Minnesota
*Department of Human Services*

# Mental Health Report to the Legislature

▸▸ 1994 ◂◂



## Submitted in Compliance With Statutory Requirements

Pursuant to: Minn. Stat. 245.461 Subd. 3
Minn. Stat. 245.487 Subd. 4
Minn. Stat. 345.73 Subd. 4
Minn. Stat. 245.4861
1992 Minn. Laws Chap. 513 Art. 8 Sec. 55

# 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 | 1-81 |
| Implementation of children's mental health services | §245.487, subd. 4 | 1-81 |
| Adult mental health residential treatment | §245.73 | 4,18,22,26,32,34, 36,40,59,71 |
| Public-academic liaison initiative | §245.4861 | 83 |
| MSA Shared Housing Demonstration Project | Laws of 1992, Chap. 513, Art. 8, Sec. 55 | 84 |

# Table of Contents

## *Summary*

This document constitutes several mental health reports that the Minnesota Legislature requires of the Department of Human Services this year. These reports are listed, with page numbers, inside the front cover.

The document is divided into four chapters. Each chapter presents information about both the adult and the children's mental health systems.

***Chapter I***

This chapter contains a detailed description of the adult and children's public mental health systems in Minnesota. It includes information on the "vision" of these systems, as written into the Comprehensive Adult and Children's Mental Health Acts. It also includes information on the organizations that provide services and administer the services systems, on the populations who need and receive these services, and on the resources that maintain the systems.

***Chapter II***

Chapter II describes the progress that was made in 1993 in meeting each of the state's mental health objectives for that year. Some of the key accomplishments include:

*For Adults*

- Development of a plan to transfer the Moose Lake Regional Treatment Center to the Department of Corrections.
- Plans for several pilot projects to test integrated funding for adult services.
- A targeted reduction in adult residential treatment days per year that was exceeded by almost twice the target amount.
- Targets for payment of adult case management and day treatment through MA/GAMC were exceeded.
- Adult CSP and housing support grants were integrated into a single grant.
- A cultural diversity task force was created to assist the Department in developing a cultural agenda.
- Reduction in the number of IMDs far exceeded the targeted reduction.

*For Children*

- The legislature passed legislation to fund development of local children's mental health collaboratives.
- Funding for children's services increased 24% over the 1992 level (including increases in Medical Assistance and state grants).
- 65 local coordinating councils received funding for integrated early identification

services for children.

- The target for case management hours per child client per year was exceeded.
- Almost 50% of child clients with SED received MA/MinnesotaCare services, assuring them access to a wide range of health and mental health services.
- Program standards for family community support services were developed.

*Chapter III*

This chapter presents the state's mental health objectives for 1994. There are 38 objectives for the adult system; 25 for the children's. Information on the need for each objective is also presented.

Key priorities for 1994 include:

*For Adults*

- Progress toward development of a model integrated services system in the Moose Lake region.
- Reduced utilization of inpatient and residential services.
- Further simplification of mental health funding.
- Provision of mental health services to victims of flooding.
- Continued development of community-based crisis intervention services.
- Human resource development, including cultural sensitivity.
- Outcomes-based program evaluation.
- Empowerment of consumers.
- Collaboration between public and private agencies in the development of community-based services.

*For Children*

- Appropriate placement of children into out-of-state and out-of-county residential treatment facilities.
- Further simplification of mental health funding, enabling dollars to follow clients.
- Provision of mental health services to victims of flooding.
- Greater availability and use of family community support services, home-based treatment, early identification/intervention, and case management services.
- Greater integration of children's mental health services with social services, education, corrections, and health agencies.

*Chapter IV*

Chapter IV contains two reports: a) a report on the public-academic liaison initiative in mental health, and b) a report on the findings of the MSA Shared Housing Demonstration Program.

### *The State Mental Health Advisory Council*

A key participant in the preparation of this document was the State Mental Health Advisory Council, many of whose members contributed valuable time to review drafts. The Council, nevertheless, does not endorse all of the content in this document, and will issue its own report on the status of Minnesota's mental health system later this year.

Some of the points of disagreement, or shortcomings, the Council sees in the plan for 1994 (Chapter III) include:

- Unambitious targets for the extent to which services will meet existing need.
- Absence of a long-range state plan for the next ten years, with cooperative planning across all levels and departments of government, and taking into account client need and satisfaction.
- Ineffective or inefficient use of existing resources, with over-allocation towards inpatient treatment programs.

### *Terms and Abbreviations*

The acronym "SMHA" stands for the State Mental Health Authority, which, for the purposes of this report, means the Department of Human Services, Community Mental Health and State Operated Services Administration. The term "the state" does not refer to the SMHA, but rather to all the mental health organizations and resources within the state of Minnesota that together constitute an agent of policymaking and implementation.

