1993 Mental Health Report to the Legislature

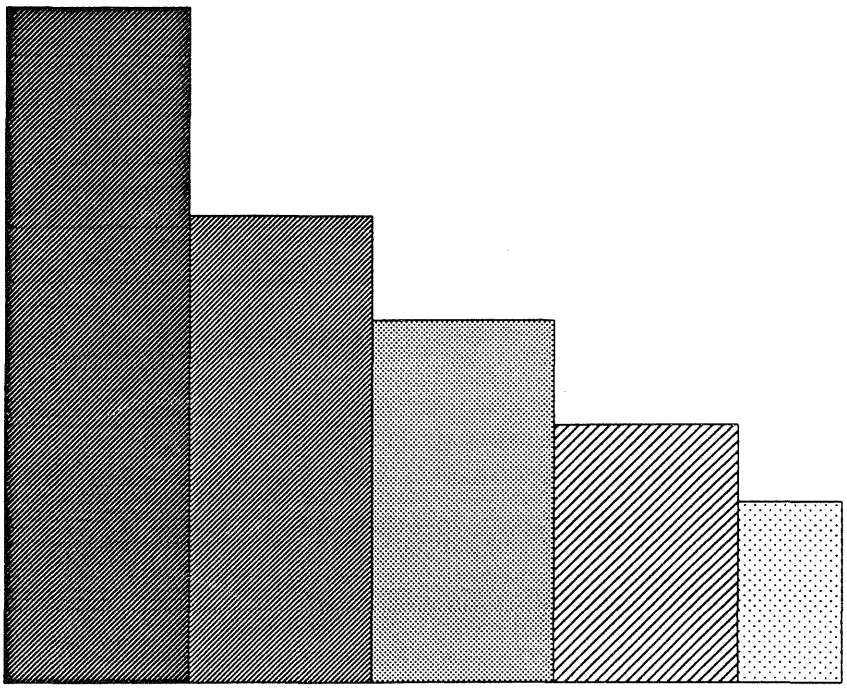


Table of Legislative Reporting Requirements

This report meets legislative requirements as indicated in the table below.

Requirement	Citation	Pages
Implementation of adult mental health services	§245.461, subd. 3	3-43
Implementation of children's mental health services	§245.487, subd. 4	3-43
State grants for adults with mental illness	§245.73	13-24, 28-40
State-operated community mental health programs	§253.28, subd. 3	45
Public-academic liaison initiative	§245.4861	44

See the following documents for additional information about recent developments in the public mental health system.

Document	Mandate
Children's Integrated Fund Report to the Legislature	Laws of 1991, Chapter 292, Article 6, Section 57, subd. 1
Legislative Report on the Minnesota Compulsive Gambling Treatment Program	§245.98, subd. 3
Minnesota's 1993 Mental Health Plan	P.L. 102-321
1992 State Mental Health Advisory Council's Report to the Governor and the Legislature	§245.697, subd. 3

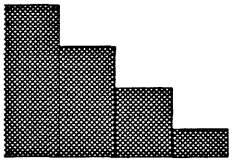
Minnesota Department of Human Services
Mental Health Division

1993 Mental Health Report

to the Legislature

February, 1993

Contents



Summary

This report summarizes the current status of the adult and children's public mental health systems in Minnesota, and describes what efforts to further develop these systems have accomplished during the period 1987 through 1992.

The Comprehensive Adult Mental Health Act of 1987 and the Comprehensive Children's Mental Health Act of 1989 define the type of system desired for each of these populations. They also define the responsibilities of the state mental health authority (the Department of Human Services, Community Mental Health and State Operated Services Administration) and county boards in developing these systems. This report is intended to convey the extent to which state and local government, as well as other organizations and individuals, have been successful since passage of these acts.

The major trends in system development since 1987 include: a) new and expanded community support programs, including case management, enhanced housing support, and individualized support programs, as alternatives to inpatient and residential treatment; b) new and expanded sources of funding at all levels of government; c) increased attention to the needs of special populations, such as adults with serious and persistent mental illness and children with severe emotional disturbance; d) identification of strategies for integrating services; and e) intensified planning and program evaluation activities.

Section I describes the status of the adult and children's public mental health systems as of the end of 1992, addressing the topics of organizational responsibilities, mission and goals, target populations and the prevalence of mental illness and emotional disturbance, the service array and its integration, service needs and utilization, and staffing. Although a comprehensive array of services is defined for both adults and children, the target populations of adults with serious and persistent mental illness and children with severe emotional disturbance still have significant unmet service needs around the state.

The critical issue of funding, its current status and trends, constitutes Section II. Adult services will receive a total of $280 million in public funding in FY 1993; children's services will receive $74 million. About 57% of adult funding will be for inpatient treatment, and about 31% will be for nonresidential community based services. For children, less than 19% of funding will be for inpatient treatment, while 36% will go for community residential treatment and 45% for nonresidential community services. While funding for all major service categories has increased in recent years, the largest percentage increases have been in the community programs.

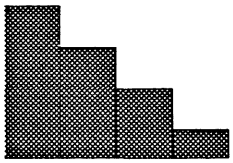
Section III summarizes the accomplishments that have been made since 1987 in developing the desired adult and children's systems of care. These accomplishments are defined in terms of the objectives established in state plans. The state has successfully defined in law a comprehensive array of services for adults and children. It has increased the share of federal funding by expanding the range of mental health services covered by Medicaid. It has also begun to address the problem of service and funding fragmentation by establishing mechanisms for coordination at the state and local levels.

Finally, Section IV contains two required reports, one on the public-academic liaison

initiative and the other on development of state-operated programs.

The organization of this year's report is different than in past years, and is intended to reflect greater attention to planning and results-oriented reporting. Reporting on most objectives takes the form of statistical, or quantified, information. This information is produced from data collected by the Mental Health Division of the Department of Human Services, either directly or from service providers and counties, or from databases operated by other divisions of the Department, such as the Minnesota Medicaid Information System.

Persons wanting more detailed information, or information about mental health policies, programs, etc. not discussed in this report, should contact the Department of Human Services, Community Mental Health Division, 444 Lafayette Road, St. Paul, MN, 55155-3828, (612)-296-4497.



I. Status of the Public Mental Health System

A. Organization

The Minnesota public mental health system is composed of three basic types of organizations: the state mental health authority (SMHA); the local mental health authority, the county board of commissioners, and its administrative agency; and the service providers contracted by counties. In addition to these organizations, clients and their families, advocates, local and state advisory councils, and the state legislature play key roles in shaping the system.

The Community Mental Health and State Operated Services Administration of the Minnesota Department of Human Services is the SMHA. This agency is under day to day management of an Assistant Commissioner. State law and federal regulations assign the following responsibilities to the SMHA:

- defining and disseminating statewide policy for mental health service delivery and administration, and monitoring compliance with established policy;
- coordinating development of statewide and local mental health system plans, including statewide goals and objectives;
- developing new programs of service and new or reorganized methods of service delivery;
- monitoring and evaluating the performance of local service delivery systems, typically with the county as the unit of analysis;
- developing and disseminating standards for service programs, service delivery, and administration;
- developing and providing programs of technical assistance to local administrative agencies;
- allocating funds to local systems and demonstrating the accountability of these systems to state and federal funding sources.

In addition, the SMHA operates six multidisability regional treatment centers (RTCs), a forensic hospital, and a nursing home that serve persons with mental illness.

State law assigns the responsibility of day-to-day administration of local community mental health systems to county boards of commissioners. Each county board is responsible for system planning, implementing and coordinating programs of service delivery among local providers, coordinating client care through case management, deciding how to allocate and expend public mental health resources, and reporting data and information requested by the SMHA.

The third type of organization is the service provider agency. Most of the services in local systems are provided by private agencies under contract with counties, although the counties themselves often provide some services directly. Outpatient services are typically provided by contracted community mental health centers (CMHCs), while private residential facilities, most under 16 beds, provide residential treatment to county clients. There are 26 CMHCs, 75 adult residential facilities, and 40 children's residential facilities in the statewide system.

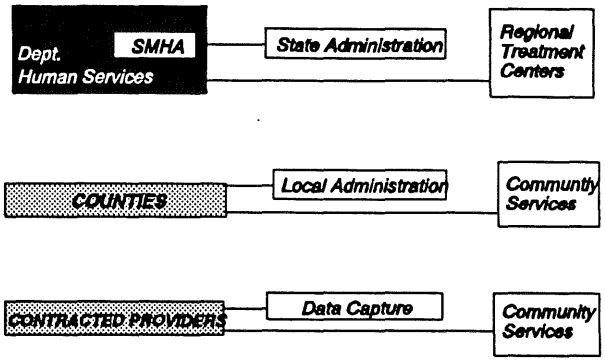
Counties also contract with community support service providers, or provide community support services directly. Most case management is provided directly by counties to their clients. Finally, inpatient treatment is contracted from private hospitals or is provided by the regional treatment centers (RTCs) operated by the SMHA.

The diagram in Figure 1 portrays, generically, the organizational structure of the publically funded mental health system in Minnesota.

In addition to the primary organizations shown in Figure 1, a state advisory council and a local advisory council in each county participate in the system. Membership on these councils includes consumers and families, advocates, providers, government staff, and others. The State Mental Health Advisory Council (SMHAC) serves as the state's planning council and includes a children's subcommittee of more than 50 members. It makes an independent annual report to the governor on the status of the mental health system and is a major contributor to the state's mental health plan.

The roles of the organizations that constitute the public mental health system are currently undergoing change due to resource shortages and a widely shared desire to reform the way in which public services are provided. Much of the change is aimed at finding ways to deliver services more efficiently, without loss of quality. Total Quality Management (TQM) philosophy and techniques are being implemented in the SMHA. This promises to redefine the state's role away from regulation, which produces friction in the system, toward support functions, such as problem identification and technical assistance, information support, policy analysis, and streamlined funding. For instance, data systems are now being used by the SMHA to identify possible problems in service delivery. Extreme values ("outliers") on performance indicators are noted in reports generated from the SMHA's databases. Counties and providers are expected to identify the reasons for these significant deviations, and may request technical assistance from the SMHA. Corrective actions are taken to move the indicator back toward the statewide norm.

FIGURE 1: Roles of Organizations



Clients and families, as well as organizations, participate in the planning and service delivery aspects of the system of care. They constitute part of the membership of state and local advisory councils with planning responsibilities. By state law and regulation, they must be included in the process of developing treatment plans and community support plans. They are consulted on an *ad hoc* basis by the SMHA on a wide range of issues and projects.

B. Mission and Goals

The mission of the mental health services system is described in two state mental health acts: the Comprehensive Adult Mental Health Act and the Comprehensive Children's Mental Health Act. The adult act defines an array of services to be implemented in each county, targeted to adults with serious and persistent

mental illness (SPMI) or acute mental illness. The children's act defines a service array for children with emotional disturbance (ED) or severe emotional disturbance (SED). Children's services have a family focus. For both the adult and child populations, the mission of the system can be summarized as follows:

> *Establishment of a comprehensive, unified, and accountable mental health service delivery system that effectively and efficiently meets the mental health needs of its target populations and helps its clients attain the maximum degree of self-sufficiency consistent with their individual capabilities.*

The primary goal of the organizations that compose the public mental health system is complete implementation of the Comprehensive Mental Health Acts. For both adults and children, this goal can be divided into six principal features. The desired system of care should be:

- *comprehensive* - provide a complete array of services;
- *unified* - planned, integrated, needs-based, with easily accessible programs;
- *accountable* - demonstrate fiscal control, professional qualifications, performance;
- *appropriate* - deliver services capable of meeting the client's needs;
- *effective* - meet the needs of the population and the individual; and
- *efficient* - produce desired results at less cost.

In addition, the system of care should ensure that client's rights are clearly explained, understood, and protected, and that clients are empowered to exercise choice in services.

C. Target Populations and Prevalence

The public mental health system targets adults with acute or serious and persistent mental illness (SPMI) and children with emotional disturbance (ED). As defined in state law, these populations are equivalent to the federal definitions of serious mental illness (SMI) for adults and serious emotional disturbance for children. Some of the state's services are designed exclusively for the more restrictive target populations of adults with serious and persistent mental illness (SPMI), and children with severe emotional disturbance (SED). Appendix A contains Minnesota's legal definitions for these more narrowly defined target populations.

Until new federal methods for estimating the prevalence of SMI and ED become available, the SMHA continues to rely on methods based on a flat rate. The new methods will allow for adjustments based on characteristics of the population that are known to be related to mental illness, such as age composition. The flat-rate methods, however, are unable to make such adjustments and produce rates for each county and for the state as a whole that are equivalent: 1% for the prevalence of SPMI in the adult population, 5% for the prevalence of SED among children.

Applying the 1% and 5% rates to Minnesota's population means that about 32,000 adults with SPMI and 57,000 children with SED are living in the state--see Table 1. Not all of these individuals, however, are in need of services from the public sector. The subject of service need is discussed below.

Table 1
Prevalence of Mental Illness and Emotional Disturbance in Minnesota
(estimated and rounded)

Type of Disorder	Number of Adults	Number of Children
Mental Illness (MI)	400,000	
Serious and Persistent Mental Illness (SPMI)	32,000	
Emotional Disturbance (ED)		170,000
Severe Emotional Disturbance		57,000

D. The Service Array

Figure 2 lists the services mandated in the Mental Health Acts for each county system. They compose a comprehensive array, ranging from inpatient to community support to prevention, and are based on a diversity of service needs in the target populations. For both the adult and children's systems, funding shortages have held back development of the community-based components of the array, and for the children's system in particular, integration of mental health with other systems serving this population is largely unrealized. Another problem facing development of the adult system is extensive reliance on the state-operated RTCs for this population. These facilities consume a relatively large proportion of total mental health funds.

Provision of locally available mental health *emergency* services is the highest priority of the Adult Mental Health Act. Typically, this service takes the form of a 24-hour phoneline with access to a mental health professional. It is important to distinguish this service from crisis intervention services, which are not mandated as a separate service, but for which several pilot projects are now being developed.

Figure 2
Adult and Children's Mental Health Services to be Available to Residents of Each County

Services to Adults and Children

- Emergency Services
- Education and Prevention
- Outpatient Treatment
- Community Support Services
- Case Management
- Community Residential Treatment
- Day Treatment
- RTC Inpatient Treatment
- Acute Care Hospital Inpatient Treatment

Services to Children Only

- Early Identification and Intervention
- Therapeutic Foster Care
- Professional Home-Based Family Treatment
- Family Community Support

Case management must be provided to any adult with SPMI or child with SED who requests or consents to receive the service; however, state regulations (Rule 79) allow counties considerable flexibility in the type of case management model they employ. In general, the case manager's role is advocacy, assisting clients in gaining access to a broad array of mental health and other services, including medical, social, educational, and vocational. Case manager qualifications and procedural and outcome specifications are defined by Rule 79. 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.

Community support programs (CSPs) and *family community support services* (FCSS) include outreach, housing support, day treatment, crisis assistance, employability services, medication monitoring, benefits assistance, psychosocial rehabilitation, and development of independent living skills. This entire range of support services, designed to help clients live and function effectively in the community, is to be available to the residents of each county. In addition to these "basic" CSP services, many counties, under special grants from the SMHA, provide enhanced or individualized support services. Enhanced housing support services, for instance, represent an intensive effort to locate or subsidize housing for clients. Individualized community support services are designed for the needs of specific client, as opposed to the usual approach of fitting clients into pre-established services.

