental health services for children and their families. Fifty-nine councils (69% of counties) responded to the survey.

LCC activities regarded as most helpful in assuring coordinated and cost-effective services

were: 1) learning about the other agencies represented on the council, 2) assessing availability of local children's mental health services, and 3) sharing data among agencies. The three top planning priorities were: 1) coordinating services, 2) planning for services, and 3) sharing of funds.

Most often mentioned barriers to service coordination and complications to collaboration are shown in Figure 13.

Figure 13

Barriers and Complications Most Often Mentioned by LCCs

Barriers to Coordinating Services

- **Inadequate funding**
- **Lack of attendance and participation by decision authorized representatives**
- **Lack of representation of all agencies**

Complications to Collaboration

- **Sharing of funds**
- **Information management**
- **Evaluation**

Collaborative ventures among local agencies require a considerable amount of time for producing and exchanging information, for planning how fiscal and human resources will be reconfigured, and for evaluation of the effectiveness of system changes. The results of the survey suggest that LCCs are struggling with the difficulties inherent in these efforts.

Respondents were also asked whether they have a local task force that has developed protocols and procedures to ensure coordinated and cost-effective community-based services. Eighty-eight percent of the councils responded that they did not have such a task force.

One of the duties of the LCC is to develop written interagency agreements with local providers, which coordinate service delivery. Fifty-four percent of the councils reported having no agreements at the time of the survey; thirteen percent reported having only one agreement. Day treatment and early intervention were the services most often involved in interagency agreements.

A detailed report on the results of the LCC survey will be included in the preliminary report for the feasibility of an integrated children's fund (see Children's Mental Health Funding above).

Finally, eight counties are participating in the Department's Children's Mental Health Demonstration Project, which is designed to allow interested counties to explore a variety of methods for implementing the Children's Mental Health Act. The experiences of these counties will be used collectively to provide the remaining 79 counties and the Department with information on the practicality of implementation.

III.

Special Initiatives

In addition to the efforts specific to adult and children's mental health that are described in the first two parts of this report, the Legislature has required the Department to develop three programs, or special initiatives, that include *both* adults and children.

Public-Academic Liaison

The Comprehensive Adult Mental Health Act requires the Department to establish a public-academic liaison initiative (PALI) 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 services to residents in regional treatment centers and other state facilities."

No appropriation has been made for this initiative, restricting the possibilities for awarding grants for research or for providing training, internships, scholarships, or fellowships for mental health professionals to work within state facilities. However, funds available through the NIMH grant to the Department for human resource development (HRD) in the state continues to foster some PALI activity.

HRD Project staff and the University of Minnesota, Department of Psychiatry drafted a joint application for consultation by the State/University Collaboration Project (S/UCP). 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. As a result of the consultation, the Department of Human Services (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.

Pursuit of these collaborative activities have been placed on hold pending the hiring of a Medical Director at DHS.

On April 26, 1991 the HRD Project sponsored a workshop entitled: State/University Collaboration: Mutual Benefits for Academic Community and State Psychiatry - Balancing the Needs of Research, Training and Public Service. The workshop brought psychiatrists and other mental health professionals together to discuss the respective missions of the different areas of psychiatric practice and the difficulties and benefits of a closer working relationship between DHS and the two psychiatric education programs in Minnesota.

HRD Project staff have facilitated successful discussions between Dakota County Community Services, the Dakota County Mental Health Center, the University of Minnesota Department of Psychiatry and the Mayo Medical School Department of Psychiatry regarding the establishment of a psychiatric residency program at the Dakota County Mental Health Center. Dakota County Community Services plans to include the creation of this residency program as part of their legislative proposal for a pilot project under the Mandates Reduction Act.

The Anoka-Metro Regional Treatment Center currently serves as an internship site for doctoral candidates in psychology through the University of Minnesota Hospital Consortium program. Staff at AMRTC have attempted to expand the internship opportunities for graduate students in psychology at AMRTC, but there are not sufficient funds available for any more internship stipends or to cover the costs of gaining APA accreditation. While the Minnesota Statutes 245.4861, Subd. 4. permits the liaison initiative to seek private funds for such efforts, the funding of a training program is a poor candidate for private foundation funding due to its ongoing nature.