"MA" refers to Medical Assistance, or the state's Medicaid program. "MNCare" denotes the state's MinnesotaCare program.

"RTC" refers to one of the state-operated Regional Treatment Centers.

Several mental health services are sometimes abbreviated, including: community support program (CSP), family community support services (FCSS), and early identification and intervention (EI/I).

### *For More Information*

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, Mental Health Division, 444 Lafayette Road, St. Paul, MN 55155-3828, (612)-296-4497.

# Chapter I

# Status of Minnesota's Public Mental Health System

This chapter describes the current status of Minnesota's public mental health system. It addresses the following aspects of the system: a) the types of organizations of which it is composed, b) the guiding policy (law) by which it is shaped, c) the populations for whom it is targeted, d) the types of services it delivers to these populations, e) the level of need for these services, and f) the types and amounts of resources that support the delivery of public mental health services.

## *Organizational Structure*

The Minnesota public mental health system is composed of three basic types of organizations:

1) the state mental health authority (SMHA), part of the Department of Human Services;

2) the local mental health authority, the county board of commissioners and its administrative agency; and

3) 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, as do recently formed state and local coordinating bodies.

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

**The State Mental Health Authority (SMHA)**

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:

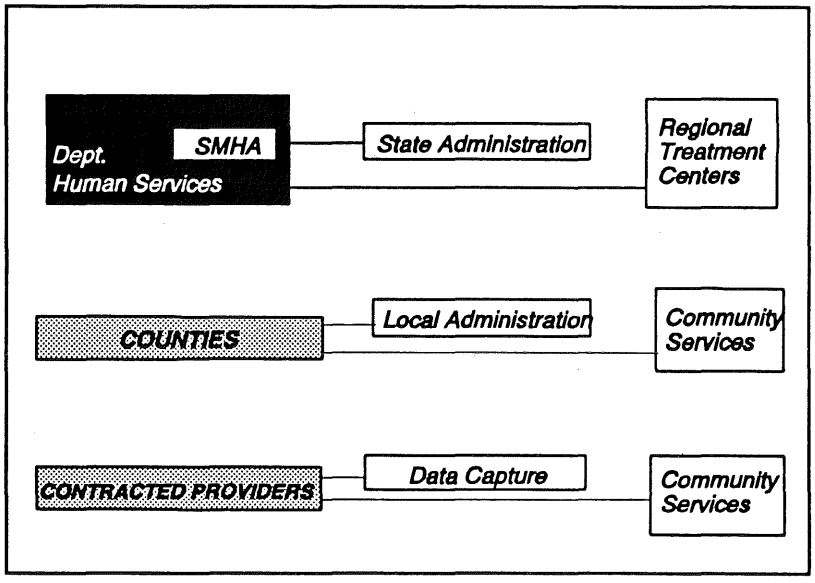
- defining and disseminating statewide policy for mental health service delivery and administration, and monitoring compliance with established policy;
- coordinating development of statewide and local mental health system plans, including statewide goals and objectives;
- developing new programs of 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 the state legislature and to 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.