In addition to FCSS, children's nonresidential community-based services include *integrated early identification/intervention* (EI/I), *professional home-based family treatment* (PHBFT), and *therapeutic support for foster care* (TSFC). Highest priority for development are EI/I and FCSS. Once these services are widely established, the SMHA will devote more resources to PHBFT and TSFC.

Inpatient treatment is provided to adults and children in acute care community hospitals and in the RTCs, while most *outpatient* and *day treatment* are provided by community mental health centers. Community residential facilities, most of which house fewer than 16 beds, provide *residential treatment* for those clients not needing inpatient care but not yet ready for independent living.

The Mental Health Acts largely represent an effort to develop and utilize the community-based, noninstitutional services while reducing reliance, to the extent appropriate to client needs, on the more costly and restrictive inpatient or residential treatment. Despite the legal requirements for development of alternatives to hospitalization, use of the RTCs has not fallen as dramatically as hoped. In part, this is due to resistance from the home communities of the RTCs, in part due to strong labor unions representing RTC employees, and in part due to shortages of funds for full development of alternative services.

In recent years the SMHA has taken a demonstration-first approach to developing new and better alternatives to hospitalization. In this approach, it is only after programs have demonstrated their effectiveness that efforts at statewide implementation are made. One important example of this demonstration-first approach is a project begun in 1990 to develop "enhanced," individualized community support services for residents of the Anoka-Metro RTC who were having difficulties remaining in the community. Most of the program's clients have avoided rehospitalization, and the SMHA is seeking funds to expand the program. Housing support programs have been developed and expanded in a similar way, and in 1992 the approach was applied to employment programs and crisis intervention services as well. Even successful demonstration programs, however, have encountered funding shortages in recent years, delaying statewide implementation.

In addition to the mental health services just described, clients in the public mental health system who are eligible for Medicaid receive the extensive range of health and dental services available through that program. Many of the adult clients not eligible for Medicaid are eligible for the state's medical care supplement program (General Assistance Medical Care) or the new MinnesotaCare program designed to ensure health coverage for persons of low income but above Medicaid requirements. Non-Medicaid children in families with incomes up to 275% of federal poverty are also eligible for the MinnesotaCare program. MinnesotaCare's

benefits package includes physician's services, vision care, prescription drugs, chiropractic services, lab, X-ray, home health, and immunizations, in addition to a limited amount of mental health services. Many mental health clients also receive social services, including employment, shelter, and child and adult protection.

E. Services Integration

Services integration is an important element in Minnesota's system of care. There are currently 2 county pilot projects underway with the aim of demonstrating methods of integrating state-funded adult mental health services. One of these projects will report its findings to the State Legislature in January of 1993.

Several children's services integration projects are planned for 1993. The SMHA and other state agencies have signed interagency agreements to develop state policy that fosters integration of children's services, and recently completed a report on barriers to integrated funding, including recommendations for several strategies to overcome these barriers. Integration of funding is seen as a necessary component of services integration. The SMHA has also applied for federal funds to support study of data system integration among local children's services agencies.

F. Service Needs and Numbers Served

Both the adult and children's systems stand short of complete implementation as defined in the Mental Health Acts. This deficit can be viewed from several perspectives: a) in terms of the elements of the desired system of care that are not yet in place; b) in terms of the extent to which the target populations are not being served, or not being served effectively; and c) in terms of the amount of resources still needed by the system.

Figure 3 lists those key elements of the adult and children's systems that are either not yet in place or, if in place, require substantial further development. Many of these missing elements are addressed in state plan objectives for 1993; others will be addressed in future plans.

Figure 3
Missing or Underdeveloped Elements of the Adult and Children's Mental Health Systems

- The full array of CSP and FCSS services available in each county
- Crisis services available in each county
- Services available to persons in corrections facilities
- Services to assist RTC discharges in transition to community
- Transition services for children becoming adults
- Early Identification/Intervention services in each county
- Mental health budgets adequate to support all mandated services
- Integrated funding streams and services
- A strategic plan toward full implementation of the Mental Health Acts
- Full participation by consumers and families in local advisory councils
- Statewide consumer organization
- Consumer/LAC liaison position in the SMHA
- Methods to evaluate the appropriateness of service to client need
- Cultural sensitivity and competence in service programs
- Methods for estimating service needs at county level
- Local advisory council recommendations incorporated in county plans
- RTC involvement in local planning and service delivery
- Single point of access to the system
- Statewide standards of service quality, utilization, funding, outcome
- Methods for evaluating the effectiveness of services
- Procedures for evaluating the efficiency of service provision

In addition to missing elements, unmet need in the service systems can be analyzed in terms of the extent of service penetration into the target

populations, in terms of levels of service effectiveness (in meeting client needs), and in terms of resource shortages. Minnesota does not yet have the technology in place to measure service effectiveness or human resource levels (client outcome and human resources data collection is just getting underway in selected program areas); however, data are available to determine unmet need in the areas of service penetration and financing.

Table 2 and Table 3 examine unmet need expressed in terms of penetration into the target populations. Unmet need is computed as the difference between estimated need and utilization (number of persons served). Estimated need represents a percentage, not all, of the prevalence--not all adults or children in need of services will need those services from the public sector. Until better methods for estimating public sector needs become available, 75% of adults with SPMI and 50% of children with SED are assumed to need the public system. (Note that service-specific levels of need are not yet established, although for children with SED, estimated need for individual services are available from a method of estimation described in Robert M. Friedman's study entitled "Service Capacity in a Balanced System of Services for Seriously Emotionally Disturbed Children." Also note that Table 2 and Table 3 do not include non-client specific services such as community education, and do not include clients served by pre-paid (HMO) Medical Assistance projects.)

Although the overall service need shown on the bottom line of Table 2 suggests the system is close to serving all adults with SPMI who need public services, because many clients in the system have needs in addition to the services they are receiving, the overall need figures mask more serious unmet needs at the service-specific level. The same is true for children with SED. Case management, for instance, is being provided to only 12% of the SED target population; FCSS to 6%; professional home-based treatment to 9%; and day treatment to 26%. It is in the outpatient, residential, and inpatient treatment categories that most of the children's need is being met. (Note that the negative unmet need for children's residential treatment reflects a reliance on this type of care in an environment in which nonresidential alternatives are not yet fully developed. When these alternatives are in place, the number of residential clients should decrease toward the level of need shown in the table.)

It is important to point out that the state's definition of SED was only recently promulgated (1989), and that data collection systems still reflect some difficulty, especially among outpatient treatment programs, in labeling child clients as SED. The outpatient SED utilization estimate in Table 3 is not highly reliable, and SMHA staff feel that clients in family community support services and children's case management are being underreported. Also, comparision of utilization to the Friedman estimates is complicated by the point-in-time nature of those estimates, and by the fact that the definition of SED used by that author is more restrictive than the state's definition. These two factors tend to underestimate the amount of unmet need in the SED population.

Table 2
Statewide Service Need, Utilization, and Unmet Need: Adults

Service	SMI			SPMI		
	Est. Need	# Served (SFY92)	Est. Unmet Need	Est. Need	# Served (SFY92)	Est. Unmet Need
CSP/Day Treatment	Not Available	12,500		Not Available	11,200	
Case Management		10,300			9,050	
Outpatient Treatment		50,700			14,800	
Commun Residential Treatment		2,900			2,600	
Commun Inpatient Treatment		6,000			4,500	
RTC Inpatient Treatment		3,500			3,450	
TOTALS (unduplicated)	300,000	57,000	243,000	24,000	22,600	1,400

Table 3
Statewide Service Need, Utilization, and Unmet Need: Children

(See narrative for explanation of reliability of numbers served.)

Service	ED			SED		
	Est. Need	# Served (SFY92)	Est. Unmet Need	Est. Need	# Served (SFY92)	Est. Unmet Need
Family Community Support *	Not Available	400		2,800	200	2,600
Day Treatment		750		2,800	750	2,050
Case Management		750		5,100	750	4,350
Professional Home-Based Trmt		300		2,800	300	2,500
Therapeutic Support/Foster Care		**		1,100	**	1,100
Outpatient Treatment		17,300		20,000	8,000	12,000
Commun Residential Treatment		1,300		150	1,300	(1,150)
Inpatient Treatment		800		1,000	950	50
TOTALS (unduplicated)	100,000	17,000	83,000	23,700	13,700	10,000

* FCSS other than day treatment, professional home-based treatment, therapeutic support.
** Data not available due to recent startup of service.

In sum, there is a significant amount of unmet service need in the state, measured in terms of service penetration. This unmet need is especially acute for the children's population and for specific community-based services.

Unmet need defined in terms of financing can be more clearly seen for children at this time than for adults. Table 4 compares the funding needed for each children's service (in 1992 dollars) to the FY 1993 level of funding. The difference defines unmet financial resource needs, which for the state as a whole is $13,650,000 not counting future increases already approved. The figures in Table 4 are derived from projections through 1997, incorporating phased-in development of children's services. Inpatient and residential services costs are held constant from 1992 through 1997 (zero growth), and outpatient services are increased only slightly. The community nonresidential and home-based services account for about 60% of total need and all of the unmet need. Some services, such as community education, emergency, and personal care attendants are not included in the table.

Table 4
Unmet Financial Need: Children's Services

Service	Total Need	Funded SFY 93	Unmet Need
Family Community Support *	$5,500,000	$2,360,000	$3,140,000
Day Treatment	6,500,000	6,300,000	200,000
Case Management	7,000,000	3,500,000	3,500,000
Home-Based Family Treatment	14,000,000	700,000	13,300,000
Therapeutic Support for Foster Care	5,000,000	1,400,000	3,600,000
Early Identification/Intervention	3,300,000	1,800,000	1,500,000
Outpatient Treatment	14,400,000	12,000,000	2,400,000
Commun Residential Treatment	23,600,000	26,300,000	-2,700,000
Inpatient Treatment	11,800,000	13,900,000	-2,100,000
Subtotal (current funding) **	$91,100,000	$68,260,000	$22,840,000
Less already approved increases (primarily MA)		$ 9,190,000	- 9,190,000
Additional Funding Needed			$13,650,000

* Includes all FCSS other than day treatment, home-based treatment, therapeutic support.
** SFY 93 figure is somewhat less than shown in Figure 8, Section II, because not all services are included in this table.

H. Service Issues

One of the key service issues today is whether patients in RTCs, when provided with individualized community support services, can live independently in the community without need for frequent rehospitalization. Table 5 shows the results of a recent survey of RTC staff who were asked to assess whether patients were ready for community living. The evidence in this table, reflecting mounting evidence on the national level, suggests that more patients than previously believed do not require institutional care, but do as well or better living in housing of their choice and with community support services tailored to their individual needs.

Table 5
RTC Staff Assessment of Patient Readiness for Community Living (1991)

Is patient now appropriate for placement into the community?	# Adults *	%
Definitely Yes	104	12%
Probably Yes	152	16%
Possibly	158	18%
Probably No	233	26%
Definitely No	255	28%
TOTAL	902	100%

* Does not include geriatric patients.

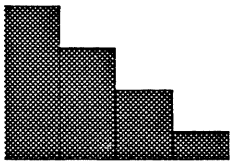
Another key issue in, related to services and funding integration discussed above, is how best to apply managed care arrangements in the public mental health sector. Several counties are already operating managed care systems for Medical Assistance (Medicaid) funded mental health services, and other counties and multi-county areas are now developing concepts that would incorporate a broader range of funding sources. In relation to the proposed closure of the Moose Lake Regional Treatment Center, the SMHA is investigating the feasibility of a managed care system in those counties within the Moose Lake catchment area.

A third key issue is the cultural appropriateness of services. Many of the state's citizens who belong to minority cultural groups find the system of care insensitive to their cultural backgrounds and are detered from entry.

G. Staffing

Data on staffing at the local level is still not available on a statewide basis; however, the SMHA has developed a method for ongoing collection of these data and will implement data collection in 1993.

The SMHA employs 23 professional staff in its community programs division and 13 in its RTC management division. These staff are responsible for providing direct assistance and training to counties, community services providers, and RTCs. Program specialists work to develop policy and programs in a wide range of areas, including: case management, community support programs, family community support programs, integrated early identification and intervention, pre-admission screening and annual screening of nursing facility residents, enhanced housing support and services to homeless persons, community residential treatment, and RTCs. Management specialists work in the areas of RTC management, local and state interagency coordination, financial policy and budgeting, grant making, planning, and information support. Staff reductions during 1992, and potential further cuts during 1993, have forced the SMHA to look for new, more efficient approaches to performing its role.



II. Funding

A. Mental Health Funds and Their Sources

Public mental health services are funded by all three levels of government--federal, state, and county. In some cases, two or more levels each contributes to a particular fund. Medical Assistance, for example, is composed of a federal share (54%) and a state share (46%). State grants to counties sometimes require a county match. Some funds are categorical, intended for a particular service or for use with a particular target population, and some take the form of block grants that offer a higher degree of local control and flexibility.

Federal funds for mental health services take the form of Medicaid (Medical Assistance), SSI, and the Federal Block Grant to the state mental health authority. The SMHA makes most of the block grant available to counties for special projects designed to demonstrate the effectiveness of new service programs. Counties also use their tax revenues to fund services, and to serve as matching funds for the state's CSSA block grant.

It is the flow of dollars from the state level to counties that is most complicated. Figures 4 and 5 portray these flows for adult and children's services. The names and abbreviations used in the figures, and elsewhere in this Section, are explained below:

MA: Medical Assistance (including federal, state, and local shares).

GAMC: General Assistance Medical Care (a state fund for low-income adults not eligible for MA).

Comm MH: Community Mental Health funds (including state allocations and grants for: CSP and FCSS [Rule 78], community residential services [Rule 12], early integrated identification and intervention, enhanced housing support, crisis intervention services, and services to homeless persons).

MinnesotaCare: A state fund for low-income families and children not eligible for MA.

CSSA: State block grants for social services, with 50% local match. Some go to mental health clients.

Title XX: Federal block grant for social services, passed on to counties with CSSA grant.

Title IVB: Federal grant for children's social services. Some go to mental health clients.

Title IVE: Federal reimbursement for children's out of home placements. Some go to mental health clients.

Family Preservation: State funds to support permanency planning for children. Some go to mental health clients.

GRH: Group Residential Housing for persons in adult residential treatment facilities.

RTC: Regional Treatment Center Fund (primarily state with small local match).

FBG: Federal Block Grant for mental health, most of which is passed on to counties by the SMHA for service demonstration projects.