Compulsive Gambling

There is mounting evidence that compulsive disorders associated with legalized gambling, and the personal and social problems that follow from these disorders, are on the upswing in Minnesota. The Legislature has taken a progressive stand by recognizing the need for services, including prevention as well as treatment, and in 1989 established the compulsive gambling initiative. The Legislature has provided funding for a gambling hotline, for training of mental health professionals, for a public awareness campaign, for outpatient treatment, and for research.

Since most of the legislative supervision for this program comes under a different set of committees than the other mental health services, the Department has published a separate annual report to the Legislature on compulsive gambling. This report can be obtained from the Department.

Indian Programs

Approximately $370,000 in federal block grant funds were used to support nine Indian mental health projects in the state in 1991. Each project received a grant from the Department to provide community support and education/prevention services to Indian children and adults. Over 2,000 clients received services during the year. Some of the funds were used to cover expenses of the Indian Mental Health Advisory Council.

IV.

Administrative Changes

The Department made several internal organizational changes in 1991, and changes in the way in which it interacts with counties, service providers, and other stakeholders, in an effort to establish greater unity and accountability in the adult and children's mental health systems.

Reorganization Within the Department

The Department made the following changes in its organization and resource base.

- Assigning one Assistant Commissioner to the Mental Health and the Residential Program Management Divisions.
- Appointing a new director for the Mental Health Division.
- Recommending recapitalization of only one regional treatment center.
- Shifting federal mental health block grant dollars to crisis services.
- Improving collaboration among Departmental divisions that administer mental health dollars.

The assignment a single Assistant Commissioner to the Mental Health and Residential Program Management Divisions, and the appointment of an individual with significant experience and credentials in mental health systems, underscored the Commissioner's commitment to implement the intentions of the Comprehensive Mental Health Acts.

The vacated position of Director of the Mental Health Division, which is responsible for implementation of the Mental Health Acts, was filled by an individual with a Ph.D. in clinical psychology and with extensive clinical, programmatic, managerial, and policy expertise, both nationally and within the Minnesota system.

The Department carefully reviewed plans for recapitalizing several of the state's regional treatment centers and developed a recommendation to the Department of Finance that only one of the centers be recapitalized.

The Department's plan for use of federal mental health block grant funds, submitted to the National Institute of Mental Health, was revised to include a shift of dollars to crisis services. Although prompt and effective crisis intervention is extremely critical to quality programming and the key deterrent to hospitalization, it had previously received the least emphasis by the Mental Health Division in implementation of the Mental Health Act. The Department expects to extend this shift of funds into the next biennium.

In addition to the Mental Health Division, the Residential Programs Management Division (RTCs) and Health Care Systems Administration

(MA/GAMC) also administer mental health funds. The Department has increased the extent of collaboration among these three divisions, in particular through routine discussions of issues and exchanges of data. Further, the Medical Director position is being rewritten to include oversight responsibility for mental health policy as it is defined for MA/GAMC and RTCs.

State-Local Collaboration

The Department instituted several new approaches to the ways in which it interacts with local organizations, including county agencies, service providers, advocates, and other stakeholders.

- Frequent meetings at the local level involving all stakeholders.
- Emphasizing technical assistance over penalty in review of county plans.
- Engaging the full range of stakeholders in writing and revision of state rules.

The local meetings have been held for the purpose of fostering direct communication among stakeholders, rather than indirect communications through the Department. This type of communication is expected to lead to enhanced unity of the mental health system.

In response to bitter complaints from counties that the Mental Health Division responded to deficiencies in local mental health plans by threatening to withhold funding, the Department has shifted to an increase in discussion with counties about the deficiencies and increased technical assistance without compromise of standards for care.

Finally, the Department is making two significant efforts to manage the writing of new rules and the revision of existing rules. First, it is engaging all types of stakeholders in a process of focusing rules on results, or outcomes, and decreasing emphasis on detailed procedural requirements. Second, it is simplifying the design of rules by combining case management requirements for adults and children into one rule, combining adult and children's community support services funding requirements into one rule, and removing MA funding requirements from mental health program rules and returning them to Rule 47.