**County Boards**

*FIGURE 1: Roles of Organizations*



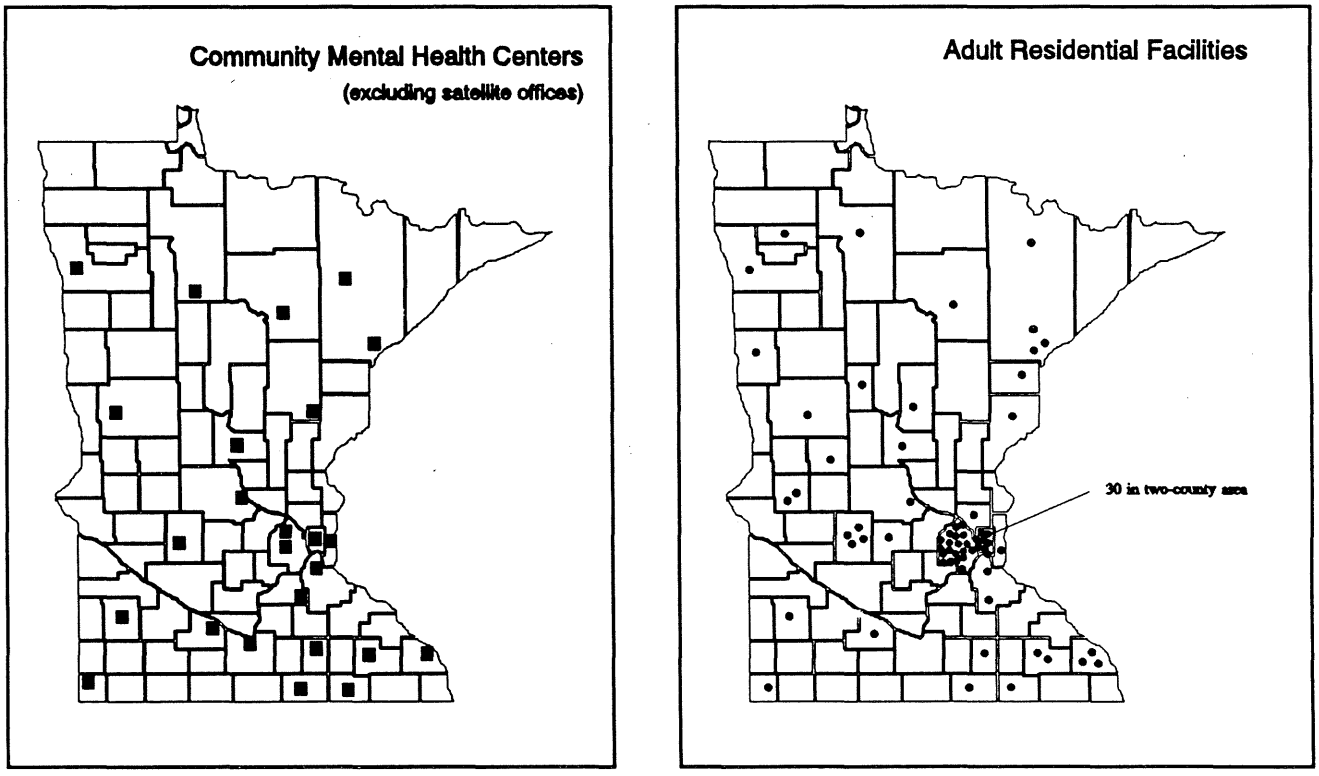

State law assigns the responsibility of day-to-day administration of local community mental health systems to county boards of commissioners. Each county board is responsible for system planning, for implementing and coordinating programs of service delivery among local providers, for coordinating client care through case management, for deciding how to allocate and expend public mental health resources, and for reporting data and information requested by the SMHA. Most public mental health services in the state are purchased by counties from contracted provider organizations, although in some cases counties are themselves providers of services.

**Providers**

The third type of organization is the service provider agency. Outpatient services are typically provided by contracted community mental health centers (CMHCs) or outpatient clinics of community hospitals, while private residential facilities, most under 16 beds, provide residential treatment to county clients. There are 26 CMHCs, 75 adult residential treatment facilities, and

42 children's residential treatment facilities in the state. 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 community hospitals or is provided by the regional treatment centers (RTCs) operated by the SMHA.

*FIGURE 2: Location of CMHCs and Adult Residential Treatment Facilities*




## Advisory Organizations

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) advises the Governor, the legislature, and the SMHA on policy and planning issues. The SMHAC includes a children's subcommittee of more than 50 members.

### State Legislature

In recent years, the state legislature has passed two major pieces of mental health legislation that outline the key features of the public system. The Comprehensive Adult Mental Health Act defines the services system for adults; the Comprehensive Children's Mental Health Act defines the type of system to be provided to children. It is these mental health acts that define the roles and responsibilities of the SMHA, county boards, and local advisory and coordinating councils.

### Coordinating Bodies

Another organizational component of the public system is the coordinating body, which exists in different forms at the state and local levels, and which is concerned with coordinating services to children among the various agencies with which children are involved. The State Coordinating Council links representatives of the state departments of health, mental health, education, corrections, and planning around issues relating to children's mental health. Its purpose is to coordinate development of state policy and procedures in order to avoid unnecessary duplication or inconsistency across agencies. Also at the state level, the Children's Integrated Fund Task Force has been in operation for the past two years, developing mechanisms by which funding for children's services can be integrated.

At the county level, Local Coordinating Councils (LCCs) have been formed to recommend mechanisms for local coordination of children's services, and in many cases to carry out the functions of coordination at the level of individual clients and across provider organizations.

### State and Local Adult Mental Health Task Forces

Under authority of legislation passed in 1993, the Department of Human Services convened a state task force to make recommendations on how to improve coordination and funding of the adult system. This same legislation enabled local advisory councils (LACs) to form local task forces and to pass on the recommendations of these local task forces to the state task force. The state task force will report its recommendations to the legislature in January, 1995.

### Consumers and Families

In addition to organizations, clients and their families also 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. In 1994, the SMHA will establish an office for consumer affairs.

## Organizational Reform

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; however, interest in channeling efforts toward those services and programs that demonstrate effectiveness, through outcome measurement and performance-based evaluation, is also growing.

Total Quality Management (TQM) philosophy and techniques are being implemented in the SMHA and in its regional treatment centers. 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. This type of "partnership" between state and local authorities does not ignore demands for accountability, however. Several efforts are underway to develop the technology upon which outcome-based performance appraisal can be implemented.