Figure 4
SMHA Funding Flows for Adults

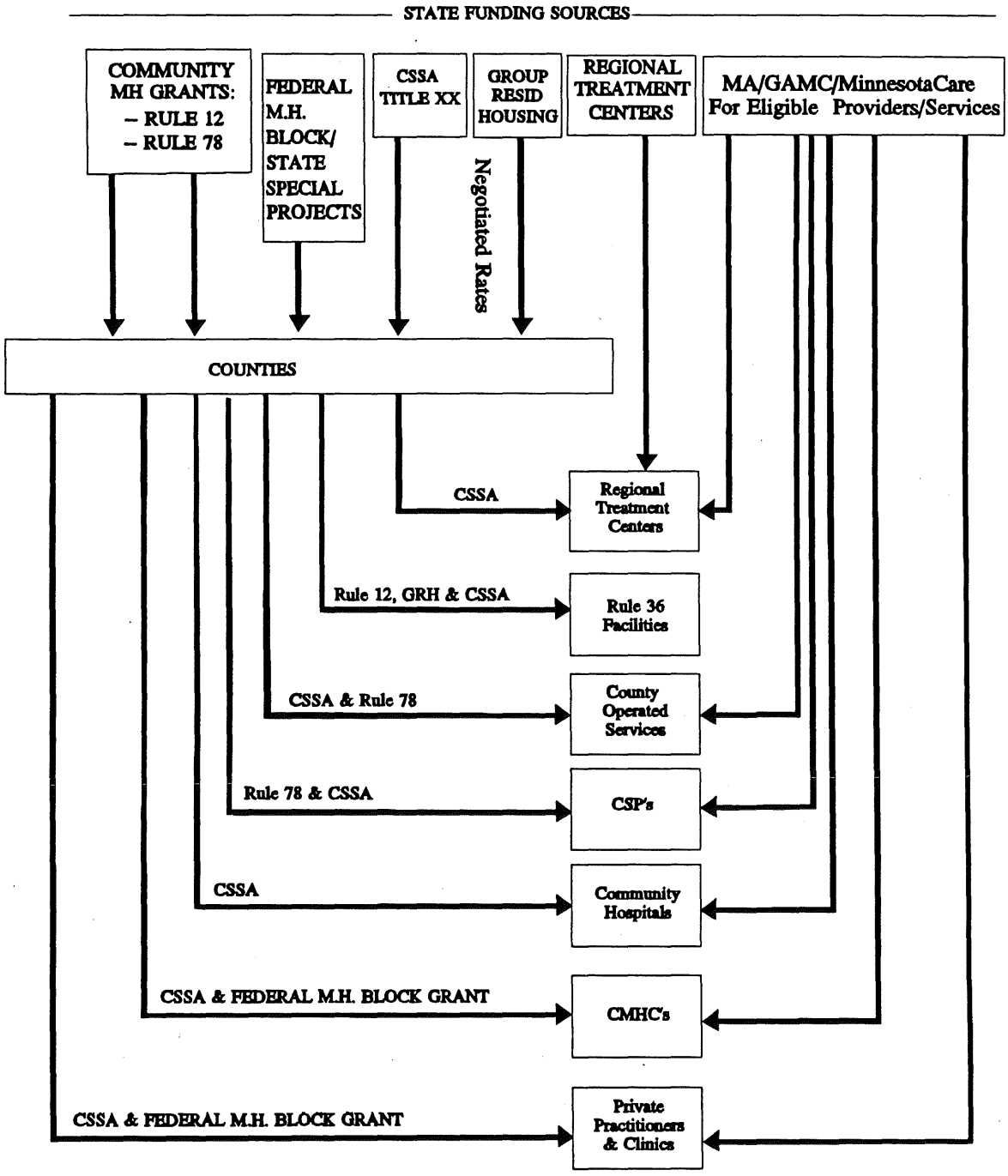
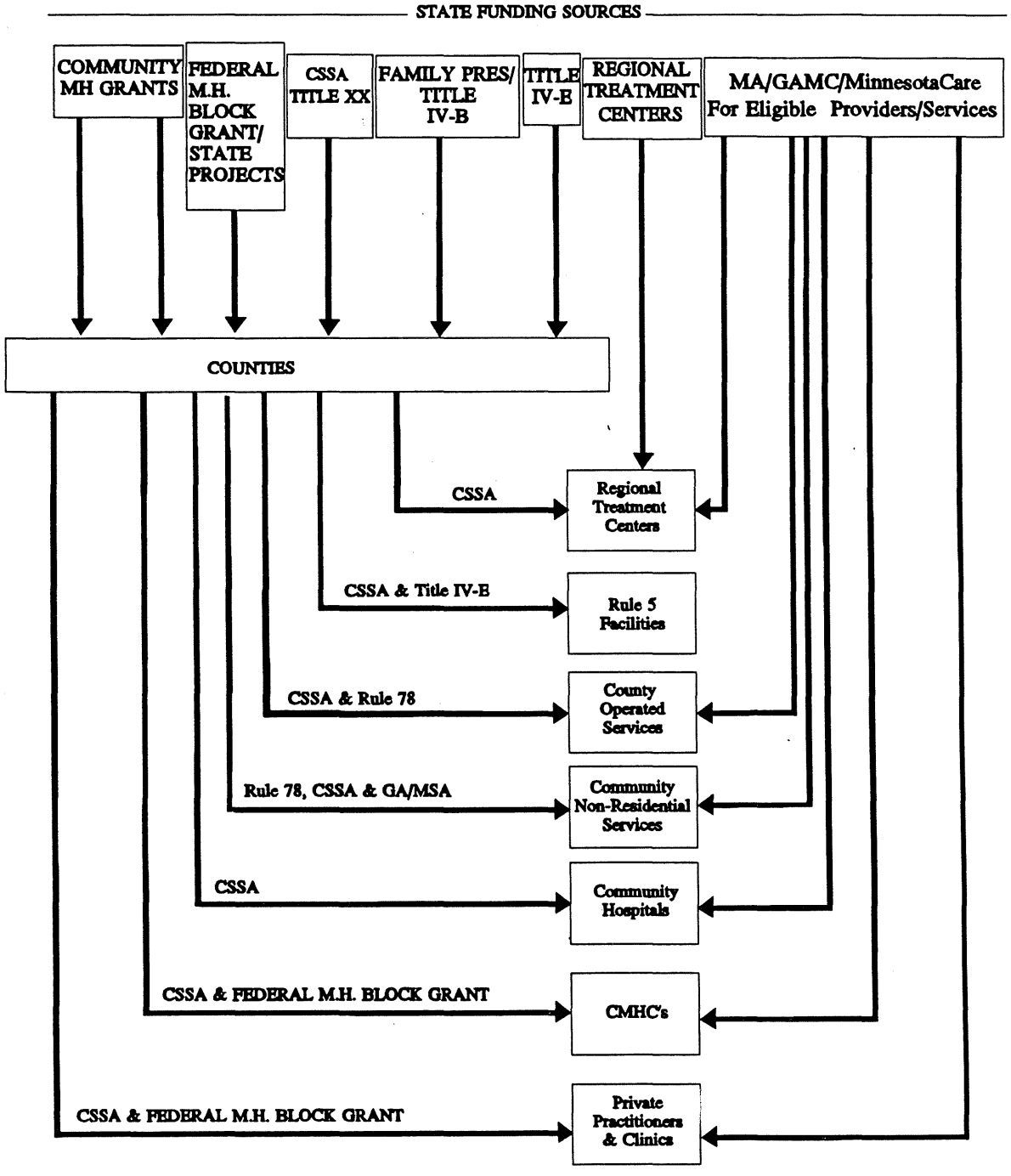


Figure 5
SMHA Funding Flows for Children



The primary state funding sources for mental health services for adults with SPMI are the state appropriations for RTCs, state community mental health grants, and state payments through MA/GAMC. The general trend in the use of MA/GAMC dollars is toward outpatient and community-based services, although the inpatient expenditures of these funds still exceeds their use for other services. Community mental health grants focus on case managment, CSP, and day treatment, in addition to residential treatment (Rule 36 and Rule 5).

B. Current Levels of Funding

For the adult system, the pie charts in Figure 6 and Figure 7 on the following page depict the percentage of total FY 93 funding from each source and for each service. Figure 8 and Figure 9 provide the same information for the children's system.

The MA dollars reflected in the pie charts include estimates for several prepaid HMO plans covering mental health services under a Medicaid waiver. Not included are funds for mental health services provided by the state Departments of Education, Corrections, and Jobs and Training, plus direct federal funding through Medicare and Veterans Administration. (Note that all statistical information used in this document refers to the public system of care that is under direction of the SMHA.)

Total public mental health funding in SFY 1993 amounted to about $354 million. About $280 million of this was for adults; $74 million for children.

For adults, federal funds amounted to 19.3% of total funding; state funds 62.9%; local funds 16.2%. Funding for non-inpatient community services represented 42.2% of total adult funding. RTC and community inpatient treatment accounted for the larger proportion, 57.4%.

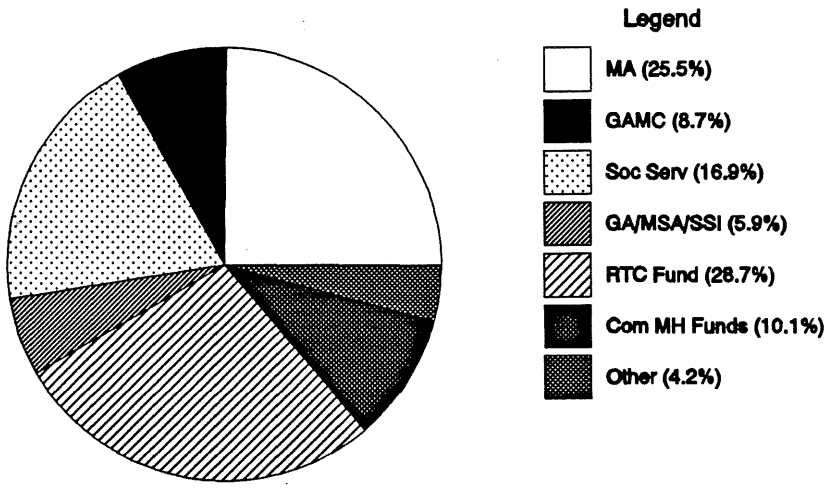
For children, the federal share of total children's funding was 27.8%. The state share was 25.9% and the local share 41.6%. Non-inpatient community services represented 80.7% of children's funding, largely for residential treatment. RTC and community inpatient treatment accounted for 18.8%.

Current initiatives focus on reducing the inpatient share of funding, in particular for adults in the RTCs, and on increasing funds from federal sources. These initiatives include:

- expanding Medicaid coverage for community-based services, including case management, home-based treatment, and community support services for RTC discharges;
- reallocating RTC human resources to community crisis services and to assist with other needs in the community, and closure of one RTC with MI beds;
- downsizing institutions for mental disease (IMDs);
- expanding housing support grants to counties.

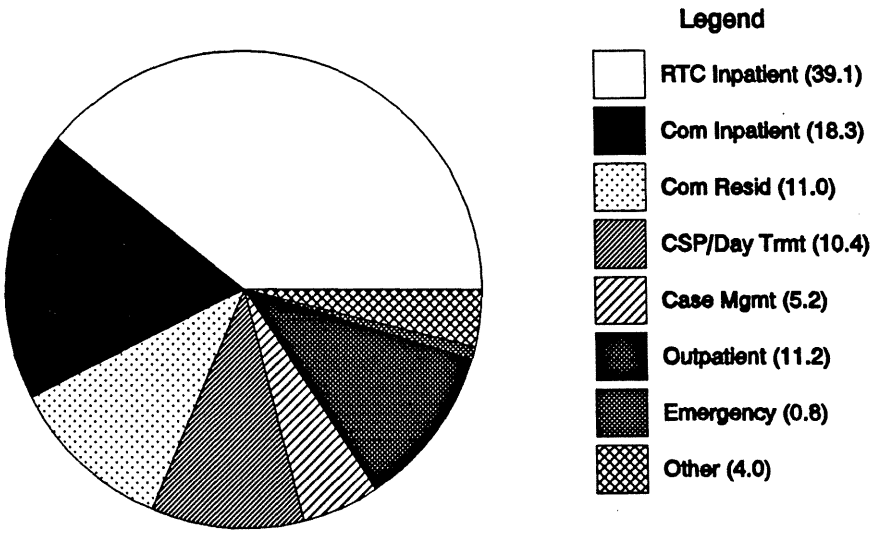
The SMHA is studying the feasibility of integrating funding streams for both children's and adult mental health, including experimenting with several counties to identify ways in which integrated funding can expedite integrated service delivery.

Figure 6
Percent of SFY 1993 Funding From Each Source: Adults



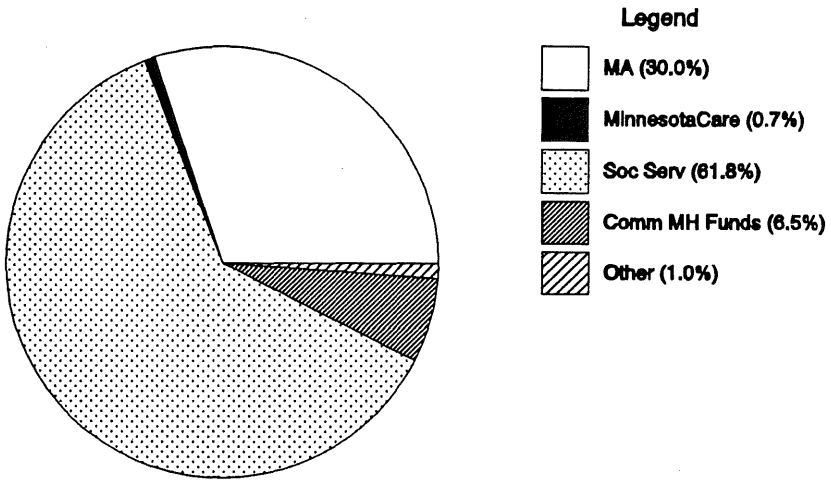
Total Funding: $280,174,000

Figure 7
Percent of SFY 1993 Funding For Each Service: Adults



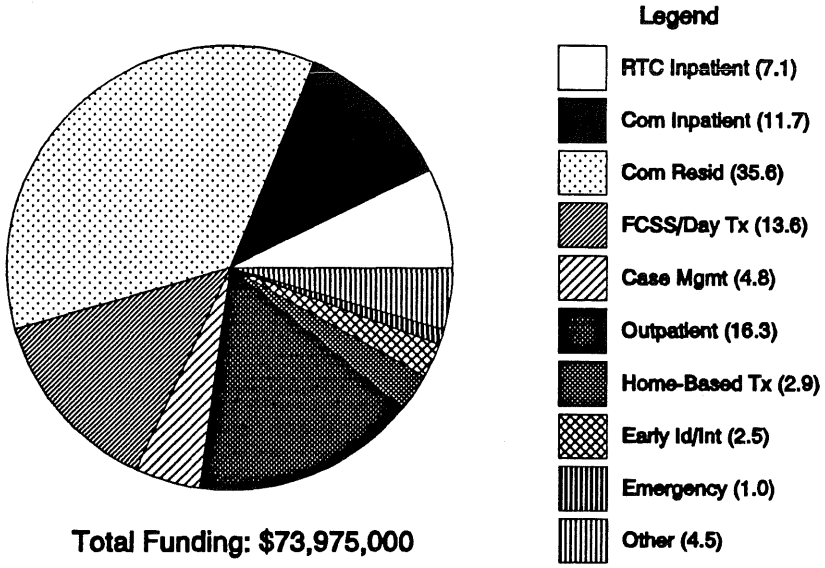
Total Funding: $280,174,000

Figure 8
Percent of SFY 1993 Funding From Each Source: Children



Total Funding: $73,975,000

Figure 9
Percent of SFY 1993 Funding For Each Service: Children



Total Funding: $73,975,000

C. State Funding Trends

Trends in state funding for the overall public mental health system are displayed in Table 6 and in Figures 12 and 13 on the following pages.

For adult services, the largest dollar increase has been for RTC expenditures ($53.8 million), while the largest percentage increase has been for community non-residential (111%). The average increase for all community adult mental health expenditures (79% from FY 87 to FY 93) is less than the increase for RTC expenditures (97%). This means that RTC expenditures are now a larger share (39%) of total adult mental health expenditures than they were in FY 87 (37%).

A large part of the increase in RTC-MI expenditures has been an increase in the percentage of fixed and overhead costs allocated to the MI program. During this period, the programs for persons with developmental disabilities (DD) and chemical dependency (CD) have undergone drastic downsizing. Persons with mental illness were 36% of the average daily population in FY 87, vs. an estimated 52% in FY 93.

For children's services, the largest dollar increase and the largest percentage increase has been for community non-residential ($21.6 million, equaling an increase of 184% from FY 87 to FY 93). Children's mental health services have been predominantly county-funded, whereas adult services have been mostly state-funded. This is still true, for the most part, in FY 93. The average state share for children's services has increased from 23% in FY 91 to 26% in FY 93, with most of the new state funds targeted to community non-residential services.

Figures 12 and 13 show the increases in spending for the major service categories in terms of net dollars and percent.

Figure 10 compares the trends in state dollars--community mental health funds (excluding MA share) and RTC funds--while Figure 11 compares the number of cases in the

Figure 10
Eight Year Trends in Funding For Selected Adult Services

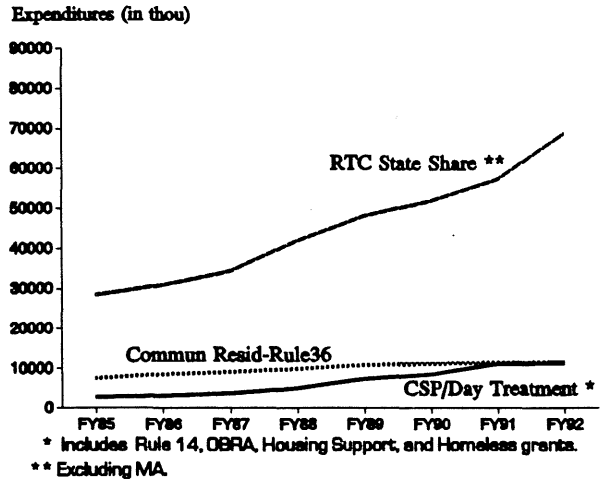


Figure 11
Eight Year Trends in Number of Cases at Year-End for Selected Adult Services

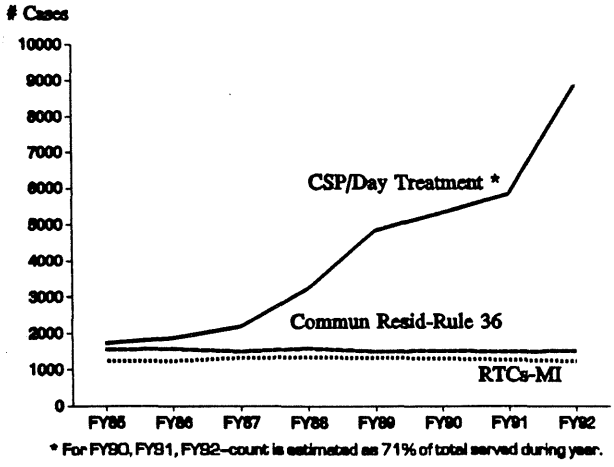


Table 6
Trends in Funding Adult and Children's Services

(dollars in thousands)

Adult	FY 1987	FY 1989	FY 1991	FY 1993	Change 87-93
Community Nonresidential	$ 41,526	$ 58,112	$ 69,475	$ 87,504	$ 45,978
Community Residential	26,272	28,098	29,999	30,853	4,582
Community Inpatient	27,084	31,975	36,151	51,159	24,074
RTC Inpatient	55,670	72,085	92,328	109,496	53,826
Other *	640	1,392	1,354	1,162	522
Subtotals	151,192	191,662	229,307	280,174	128,982
Children's	**FY 1987**	**FY 1989**	**FY 1991**	**FY 1993**	**Change 87-93**
Community Nonresidential	11,743	16,434	21,417	33,365	21,622
Community Residential	17,000	20,200	23,800	26,324	9,324
Community Inpatient	7,945	7,150	6,302	8,661	716
RTC Inpatient	2,320	3,059	4,270	5,256	2,937
Other *	71	536	144	369	298
Subtotals	39,079	47,379	55,933	73,975	34,897
TOTALS	$ 190,271	$ 239,041	$ 285,240	$354,149	$ 163,879

** Community education and prevention, training, administration.*

Figure 12
Increases in Mental Health Spending: Adults

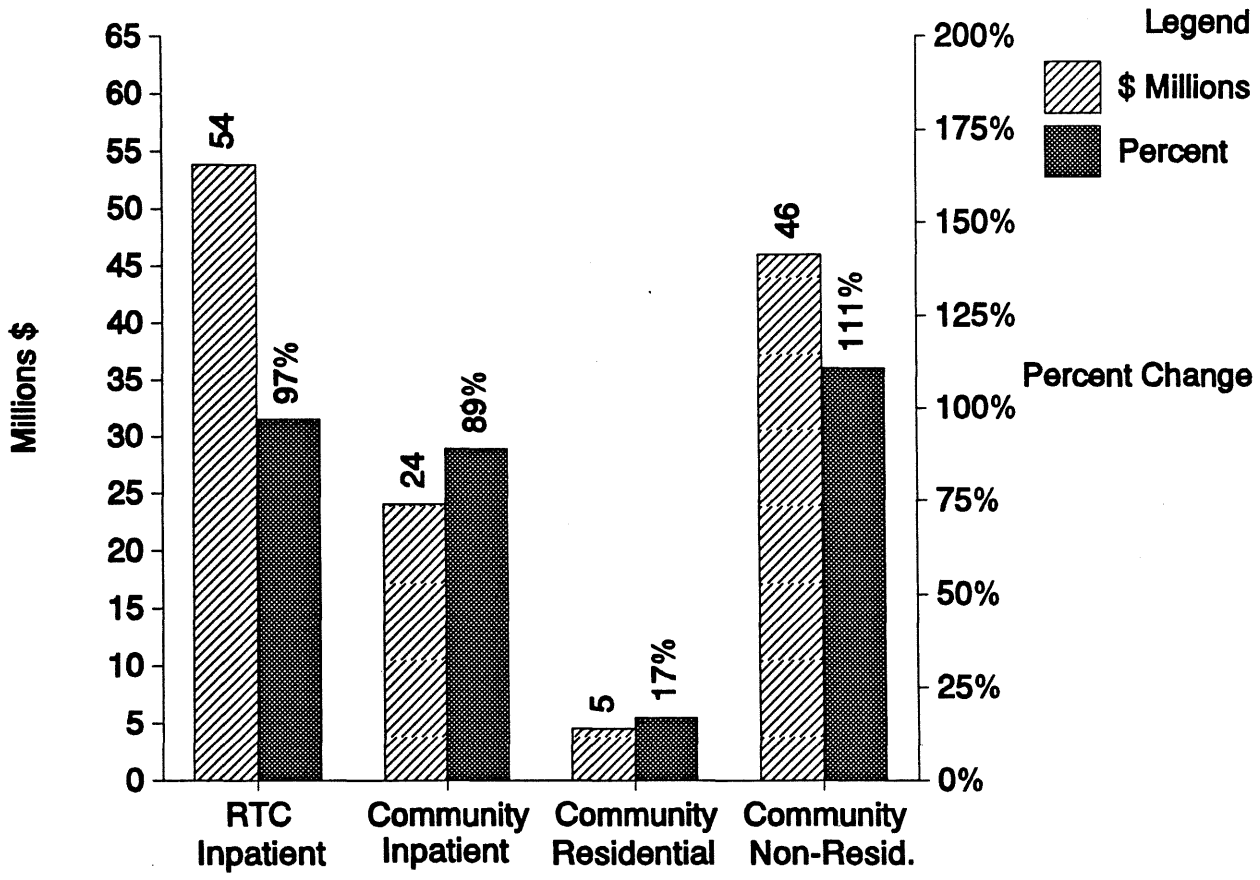
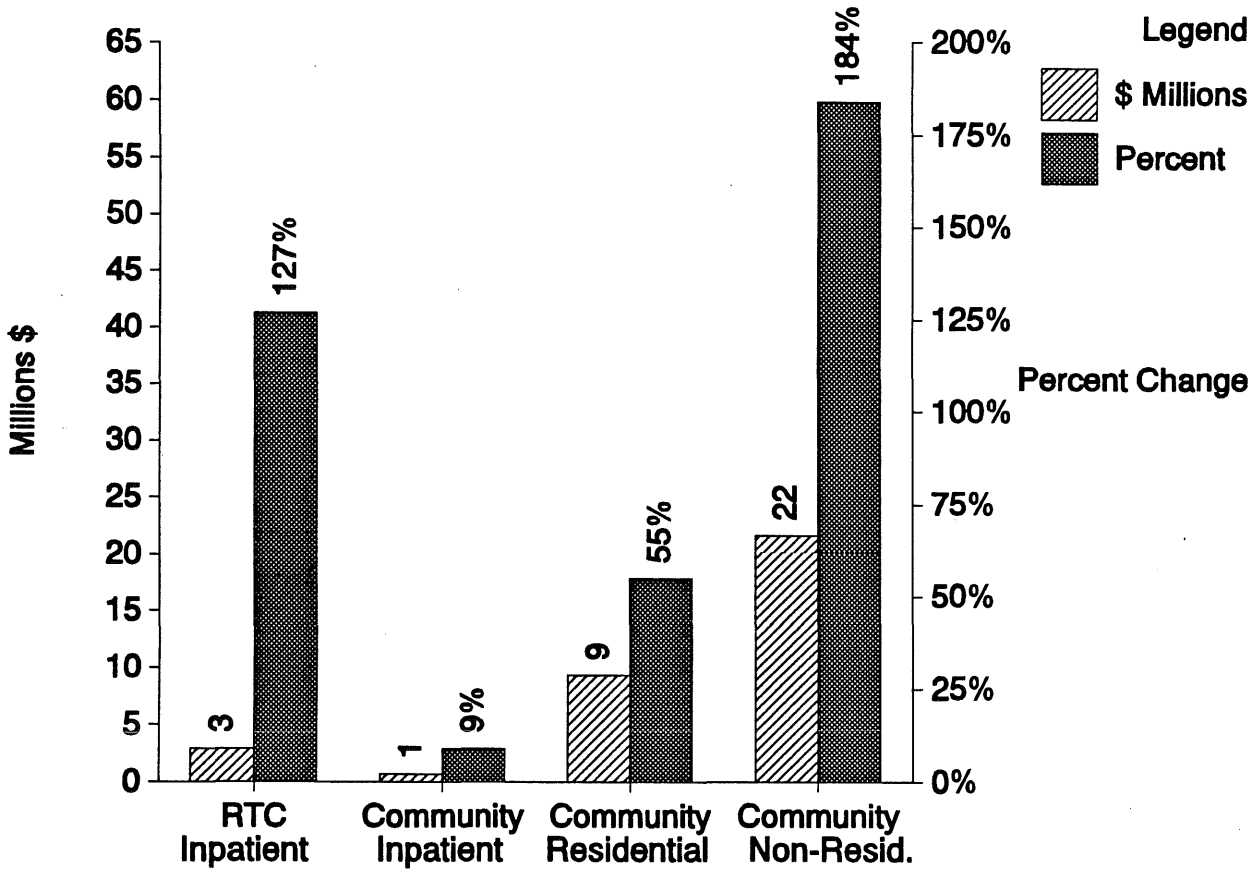


Figure 13
Increases in Mental Health Spending: Children



corresponding programs at year-end. During the period 1985 through 1992, RTC-MI expenditures have more than doubled, while the number of beds have remained roughly the same. Community residential beds have likewise remained about the same, but without a signficant increase in expenditures. CSP state share expenditures have more than tripled (from a state share of less than $3 million in FY 85), while CSP clients served are now more than four times the FY 85 level.

D. County Funding Trends

The term "county funds" is usually used to refer to all county discretionary funds, including county taxes, state social services block grants under CSSA, and federal social services block grants. 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. The only significant exception has been a $4 million increase in the state CSSA block grant for 1992. Total county tax funding for social services has increased from $152 million in 1985 to $298 million in 1992. This has resulted in an overall increase in "county funds" of 96% over seven years.

Unfortunately, reliable reporting systems have not been in place to track the mental health share of these county expenditures in a consistent manner. In 1987, counties expended an estimated $50 million for adult and children's mental health services, which equaled 20% of total county social service funds.

County plan data for 1992 indicates that counties are now budgeting about 28%, or about $112 million, of their total county funds for adult and children's mental health. This amounts to an increase of 124% over seven years. However, due to inconsistent reporting methods, it is not clear how much of this increase is due to changes in these methods, e.g., counting children's mental health under the mental health category instead of the children's services category.

The Comprehensive Mental Health Act 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 pertains only to county funds. This means that counties receiving new state or federal categorical funds for existing county expenditures must redirect their county funds toward expanded mental health services. Appendix B contains maintenance of effort figures for each county, and shows that most counties are reporting much higher commitment of county funds for mental health services than the minimum level of effort required by law. (Note that the 1987 base established in law pertains to a combined total for adult and children's mental health. Reliable figures are not available to separate the 1987 base into adult and children's amounts.)

E. Fiscal Incentives and Comparative Costs

Advocates have criticized the state funding system for "driving" clients towards inappropriate services by providing too many incentives for institutional care and not enough for home-based community support services. The information in Figures 14 and 15, the last two pages of this section, indicates that signficant progress has occurred in this regard over the last 4 years, particularly in children's services.

This progress was partly a result of the 1991 Mental Health Report to the Legislature, which highlighted the fiscal incentives for children's RTC inpatient services. As a result, the legislature increased the county share for children's RTC inpatient from 10% of the non-federal share (which was in effect in 1990) to 50% of the non-federal share (which became

effective January 1992.) Although progress has occurred, the average county share for RTC or community inpatient services is still less than the average county share for community support services.

Table 7 shows estimated daily costs for a complete package of services for adults with serious and persistent mental illness in three settings: RTC, community residential (Rule 36) and intensive supported housing. Similar data are not available for children's services.

The RTC and community residential figures in Table 7 represent current averages. The supported housing figures are estimates based on recently developed and newly developing programs. The supported housing figures assume a housing subsidy and a full range of support services, which are now available to only a very few people in the state.

Although there is a considerable overlap in the types of people served in all three settings, the most disabled--i.e., more costly to treat--people tend to be placed in the RTCs. Another important variable that must be considered in any comparison of costs is length of stay. Based on client assessments conducted in April 1991 for all RTC-MI patients (excluding Security Hospital), 32% had been in the RTC less than 90 days, 26% had been in 90 days to 1 year, and 42% over 1 year. Similar data for community residential facilities, based on assessments done in 1989, indicated that 33% had been in the community Rule 36 facility less than 90 days, 37% had been in 90 days to 1 year, and 30% over 1 year. On the other hand, housing support services are intended to be on-going as long as the services are needed, with the intensity of the support services varying based on need.

Table 7
Estimated FY92 Total Cost Per Adult Day by Residential Setting

Program or Service	Setting		
	RTC	Rule 36 Community Residential	Intensive Supported Housing
RTC	$236.33	0	0
Case Mgmt	3.10	3.10	3.10
Room and Board	0	28.82	21.00
Rule 36 Program	0	31.34	0
CSP/Day Trmt	0	7.08	50.00
Outpat Trmt	0	2.20	2.20
Pharmacy	0	4.11	4.11
Periodic Hospital-ization	0	3.00	3.00
Non-MH Medical Services	0	2.80	2.80
State Admin	**	0.14	0.14
TOTALS	$239.43	$82.59	$86.35

** State administration for RTCs is included in the RTC per diem.

Figure 14
Federal, State, and County Shares for Selected Adult Services

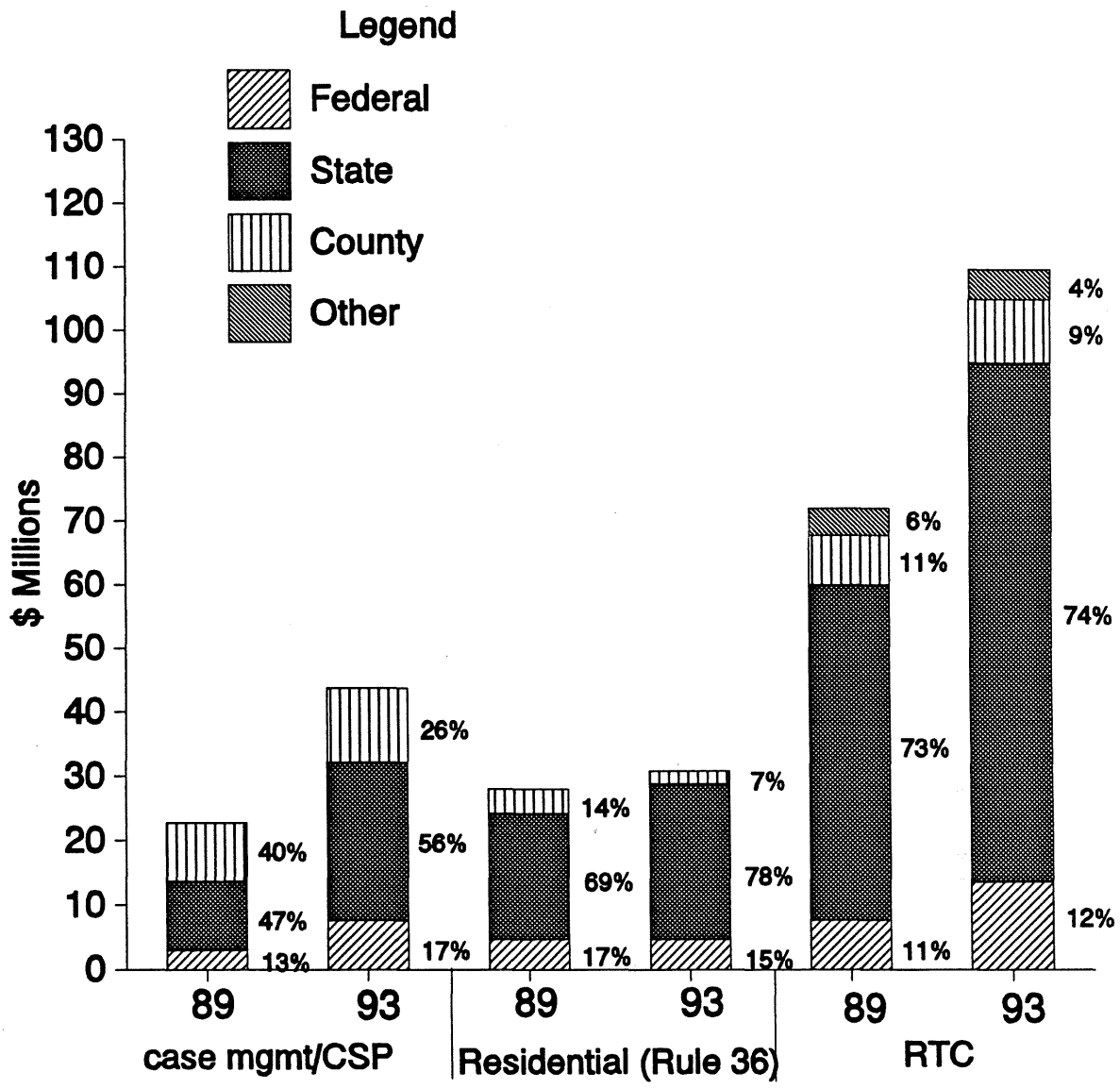
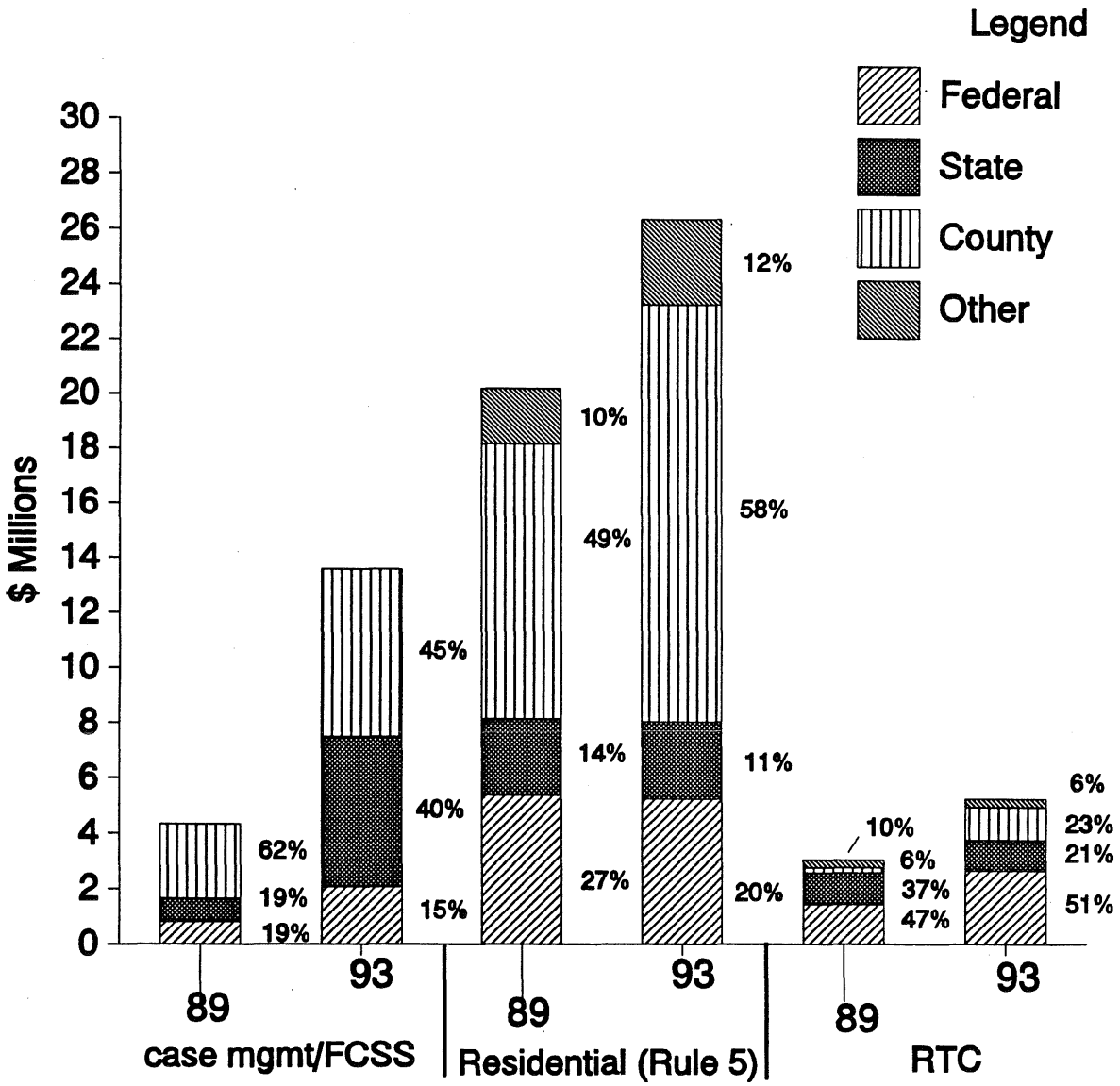
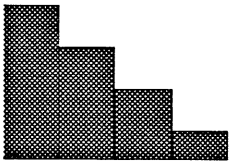


Figure 15
Federal, State, and County Shares for Selected Children's Services





III. Report on Implementation of the State Plan

Since the federal government initiated state mental health planning in 1987, and in the aftermath of passage of the two state mental health acts, the state mental health authority, in coordination with the state planning council, county agencies, providers, advocates, and consumers, has engaged in a broad range of efforts to improve the mental health system. This section summarizes the extent to which those efforts have been successful as of the end of 1992.

More specifically, this section reports the extent to which objectives of the state plan have been accomplished since the planning process began in 1987. Starting with next year's *Report to the Legislature*, this report on progress will address only those objectives established for the report year, e.g., 1993. (See *Minnesota's 1993 Mental Health Plan* for more information about state plan objectives.)

Progress made on each objective is discussed separately below. Quantitative assessments are included wherever possible and appropriate. Note that an objective can be assumed to apply to both adults and children unless stated otherwise. All statistical information refers to clients and services in the public mental health system only. Statistics pertaining to community services are based on data as reported by providers and counties to the SMHA, while Medical Assistance information is taken from claims databases. It should be noted here as well that information about services refers to those services defined in state law and regulation. Some counties provide additional services of similar type and name, but not meeting all regulatory requirements. These "additional" services are not included in the progress report.

Several abbreviations used in the following progress summary, although used in previous sections, should be re-clarified. "SMHA" refers to the state mental health authority, which is the Department of Human Services' Community Mental Health and State Operated Services Administration. "SMHAC" is the State Mental Health Advisory Council, or planning council. "RTC" means one of the state-operated regional treatment centers, or state hospitals. "MA" (Medical Assistance) refers to federal Medicaid funds and the state's match; "GAMC" to the state's General Assistance Medical Care program covering disabled adults not eligible for MA; "CHP" to the Children's Health Plan, covering children not eligible for MA. "Case management" refers to a type of case management defined in law and state regulation specifically for persons with SPMI or SED.

OBJECTIVE 1

Define and mandate in law a comprehensive array of services.

The Comprehensive Adult Mental Health Act (passed in 1987) and the Comprehensive Children's Mental Health Act (passed in 1989) define and mandate comprehensive services for adults and children. These acts also define target populations, service quality factors, and the responsibilities of the state and county government agencies, and local advisory councils, in implementing the services systems.

See Section I for a description of the current mandated service array.

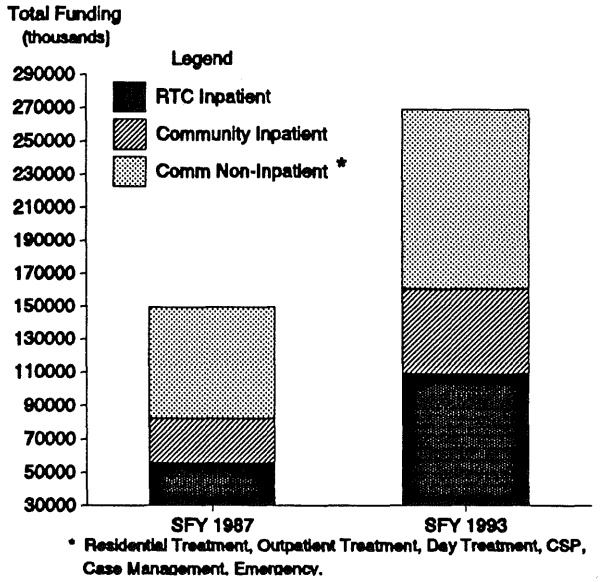
OBJECTIVE 2

Provide levels of funding adequate to support the mandated array of services in each county.

Section II describes 1993 funding levels for services and Section I discusses unmet need in terms of funding shortages.

Total funding of the adult system has increased from about $150,000,000 in SFY 1987 to $280,000,000 in SFY 1993. This is a 87% increase over the five years. Much of this increase ($41,000,000) was for non-inpatient community programs. Figure 14 is a comparison of service funding proportions for 1987 and 1993.

Figure 14
Adult Mental Health Services Funding for 1987 and 1993



Much of the increase for adult and children's community support and case management services has been in the form of state grants, made available on a population-based formula to all 87 counties. In FY 93 these grants totaled $9,250,000 for adult services and $3,360,000 for children's services. New projects aimed at demonstrating enhanced CSP services, and financed with both federal and state dollars, account for some of the community increase. In state fiscal year 1993, these programs and funding amounts included: housing subsidies ($1,000,000), enhanced housing support services ($1,060,000), downsizing of IMDs ($1,400,000), enhanced employability services ($320,000), transition from RTCs to community living ($430,000), and relocation/alternative disposition of nursing facility residents with MI ($2,100,000). An additional $238,000 in community residential facility grants were shifted to CSPs in 1992, as part of a demonstration project, and an additional $350,000 were leveraged for CSP services through interagency

agreements within the state's departments of housing and jobs.

In addition to administering more state grant funds for community services, the state has expanded MA funding (see OBJECTIVE 5) for day treatment, professional home-based services, case management, and personal care attendants, and has begun a study of the feasibility of expanding MA coverage for CSP under the rehabilitation option. This would include client assessments done in crisis intervention programs.

Although overall funding for the adult system in some counties might be adequate, and despite the increases in CSP funding in recent years, overutilization of the RTCs leaves too few of these resources for CSP development in many counties. Recent cost-shifting in the RTCs from the chemically dependency and developmental disability programs to the mental health program, due to successful efforts to divert these other two populations, only partially explains the increase in RTC expenditure for MI since 1987. A disproportionate share of the available adult funding is still being spent on RTC inpatient treatment, leaving many counties with CSPs that are missing some of the mandated component services. Direct transfers of RTC appropriations to community programs have thusfar not been approved by the state legislature.

The children's system, which was undefined and unfunded until 1989, is now funded and making headway in developing services. However, the overall level of funding, due to budget shortfalls, is inadequate to support the service array, particularly nonresidential community services and home-based services. Most counties have some of these community services in place, but access, in the form of long waiting lists and poor service coordination, remain serious problems in some areas. Table 4 in Section I shows that over $13,000,000 are still needed to implement these services for children.

Current spending for children's services totals $73,975,000. Most of these dollars, about 92%, are being spent on community programs, but this includes 35.6% for community residential and 11.7% for acute hospital inpatient. Early intervention, family community support (including day treatment and case management), and home-based treatment services together account for only 23.8%. In 1991, providers of case management were allowed to bill MA for services, and in 1992 providers of professional home-based treatment and therapeutic support for foster care were allowed to bill MA.

OBJECTIVE 3

Implement a method for reviewing at the state level the direction of service development proposed in each county plan.

In 1987 the SMHA initiated a method for collecting local plan information for the purpose of reviewing proposed development of services and other aspects of the desired adult system. A similar method was implemented for children's services in 1989. These county plans transmit data on unmet needs, goals and objectives, and planned revenues and expenditures. Detailed program descriptions are collected for relatively new services such as CSP, case management, and integrated early identification/intervention. The county plan data are linked with data from other sources, such as reporting systems and Medicaid claims, to allow the SMHA to review each county's planned progress toward further implementation of the Mental Health Acts.

The SMHA supports the local planning process by providing resource materials, including census data, local prevalence estimates, and service utilization tables. It also provides specific state objectives and progress indicators to guide counties in developing their local objectives.

OBJECTIVE 4

Implement a method for monitoring service delivery at the state level in order to determine the level of system development attained in each county.

The SMHA and many local organizations (providers and counties) underwent extensive information system development during the period from 1987 to 1992, in part due to improvements in computer technology, but also due to the availability of federal funds to support efforts to adopt national data standards. The SMHA implemented the Community Mental Health Reporting System (CMHRS), which collects client and services data from over 250 providers. For the most part, these data are reported on electronic media, allowing direct transfer from the local database to the state's database, and thus making collection of client-specific data feasible.

In addition to a new reporting system, the SMHA developed a set of procedures for extracting client-specific data from the state's MA/GAMC system and from the RTC system. Together with the CMHRS, these extracts provide the SMHA with the capability of meeting roughly 80% of its routine information requirements, and most special requests from outside sources. Other data collection methods, such as the county plan, fiscal reports on categorical grants, program evaluation instruments for pilot projects, and two important new methods implemented on a test basis in 1992--a client outcome survey and a provider organization and staffing survey--address the other information requirements of the SMHA.

From its databases, the SMHA produces periodic reports for state staff and management personnel, and for counties and providers. The statistical information in these reports allow state staff to monitor system development and performance, and to "note" possible problem situations. The reports to counties and providers support the same capabilities locally, and thus enable local, immediate corrections to be implemented without direct state intervention.

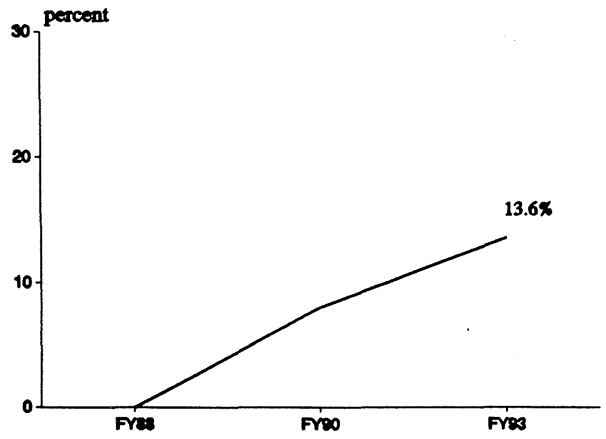
OBJECTIVE 5

Establish mechanisms for developing new sources of funding for community programs and for optimizing use of existing funds.

Several mechanisms were established to increase funding for community-based, nonresidential programs. As reported above, case management and children's home-based treatment services were redefined as MA services, allowing payment from this source in addition to state and local sources. It is too soon to detect changes in home-based treatment funding levels resulting from the new coverage; however, the trend for case management is clear, and can be seen in Figure 15.

In 1988, day treatment and outpatient services were the only community services covered by MA. By 1992, case management, personal care attendants, and professional home-based treatment were added to the list. In actual dollars, MA funding for case management has increased from $0 in 1988 to $2.5 million in 1993. For nonresidential community programs other than outpatient treatment, MA funding has increased from $3 million in 1988 to $13.6 million in 1993. For all services, MA represented 26.5% of total mental health funding in SFY 1993.

Figure 15
Percent of Case Management Funding From MA (Adults and Children Combined)



A second mechanism for increasing nonresidential community services funding was a change in legislation that allows dollars previously allocated to residential programs to be shifted at county option to nonresidential services. Over $238,000 were shifted this way in 1992.

The third mechanism for increasing community services funding was development of interagency agreements between the SMHA and state housing and jobs agencies to utilize funds from these other agencies to support CSP services. In 1992, $350,000 was leveraged for employability services and $250,000 for housing subsidies.

Finally, the Children's Integrated Fund Task Force (see OBJECTIVE 11) published a preliminary report in 1992 that describes the feasibility of developing an integrated children's mental health fund. The report identified the barriers to integration, and offered several strategies to overcome these barriers. The report is being used by the State Coordinating Council for children's mental health as a starting point for design of an operational approach to integrated funding.

OBJECTIVE 6

Implement procedures for assisting RTC discharges in making successful transition to community services.

The SMHA implemented a demonstration project at Anoka-Metro RTC to develop individualized CSP services for discharges and to manage the discharge and transition process. During state fiscal years 1991 and 1992, 164 of the "hardest to place" patients at the facility were discharged into the program. Analysis of how these patients have done after discharge indicates that their rate of rehospitalization is low and that the costs of their services post-discharge are lower than when they were patients. The state legislature has authorized funds to continue this project in 1993, and these funds are now part of the SMHA's funding base. Despite the success of this project, funds for expanding it to other RTCs are not yet available.

OBJECTIVE 7

Improve the skills, knowledge, availability, and employment levels of mental health clinical and administrative professionals, and recruit persons of cultural minority and consumer backgrounds.

The SMHA has identified a number of human resource needs and human resource development strategies to meet those needs. The SMHA is currently developing an HRD plan to summarize and provide ongoing direction to these human resource development needs and activities.

Accomplishments to date under this objective include:

a) completion of a key informant survey to identify human resource needs of mental health programs, which include: statewide shortage of psychiatrists, a shortage of all mental health professionals in rural areas, a shortage of professional skilled in meeting the needs of children and adolescents with emotional disorders, and an under representation of Minnesota's growing minority population among mental health service staff.

b) completion of a joint project with the Minnesota Association of Community Mental Health Programs to study and make recommendations to improve access to and utilization of psychiatrists in community programs. Recommendations of this project include the use of team approaches pairing psychiatrists with nurses and primary care physicians; strategies to redeploy state employed psychiatrists to community service settings; joint state, community and academic recruiting; closer relationships between public and academic department of psychiatry. This project has encouraged a number of local efforts including: a psychiatry task force uniting public and private mental health providers in an urban county; tentative plans to begin a community psychiatry rotation at a local mental health center for psychiatry residents at the Mayo Medical School, and an agreement to pursue a joint appointment for a state psychiatrist with the University of Minnesota Department of Psychiatry.

c) a legislative appropriation to increase salaries of direct care workers in response to studies that showed high turnover rates in residential and community support programs. (This increase, however, is not likely to be sufficient to solve the problem of inadequate compensation for staff in community programs.)

d) formation of a multicutural task force to study and make recommendations to ensure culturally appropriate mental health services for minority racial and ethnic groups in Minnesota.

e) publication of a list of special mental health consultants with minority cultural background, to serve as a resource for providers, particularly case managers.

Although during 1992 the SMHA had intended to submit a proposal to the NIMH for a human resources development grant to accomplish more on this objective in the future, unavailability of federal funds precluded that effort.

OBJECTIVE 8

Provide all mandated services in each county, in a manner that ensures accessibility and affordability to clients.

Table 8 summarizes the extent to which counties are providing the service array mandated in the 1987 and 1989 mental health acts. Some children's services are designed for children only, and some adult services for adults only. These services are represented by blank cells in the table.

Table 8 shows the different levels of development between the adult and children's systems, although it does not address the issues of quality of service or degree of penetration into the target populations (see OBJECTIVES 19, 22, and 25). As previously discussed, this difference between the adult and children's systems is due to a later startup for children's mandates, and to lower levels of funding for children's services in regard to overall funding need.

Table 8
Number and Percent of Counties Providing Each Service in 1992

Service	Adults		Children	
	#	%	#	%
Case Management	87	100%	66	76%
CSP	87	100%		
FCSS			43	61%
Day Treatment	85	98%	34	39%
Community Residential Treatment	84	97%	68	78%
Outpatient Treatment	87	100%	87	100%
Professional Home-Based Treatment			16	18%
Integrated EI/I			30	34%
Therapeutic Support/ Foster Care			6	7%
Community Hospital Inpatient	87	100%	79	91%
RTC Inpatient	87	100%	56	64%

It should be pointed out here that professional home-based treatment and therapeutic support for foster care are mandated in second priority to integrated early identification/intervention (EI/I) and family community support services (FCSS). Counties must first establish EI/I and FCSS before using state funds to support the other two services. To assist counties in implementing EI/I, the SMHA began awarding grants to local coordinating councils (LCCs) in 1992. Sixty-four grants were awarded, totaling $1,600,000. Some of these grants were to pay for further LCC development, the others for service delivery.

Finally, some counties have obtained waivers on provision of day treatment, based on availability of similar services through the community support program.

The results in Table 8 indicate that the state has been successful in establishing mandated services to adults. It is important to add, however, that widespread availability does not necessarily translate to adequate capacity, or to accessibility to all subpopulations. Development of the state's longrange plan, beginning in 1993, will take a closer look at these two other dimensions of service provision. For children, widespread availability is still a distant reality.

OBJECTIVE 9

Establish county mental health budgets adequate to support the mandated array of services.

Table 8 provides an indication of the extent to which counties have been successful in establishing the mandated array of services. As a group, counties have funded services in accordance with mandates and with levels of support from state sources. For children's services, counties account for 42% of funding.

One area in which counties can do more with available sources is to maximize use of MA for eligible services.

{See OBJECTIVE 2 for more information}

For a Unified System ...

OBJECTIVE 10

Implement a method for state-level review of local plans and grant applications, which ensures adequate methods of local coordination and needs assessment.

The local planning process described under OBJECTIVE 3 serves as a method by which the SMHA and the SMHAC, as well as the public, can review the methods and results of needs assessments and local coordination activities. This method has been improved each year and further improvements are included among the 1993 plan objectives. The SMHA hopes to expand its capabilities to collect data from LACs, which will reveal more about the nature and extent of local needs assessment methods and planning and coordination efforts.

OBJECTIVE 11

Develop inter- and intra-agency coordination mechanisms at the state level to further development, implementation, and funding of services.

The SMHA reorganized in 1991 to provide for better coordination between RTC management and management of community mental health programs. The two divisions of the state agency now form the Community Mental Health and State Operated Services Administration, under a single assistant commissioner. Several routine data exchanges between these two divisions and between the SMHA and the Health Care Systems Administration (incl. MA) have been implemented. These units also co-form project teams, such as those responsible for modifying state MA policy and for planning crisis intervention services.

State-level interagency agreements for services funding are discussed above under OBJECTIVE 5. For children's services, several interagency coordination committees have been established. These are summarized in Figure 16. In addition, multi-agency RFPs have been developed to fund family community support services and early intervention/identification services. The EI/I funds have been awarded to 28 local coordinating councils (see OBJECTIVES 12 and 22 for more information).

Figure 16
State Coordination of Children's Services

- State Coordinating Council:

  Representatives of the Departments of Human Services (SMHA), Corrections, Education, Health, Jobs and Training, Commerce, and State Planning meet monthly to develop mechanisms for interagency coordination.

- State Transition Interagency Committee:

  Representatives of the Departments of Human Services (SMHA) and Jobs and Training meet with advocates to develop mechanisms for easing the transition of disabled children to adulthood.

- Children's Integrated Fund Task Force

  Established by the 1991 Legislature to study the feasibility of creating an integrated fund for children's mental health.

The Mental Health Act requires the State Coordinating Council for children's mental health to report each year on the policy and procedural changes needed to implement a coordinated system for children.

The Children's Integrated Fund Task Force is reporting in February 1993 the results of its study of integrated funding for children's services. The report finds that an integrated fund is feasible in Minnesota, and recommends a design that includes:

- coordination among state agencies serving children, including regulatory flexibility and a common information system;

- local collaboration among counties, service providers, and third party payors to phase-in implementation of the integrated fund and services system;
- accountability based on results rether than adherence to procedural requirements;
- service standards for the integrated system, including coordinated service plans for each client, unitary case management, and equal access.

OBJECTIVE 12

Establish mechanisms in each county for involving consumers and families in service delivery, and for coordination of services.

The Mental Health Act requires all county boards to develop local advisory councils (LACs) for advice and advocacy on mental health issues, and local coordinating councils (LCCs) to actively develop coordination among children's services.

Nearly all counties have established LACs, and most meet the composition mandate for inclusion of consumers and families as well as representatives of government and providers agencies. The SMHA has contributed funds to a League of Women Voters project to train members of these councils in mental health issues and in the skills needed to perform their role.

About 50 counties have established local coordinating councils (LCCs) composed of representatives of mental health, health, education, corrections, and human services agencies. The LCCs meet quarterly, and in some cases monthly, to develop recommendations for county children's mental health plans and to develop local policies and procedures for coordinating service delivery.

The case management model employed in Minnesota is another local mechanism of coordination, at the individual case level, that incorporates client and family input.

OBJECTIVE 13

Identify unmet service needs of local populations every two years.

The local planning process provides an opportunity for counties, their LACs and LCCs, for providers, advocates, and the general public to identify and document unmet needs. Every two years the SMHA receives a list of needs from each county, along with a set of objectives designed to meet those needs. In 1992, several local needs for adults were commonly cited: a) housing, b) CSPs, c) public education, d) crisis services, and e) employability.

Needs cited by counties for children include: a) funding, b) day treatment, c) family community support services, d) public education, e) EI/I, f) coordination with the school system.

The SMHA supplies counties, LACs, and LCCs with periodic reports designed to assist in the process of needs identification (see OBJECTIVES 3, 4, and 19 for more information).

OBJECTIVE 14

Develop local (county) plans every two years, which meet state requirements and incorporate recommendations of local advisory councils.

The local planning process discussed under OBJECTIVE 3 and OBJECTIVE 13 requires county plans to incorporate recommendations of the LACs and LCCs, and to meet state

requirements for format and content. All plans submitted for 1992 passed state review, and 89% of these plans cited recommendations of their local advisory councils.

OBJECTIVE 15

Provide case management services, as defined in state law and regulations, to adults with SPMI and children/families with SED in every county.

All counties provided case management services to adults in 1992; 76% of counties reported providing case management services to children that year. Case management to children with SED was not mandated in law until 1989, and not described in Rule until late 1991, so implementation has been slower in development for that population.

One-half of the 87 counties provide case management to more than 25% of their estimated SPMI populations, the target level set for 1992.

For an Accountable System ...

OBJECTIVE 16

Promulgate statewide standards of service quality, utilization, and funding.

From 1987 through 1992, three state rules governing mental health services and providers were promulgated or modified. Figure 17 summarizes these rules.

The emphasis on statewide standards has recently shifted toward fewer procedural requirements, as part of a general effort to reduce mandates; however, to ensure service quality remains high, service providers are now being required to incorporate outcome measurement and reporting into their programs and as part of their relationship with counties. The revised Rule 79 is the first mental health rule to include these requirements. Meanwhile, the local planning process has been modified to allow counties to develop outcome targets based on indicators defined by the SMHA.

Figure 17
State Mental Health Rules Promulgated or Revised Since 1987

- Rule 79

  Defines standards for case management services to adults and children and the qualifications for case managers.

- Rule 78

  Defines how CSP funds are to be distributed among counties, and how counties are to be held accountable for these funds.

- Rule 47

  Establishes standards for MA reimbursement.

OBJECTIVE 17

Implement statewide methods for monitoring local service system performance against standards.

New planning and evaluation approaches

implemented by the SMHA and counties make use of progress, or performance, indicators. These indicators allow measurement of progress toward plan objectives, but also provide counties and the SMHA with a means of monitoring status on system variables not associated with formal objectives. The indicators are data-based, and thus rely on standardized data collection systems.

(See OBJECTIVE 4 for a discussion of the SMHA's data collection methods.)

OBJECTIVE 18

Ensure that contracts with providers include monitoring and evaluation procedures, requirements for financial control, and requirements for compliance with laws and standards.

The SMHA issued recommendations for services contracting to all counties in 1990. There were 26 recommendations, including explicit description of services to be provided and unit cost of services, professional qualifications of staff, payment contingent on compliance with state statutes, procedures for evaluating achievement of client goals, and an itemized list of fiscal records to be maintained.

The extent to which counties have implemented the state's recommendations is not yet known. The county monitoring division of the Department of Human Services was dissolved before it could collect this information for the SMHA.

To Provide Appropriate Services ...

OBJECTIVE 19

Implement procedures for reviewing service utilization that determine whether services provided are appropriate to client needs.

The new information systems discussed under OBJECTIVE 4 provide the SMHA, counties, and providers with a means for assessing levels of service utilization and for determining the extent to which services are being utilized by the subpopulations for which they are intended.

For example, from its databases the SMHA generates reports showing the percentage of clients receiving each service who are SPMI or SED. Services such as case management and CSP services are intended specifically for these subpopulations, and counties or programs with more than 10% utilization by other subpopulations are noted for quality assurance followup. Another example: recipients of outpatient services are grouped into diagnostic categories, assisting counties and the SMHA in assessing the appropriateness of various psychotherapies in light of diagnosis.

OBJECTIVE 20

Promulgation of state regulations that define appropriate service delivery.

State statutes and rules require providers of case management, CSP services, outpatient treatment, residential treatment, or inpatient treatment to develop individual treatment plans and community support plans based on diagnostic and functional assessments of clients.

OBJECTIVE 21

Systematic biennial examination of the service needs of regional treatment center (RTC) patients on a statewide basis.

In 1989 and 1991, the SMHA used federal block grant and state funds to support a study of the service needs of patients in RTCs. Data were collected on all patients in the state system, according to a standard protocol, and each patient was scored for readiness for community living. Results of the 1991 survey (shown in Table 5, Section I) indicated that about 28% of patients were ready for the community. This study will be repeated in 1993, and should reveal the effects of recent efforts to discharge this segment of the patient population into the community with appropriate support and treatment services.

OBJECTIVE 22

Develop and provide service programs to special populations, which incorporate culturally sensitive and age-sensitive components.

Service programs have been developed and implemented for several special adult populations, including: American Indians, Southeast Asian refugees, homeless persons, persons with mental illness residing in nursing facilities, and compulsive gamblers. In addition, a study of the needs of rural populations suggests new methods for delivering services in rural counties. Minority populations in Minnesota are for the most part concentrated on Indian reservations and in inner cities. Programs targeted to these populations are, therefore, localized.

For the last 11 years, American Indian communities have been providing mental health services to their residents through programs that incorporate culturally appropriate components. These programs have grown in number and utilization, from 5 programs serving 370 in 1983 to 9 programs serving approximately 4000 in 1992. The SMHA has dedicated a staff position to supervision of these programs. Twenty-five percent of federal block grant funds are set aside each year for American Indian programs.

Over 1500 Southeast Asian refugees have received mental health services through two programs located in the high population counties of the state. These programs are supported by a combination of federal funds and foundation grants provided under guidance of multicultural advisory groups.

A 1991 statewide survey of homeless persons estimates that about 6,300 homeless persons with mental illness live in Minnesota, and that about 800-900 of these are children with emotional disturbance. Most of these individuals are not reached by conventional mental health service systems. For the last five years, the state has made special efforts to extend services to the adult homeless population, and to train the providers of these services. The SMHA has provided counties that are known to have large concentrations of homeless persons with grants to locate those in need of services and to provide the services needed. These services cover the range defined in the Projects for Assistance in Transition from Homelessness (PATH) program, including outreach and referral, temporary housing, federally defined case management, therapy and screening, among others. The SMHA provided information to local providers on how to reach homeless and runaway youth.

In FY92, $730,000 were expended on the homeless projects. An estimated 180 homeless persons received case management services, and another 400 received other types of mental health services.

Applicants to nursing facilities, and residents of those facilities, have been another special target population. About 6700 residents and 4850 potential admissions have been screened under PL 100-203 regulations to determine appropriateness of residence or admission; 153 have been relocated or diverted.

Another subpopulation of interest has been compulsive gamblers. Rapid growth of state-supported gaming and casino enterprises on Indian reservations has led to increased attention to gambling problems. The incidence of compulsive gambling appears to be increasing. The SMHA now employs a fulltime staff person dedicated to supervision of 6 compulsive gambling treatment programs. State funding for compulsive gambling services in 1992 was $700,000.

Methods for delivering services to the rural population developed as an issue in the mid 1980's. Although there are no reliable prevalence estimates yet available for rural counties, the state has carried out three demonstration projects, covering 15 rural counties, to identify a method of delivery. These projects revealed that reliance on "natural helpers" in the communities--churches, educational services, etc.--was a viable approach, with support in the form of training for local counselors and outreach from the community mental health centers.

Assuming counties with populations under 20,000 constitute rural counties, the populations of these counties use the existing services system as shown in Table 9. The per 10,000 figures for the rural population are not dramatically different from the nonrural population of the state, although there is a somewhat lower use of case management and community inpatient services, and a somewhat higher use of outpatient treatment. In sum, the current system appears to be serving rural populations about as well as it is serving nonrural populations, with the possible exception of case management. Efforts will be made to improve case management to rural populations in 1993.

Several special populations of children have received attention, including children in community detention facilities, minority children, and children at risk of developing SED.

New legislation was passed in 1992 to fund screening for mental health service needs among children in community detention facilities. Children found to be in need must be linked to appropriate services, preferably in-home treatment or support services.

Table 9
Number of Rural and Nonrural Clients Served per 10,000 Population in 1991

Service	Rural		Non-Rural	
	Adults per 10K	Children per 10K	Adults per 10K	Children per 10K
Case Management	18	*	24	*
Community/ Family Support	21	1	20	1
Day Treatment	10	1	7	2
Outpatient Treatment	104	36	82	29
Community Residential Treatment	7	4	8	4
Community Hospital Inpatient	10	2	15	2
RTC Inpatient	10	1	8	1

* State regulations not promulgated until December 1991.

To assist in development of culturally sensitive

programs for minority children, the SMHA has hired a fulltime minority person and incorporated suggestions from American Indian and Hispanic communities for revising state regulations for home-based family treatment. In addition, case managers are required in law to consult a special mental health consultant when assessing the needs of children from a minority racial or ethnic group.

Finally, 28 local coordinating councils (LCCs) received state grants in 1992 to provide integrated EI/I services to children at risk of developing SED. These grants require that outreach efforts be multicultural and include parents, schools, health care providers, mental health professionals, child advocates, and daycare providers.

To Provide Effective Services ...

OBJECTIVE 23

Implement procedures for determining the extent to which services are meeting the level of need in each county and resulting in desired client outcomes.

A discussion of the new information systems used for monitoring service penetration into the target populations and service cost can be found under OBJECTIVE 4. Soon to be added to this system are client outcome data for CSP services. Plan objectives for 1993 include expansion of outcome data collection and outcome-based decision support to children's services.

OBJECTIVE 24

Promulgate state regulations that define the use of outcome standards for services.

Rule revisions discussed under OBJECTIVE 16 include efforts to define ways in which outcome standards can be used for case management, community support services, family community support services, and residential treatment. Revision of the case management rule is now complete. These rules will require counties to define desired client outcomes to all contracted providers of these services, and further require providers to report outcomes to counties.

The revision of Rule 79 (case management) increased the flexibility of the service by broadening the types of relationships allowed between providers and clients. Case managers had been advocating for this change since promulgation of the original case management rule in 1989.

OBJECTIVE 25

Increase the percentage of SPMI and SED populations receiving services.

(Section I, *Service Needs and Numbers Served* contains service-specific utilization tables for adults and children.)

The percentage of the state's adult SPMI population receiving services in the public system rose from 40% in 1987 to nearly 70% in 1992. There are now (1992) approximately 27,600 adults with SPMI receiving public mental health services.

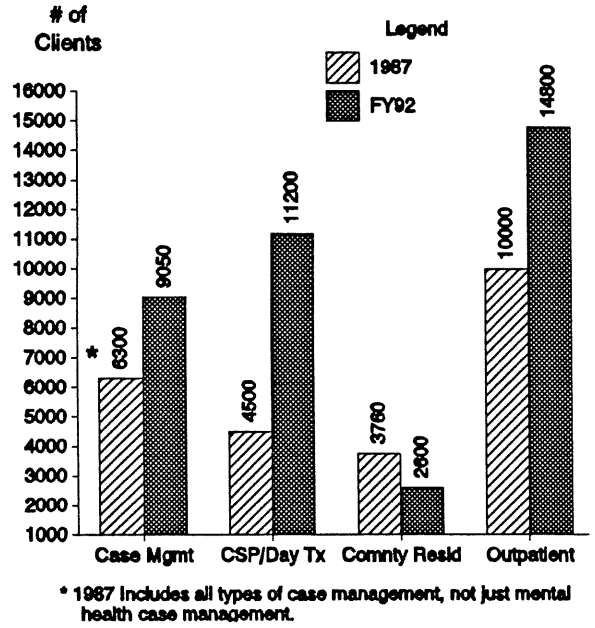
For children with SED, significant increases in the number receiving community or home-based services are not expected to be evident in the

data until 1993. The Children's Mental Health Act required implementation of most of these services in late 1991 and in 1992, and the SED population was not defined until mid-1989, making comparisons to children with SED served in prior years impossible. The data do show that about 17% (17,000) of the estimated statewide ED population in need of public services did receive these services in SFY 1992, and that most of these ED clients are children with SED.

Figure 18 shows how counts of SPMI clients have changed for each service from 1987 through FY 1992.

CSP services are defined in law as services for the SPMI population, so the increase in adult CSP/Day Treatment utilization from 1987 through FY92 (150%) is meaningful. Case management is also defined as an SPMI service, but not until 1989, meaning that 1987 numbers include non-mental health case management. There was a recorded 42% increase in this service nevertheless.

Figure 18
Changes in the Number of Adult Clients with SPMI, by Service



For children, comparable data are largely unavailable, due to delayed startup in services, recent definition of the SED population, and lag-time needed for automated recordkeeping systems to incorporate these new services and SED criteria. There are about 14,000 SED children now in the system of care.

To Provide Services Efficiently ...

OBJECTIVE 26

Provide services in least costly community settings when appropriate.

The trend toward greater use of nonresidential community-based services can be seen in the service utilization graph under OBJECTIVE 25. For adults, the proportion of clients served in community programs is increasing relative to institutional services. The pattern for children's services is not yet evident, since most of the children's community and home-based services were not scheduled for implementation until late 1991 or 1992; however, it is clear that most funding added to the system since 1989 is directed toward community and home-based programs.

Some of the special efforts made to shift resources and clients to community support services include: a) downsizing or converting 17 institutions for mental disease to non-IMD status; b) shifting residential treatment funds in 3 counties to community support services; c) development of individualized CSP services to enable discharge of RTC patients and nursing facility patients to the community; d) developing enhanced housing support services for over 200 people in 28 counties; e) developing 4 enhanced employability pilot projects; f) funding 14

consumer self-help programs; g) providing MA coverage for case management and home-based treatment; h) developing family community support programs in all 87 counties; and i) funding integrated early identification and intervention services in 28 counties.

Efforts to reduce the use of inpatient services have focused on the RTCs--use of community hospitals is already under rigorous controls such as Medicaid legislation. Control of RTC utilization has focused on "appropriate use" and higher quality of services, and on continuity of care between the RTCs and the community system, rather than on raw reduction of admissions. In other words, the goal has been to reduce the rate of *unnecessary* admissions and length of stay, not admissions overall. This has led to modest decreases in length of hospitalization and average monthly census, while admissions have held steady. (Admissions are defined as adults admitted to the RTC who were not previously discharged, transferred, or given leave within the report period.)

Measured in terms of patients, 1992 average daily RTC-MI census levels were roughly equivalent to 1987 levels, while the general increase in statewide SPMI caseload for all programs during these years was about 70%. This represents a relative decrease in the use of RTCs. (It is also important to note that Minnesota includes forensic patients and geriatric patients in its patient counts.)

Table 10 shows some comparisons of RTC statistics between 1987 and 1992. Statistics include both children and adults.

The fact that census and patient-days held steady against population and caseload increases implies more efficient use of the state-operated hospital system.

Table 10
RTC Admissions, Average Monthly Census, Long-Term Stays, and Patient-Days for SFY 1987 and SFY 1992

Statistic	SFY 1987	SFY 1992
Number of Admissions	2,787	2,875
Average Monthly Census per 10,000 pop.	3.0	2.8
Number of Patients Residing More Than One Year	812	649
Patient-Days per 10,000 pop.	1,373	1,368

OBJECTIVE 27

Establish a cooperative relationship between the State Mental Health Advisory Council (planning council) and the SMHA.

The SMHAC meets monthly to obtain information from the SMHA on progress in developing the adults and children's systems of care. The SMHA willingly participates in these meetings and attempts to meet all the requests of the Council. It makes a routine oral report to the Council and provides special reports, data, and documentation when requested. The SMHAC appoints task forces to work with the SMHA on specific issues or projects.

OBJECTIVE 28

Implement a model of case management that streamlines and coordinates service delivery to individuals with SPMI or SED.

Mental health case management in Minnesota is

defined generally in law and specifically in rule. The rule was promulgated in 1989 and significantly modified in 1991 and 1992. The case management model defined in this rule is one in which the case manager serves as an advocate, assisting clients to gain access to the broad array of mental health and other services. The model requires each case manager to have specific educational and experience qualifications, and contains frequency of client contact requirements. Case managers are expected to document the service activity of each client and his or her well being. Coordination of services is a key component of the model, as are development of a functional assessment and community support plan with each client. Services to children are to be provided in a manner that maximizes the opportunity for involvement of parents in the development and implementation of the client's service plan.

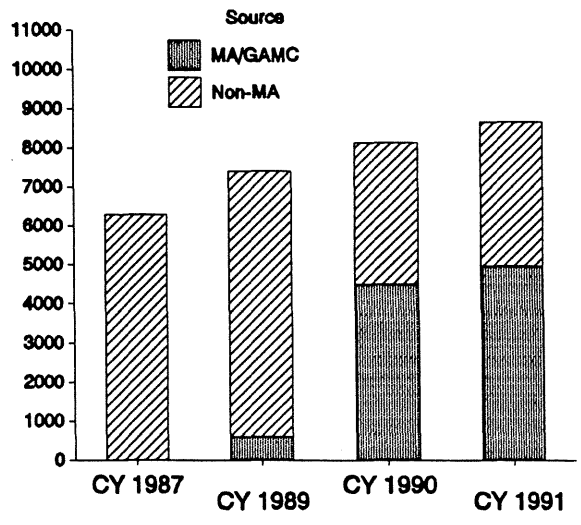
Even though a large increase in the number of recipients of case management was foreseen after promulgation of the state rule, it has been important to maintain reasonable caseload sizes and hours of service per client as well. Caseload sizes decreased between 1989 and 1992, and hours per client per year held steady. (Hours per client computation includes short-term clients, which tends to draw the average down.)

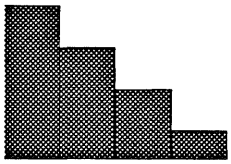
In order to make the new case management model viable, it was necessary to implement MA/GAMC reimbursement. This was done as part of the state rule, and its effects can be seen in the graph in Figure 19. The graph shows the rise in the number of adults with SPMI receiving case management services since 1987, and the proportion of these clients for whom the services were reimbursed by MA/GAMC. Fifty-seven percent of adult case management clients in 1991 were MA/GAMC clients.

All 87 counties provide mental health case management to their residents with SPMI, and three-fourths of the counties to their residents with SED. In FY92, about one in three adults with SPMI received the service, which translates to nearly half of the number of SPMI in *need* of the service (three-fourths of prevalence). Case management for children with SED has been slower to develop, primarily because children were not included in the state regulation until late 1991.

Current regulations require all counties to reduce average adult caseload size to 40:1 by December, 1992. Data collected during FY92 show that this goal, on a statewide average, has nearly been met; however a number of counties still exceed the 40:1 ratio. The 1992 revisions to the case management rule require all counties to reduce average adult caseload size to 30:1, and average children's caseload size to 15:1, by January, 1994. This requirement is, however, dependent upon the county's ability to expand MA revenues for case management.

Figure 19
Number of Adults With SPMI Receiving Case Management (by pay source)





IV. Special Reports

A. Public Academic Liaison Initiative

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 of Human Services (DHS) 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 DHS, the University of Minnesota, and other interested groups participated. As a result of the consultation, the 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 was placed on hold during 1992 pending the hiring of a Medical Director at DHS. Now that DHS has retained a new Medical Director and has the medical leadership necessary to effectively pursue these efforts, DHS and the Department of Psychiatry can revisit the appropriateness and feasibility of these agreements.

B. State-Operated Community Services

Beginning July 1, 1991, Minnesota Statutes 253.28, empowers the Commissioner of Human Services to establish a system of state-operated, community-based programs for persons with mental illness. Efforts to develop these programs are largely in the planning phase as of the end of 1992.

The focus of planning efforts has been to respond to locally defined needs and for the SMHA to work cooperatively with counties. Two mental health services commonly identified by counties as being inadequate are: a) psychiatric services in the community, and b) responsive mental health crisis intervention services.

Cambridge Regional Human Services Center (CRHSC) and Moose Lake Regional Treatment Center (MLRTC), in cooperation with Pine, Chisago, Mille Lacs, Isanti and Kanabec counties and the Five-County Mental Health Center have been studying the feasibility of converting a building on the campus of CRHSC to a crisis services center that would provide crisis shelter and mobile crisis intervention outreach services to residents of this five county area. If this crisis services center becomes a reality, admissions and 72-hour holds at MLRTC could be reduced. Shared service agreements, or other agreements between the RTCs and the counties, may include the use of some RTC psychiatrists time to provide psychiatric services to clients of the crisis services center and other county residents.

Willmar Regional Treatment Center (WRTC) has had a presence in the community for several years. This presence has been informal and generated as a response to locally defined needs. Examples include:

- consultation to Rule 36 residential treatment programs, and nursing homes,
- education of community care givers,
- informal follow-up on placements,
- and specific aftercare services to some former patients.

WRTC has a shared service agreement with Rice Memorial Hospital for psychiatrist time to address the community's need for more psychiatric services. It has also formed a State Operated Services Task Force with a goal to implement a state operated service in the community during fiscal year 1993.

Moose Lake Regional Treatment Center (MLRTC) has been active with community based providers in a number of areas.

- Consultation to community providers regarding treatment issues and behavioral intervention planning.
- A community residential treatment program (Rule 36 facilities) project with catchment area providers that includes training, joint planning, workshops and a crisis bed for early intervention.
- Staff members of the MLRTC are on each of the mental health subcommittees in each county. Feedback regarding issues with that county and MLRTC are discussed at those meetings.
- MLRTC staff informally contact some discharged clients to assist with the post-RTC discharge, and the clients adjustment to residing in a Rule 36 facility. Members of the MLRTC medical, nursing and social work staff have participated.
- With proposed closure, an assessment tool to assist the Department of Human Services and county personnel has been developed for placement purposes. Staff also consult with the planning board regarding closure issues.

The Mental Health Division of the Fergus Falls Regional Treatment Center (FFRTC) has been informally providing the following community-based services at the request of

counties and community services providers:

- training in the areas of therapeutic intervention, dual diagnoses, suicide and suicide prevention, and mental illness,
- consultation concerning discharged patients for local providers including nursing homes, group homes, and families, and
- education and support groups for families members and significant others.

Current discussions with Becker County are addressing their request for community-based services in the following areas:

- psychiatric follow-up for some discharged patients,
- ongoing consultation regarding the people who are elderly and have a serious and persistent mental illness,
- immediate crisis intervention phone consultation or in some cases on-site consultation for persons suffering from an acute episode of mental illness, and
- short-term inpatient evaluation, without going through the court system, for people who are elderly and have a major mental illness.

Discussions with the Northwestern Mental Health Center in Crookston are focusing on a shared services contract for psychiatric services.

St. Peter Regional Treatment Center (SPRTC) is working with Blue Earth County Mental Health Center to explore a shared services agreement to provide additional psychiatric services at the Mental Health Center. SPRTC and Olmsted County are discussing the feasibility of a shared services agreement for SPRTC to provide patient transportation to and from the Regional Treatment Center to that area of the region for court hearings, admissions to and discharges from the Regional Treatment Center. The Olmsted County Sheriff's Office is completing a needs assessment with the surrounding counties.

In cooperation with the Department of Human Services (DHS), counties in the Anoka-Metro Regional Treatment Center (AMRTC) catchment area, and community service providers, AMRTC is involved in the Anoka Alternatives Program (AAP). This is a contracted program for financial and service support after discharge for those AMRTC patients who are at risk of returning to AMRTC. Patients eligible for AAP services are those who have been hospitalized for a long period of time without discharge and those who, when discharged, have been unable to remain out of the hospital for a substantial length of time. This program has enabled many patients who would have had great difficulty leaving AMRTC in the past to be successfully discharged. (See OBJECTIVE 6 in Section II for more information about the Anoka Alternatives Program.)

AMRTC is currently planning a Centralized Services Program to integrate inpatient programming and to provide a bridge between hospital and community services for selected patients, especially those who require transitional involvement in group or individual psychotherapy and/or medication follow-up. Rehabilitation and social service staff will be working actively to involve patients in county community support programs prior to their discharge form AMRTC. On 1/28/93, the AMRTC Rehabilitation Therapy Department conducted a CSP Fair, at which representatives from all CSPs and related programs from all of the counties in the AMRTC catchment areas came to AMRTC to discuss their programs and services with AMRTC patients and staff. Such educational and information-sharing ventures will continue under the auspices of AMRTC's Centralized Services Program.

Another educational service planned for both inpatients and discharged patients is a

family psycho-education program. As a step in this direction, AMRTC Social Service Staff have already offered time-limited family psycho-educational groups for families of AMRTC patients on the AMRTC campus and at various locations in the community. As one component of the Centralized Services Program, DRS will be offering on-campus vocational services to AMRTC patients. The inpatient component of the program is designed to train patients to seek and obtain treatment in a way that will enhance their ability to cooperate with treatment in the community. The outpatient component is designed to provide support as patients make the transition form hospital to community and to enhance the probability that patients will be able to remain out of the hospital after discharge. Initially, all services associated with this program will be offered at AMRTC. But in the future, in order to increase the accessibility of the services to patients and their families, some of the transitional components will probably be offered at other locations in the community.

The AMRTC is also working with DHS and Hennepin County Medical Center to develop a proposal to provide for the treatment of Hennepin County committed patients at either HCMC or AMRTC, thus eliminating the need for these patients to be diverted to out-state hospitals and increasing cooperation between AMRTC and HCMC in the treatment of patients with serious and persistent mental illness. Under this plan, those patients requiring only short-term hospitalization would be treated at HCMC, and those needing longer hospitalizations would be admitted to AMRTC. Triage would be accomplished via regularly scheduled meetings of HCMC and AMRTC psychiatrists. This plan would increase the efficiency of discharge efforts by keeping patients closer to their county case managers and to those family and community resources that are key factors in successful discharge planning.

Also under the auspices of AMRTC, one psychiatrist is providing one-day-a-week consultation to Dakota County community mental health providers working with person with serious and persistent mental illness. AMRTC psychiatrists and psychologists are currently providing follow-up and transitional services (medication management, individual and group psychotherapy) to a limited number of discharged AMRTC patients (i.e., those who have difficulty establishing relationships with providers in the community, those for whom appropriate services are not available, and those who are on waiting lists for community services). Eventually, these services will be formalized and consolidated under the Centralized Services Program.

Appendices

-- Appendix A --
Legal Definitions of Target Populations

Sub 20. [MENTAL ILLNESS.]

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

(b) An "adult with acute mental illness" means an adult who has a mental illness that is serious enough to require prompt intervention.

(c) For purposes of case management and community support services, a "person with serious and persistent mental illness" means an adult who has a mental illness and meets at least one of the following criteria:

(1) the adult has undergone two or more episodes of inpatient care for a mental illness within the preceding 24 months.

(2) the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding 12 months;

(3) the adult:

(i) has a diagnosis of schizophrenia, bipolar disorder, major depression, or borderline personality disorder;

(ii) indicates a significant impairment in functioning; and

(iii) has written opinion from a mental health professional stating that the adult is reasonably likely to have future episodes requiring inpatient or residential treatment, of a frequency described in clause (1) or (2), unless an ongoing community support services program is provided; or

(4) the adult has been committed by a court as a mentally ill person under chapter 253B or the adult's commitment has been stayed or continued.

Sub 6. [CHILD WITH SEVERE EMOTIONAL DISTURBANCE.]

For purposes of eligibility for case management and family community support services, "child with severe emotional disturbance" means a child who has an emotional disturbance and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

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

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

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

-- Appendix B --
County Maintenance of Effort Levels and CY 1992 Planned Expenditures

COUNTY NAME	MAINTENANCE OF EFFORT*	1992 CTY SHARE	PERCENTAGE INCREASE
AITKIN	$145,150	$268,331	85%
ANOKA	$1,910,376	$3,049,579	60%
BECKER	$344,200	$608,300	77%
BELTRAMI	$370,850	$686,967	85%
BENTON	$311,101	$526,948	69%
BIG STONE	$90,692	$113,950	26%
BLUE EARTH	$637,089	$2,734,580	329%
BROWN	$306,120	$319,397	4%
CARLTON	$307,684	$1,176,728	282%
CARVER	$581,777	$1,423,342	145%
CASS	$165,800	$696,560	320%
CHIPPEWA	$248,269	$358,841	45%
CHISAGO	$219,956	$414,346	88%
CLAY	$486,290	$1,028,203	111%
CLEARWATER	$92,083	$217,018	136%
COOK	$29,882	$144,020	382%
COTTONWOOD	$171,588	$506,067	195%
CROW WING	$300,982	$1,051,237	249%
DAKOTA	$2,470,163	$5,074,560	105%
DODGE	$130,242	$167,428	29%
DOUGLAS	$142,263	$882,770	521%
FILLMORE	$155,306	$222,749	43%
FARIBAULT/MARTIN	$404,720	$1,004,262	148%
FREEBORN	$573,100	$1,774,124	210%
GOODHUE	$469,143	$774,290	65%
GRANT	$61,210	$102,675	68%
HENNEPIN	$20,611,220	$35,949,771	74%
HOUSTON	$169,019	$395,804	134%
HUBBARD	$110,000	$711,420	547%
ISANTI	$235,326	$629,586	168%
ITASCA	$452,122	$938,550	108%
JACKSON	$119,651	$151,302	26%
KANABEC	$80,370	$228,826	185%
KANDIYOHI	$955,586	$1,443,941	51%
KITTSON	$54,741	$57,090	4%
KOOCHICHING	$313,930	$373,026	19%
LAC QUI PARLE	$73,681	$186,079	153%
LAKE	$118,106	$266,695	126%
LAKE OF WOODS	$28,194	$108,096	283%
LE SUEUR	$187,231	$396,780	112%
MCLEOD	$205,155	$593,660	189%
MAHNOMEN	$50,470	$188,280	273%
MARSHALL	$111,801	$184,720	65%
MEEKER	$226,436	$388,813	72%
MILLE LACS	$180,636	$640,000	254%
MORRISON	$330,870	$374,845	13%
MOWER	$839,601	$911,710	9%
NICOLLET	$270,258	$560,511	107%
NOBLES	$370,063	$429,497	16%
NORMAN	$141,567	$141,567	0%
OLMSTED	$1,262,603	$1,784,791	41%
OTTER TAIL	$323,496	$900,866	178%
PENNINGTON	$136,221	$205,054	51%
PINE	$342,013	$506,750	48%
PIPESTONE	$106,565	$207,242	94%
POLK	$492,700	$1,064,111	116%
POPE	$107,400	$128,000	19%
RAMSEY	$7,235,139	$16,055,876	122%
RED LAKE	$27,084	$48,387	79%
REDWOOD	$248,757	$336,994	35%
REGION VIII	$632,938	$862,245	36%
RENVILLE	$383,000	$621,683	62%
RICE	$420,294	$604,044	44%
ROCK	$105,750	$148,104	40%
ROSEAU	$74,150	$125,820	70%
SAINT LOUIS	$2,611,000	$5,370,000	106%
SCOTT	$447,501	$712,503	59%
SHERBURNE	$384,545	$736,631	92%
SIBLEY	$187,400	$321,500	72%
STEARNS	$900,796	$2,096,055	133%
STEELE	$388,035	$420,839	8%
STEVENS	$59,409	$81,700	38%
SWIFT	$213,100	$253,795	19%
TODD	$171,987	$340,191	98%
TRAVERSE	$77,940	$159,505	105%
WABASHA	$207,910	$257,800	24%
WADENA	$83,470	$127,684	53%
WASECA	$176,476	$409,545	132%
WASHINGTON	$1,312,863	$3,046,418	132%
WATONWAN	$118,641	$182,108	53%
WILKIN	$139,064	$215,495	55%
WINONA	$323,702	$699,322	116%
WRIGHT	$495,276	$1,113,163	125%
YELLOW MEDICINE	$145,845	$326,600	124%
TOTAL	$57,705,140	$112,048,662	94%

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