## Benefits and Drawbacks to This Structure

The advantages to the decentralized administrative structure in Minnesota are that it allows decisions to be made closer to the level of program operation, that it permits local involvement in planning and policymaking, and that it promotes variation in programs to meet differing needs. Local decisionmaking includes evaluation and selection of providers, as well as program management and case management activities. Residents of the county, consumers and providers of services, and other local sources of knowledge and experience are easily incorporated into local planning processes that inform statewide planning and policymaking. Finally, variation among local programs provides opportunities to test new ideas and to identify options that are most effective.

Drawbacks to the decentralized system have mostly to do with the production of information and with regulation. Decentralization means that mental health organizations, even within the same county, will operate different data systems. This makes procedures for the transfer of data to the higher administrative levels difficult to standardize, meaning that data-receiving systems have to be able to accept data in a variety of formats and on various media. Some counties cannot receive data from their providers because their level of technological capability is below that of their provider organizations. The SMHA also finds it difficult to develop regulations that apply to all programs, when those programs are inherently different from one another in approach.

## Prospective Changes

Several changes in the organizational structure of the public system are foreseen in the future.

These include:

- A reduced role for the SMHA as a provider of inpatient treatment;
- An increased role for consumer organizations and local advisory councils;
- Creation of local children's mental health collaboratives; and
- An increased role for the State Coordinating Council for children's mental health.

The SMHA is in the process of converting the role of its regional treatment centers from inpatient services to alternative (community-based) mental health services, or to other roles. Last year saw the passage of a law that converts a 200 bed center from adult mental health inpatient treatment to corrections, and that transfers most of the funding to community alternatives. At the same time, several pilot projects are underway to test the feasibility of converting the RTCs to provision of crisis intervention and community-based mental health services.

Federal block grant funds have assisted establishment of a statewide consumer network that has elected officers and is currently in the process of forming county chapters. The SMHA further supports this effort with technical assistance and by providing access to mailing lists. The SMHA provides stipends each year to allow consumers to attend a national conference on mental health consumer issues, and scholarships to consumers in each county for attendance at the state's annual CSP conference.

For the purpose of integrating children's services, the state has provided planning grants to collaboratives that are formed under agreements among the various local systems serving children. These collaboratives will submit integrated services and funding plans to the SMHA in late 1994.

## *Comprehensive Mental Health Acts*

In 1987 the state legislature passed the Comprehensive Adult Mental Health Act, and, in 1989, 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, and emphasizing further development of community-based services. Like the adult act, the children's act defines a service array, in this case for children with serious emotional disturbance (SED), which emphasizes development of community-based services. The children's act also requires that services have a family focus, and that mental health services be integrated across the health, mental health, educational, social service, and correctional systems.

## Mission

Both mental health acts express essentially the same mission for the adult and children's systems. This mission 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.*

This mission statement shapes service system development by maintaining focus on the key concepts of comprehensiveness, unity, accountability, effectiveness, and efficiency.

## Values

In addition to the mission statement, key values also shape development of the adult and children's service systems. These values are:

- Community living
- Client's rights and empowerment
- Equal access to services
- Improvement in client functioning and quality of life
- Partnership among organizations

The adult and children's service systems should allow persons with mental illness or emotional disturbance to live in environments available to the general public; in stable, affordable housing; in regular educational settings; and in settings that maximize integration with families and the community, and that provide opportunities for acceptance. Living arrangments and settings should promote independence and safety for the client, and for the child should permit services to be delivered in the contexts of home and school.

The adult and children's systems should ensure that client's rights are clearly explained, understood, and protected, and that clients are empowered to exercise choice in the services they receive. They should also ensure that, regardless of ethnic or cultural background, age, sex, or other disabilities, members of the target populations have equal access to services, and that these services are designed to accomodate their special needs.

The aim of the adult and children's system's is to improve the level of functioning of clients, and their quality of life, through reduction in symptoms of mental illness or emotional disturbance, including reduction in the frequency or duration of emotional crises.

Finally, organizations that participate in planning, funding, managing, coordinating, or providing services should work cooperatively in the best interest of client and family.

**Vision**

Within the framework of the mission statement and values discussed above, the adult and children's mental health acts define a desired system of care that is composed of the key elements shown in Figure 3.

The adult system is several years ahead of the children's system in terms of implementation of the elements in Figure 3, and is currently focused on development of greater partnership among organizations, on methods for assessing levels of need and program effectiveness, on individualization of services, and on creative funding strategies and management techniques.

The children's system emphasizes integration and continuity of care across agencies as it strives to extend community-based and home-based services to a larger portion of the target population.

*FIGURE 3: Key Elements of the System of Care*

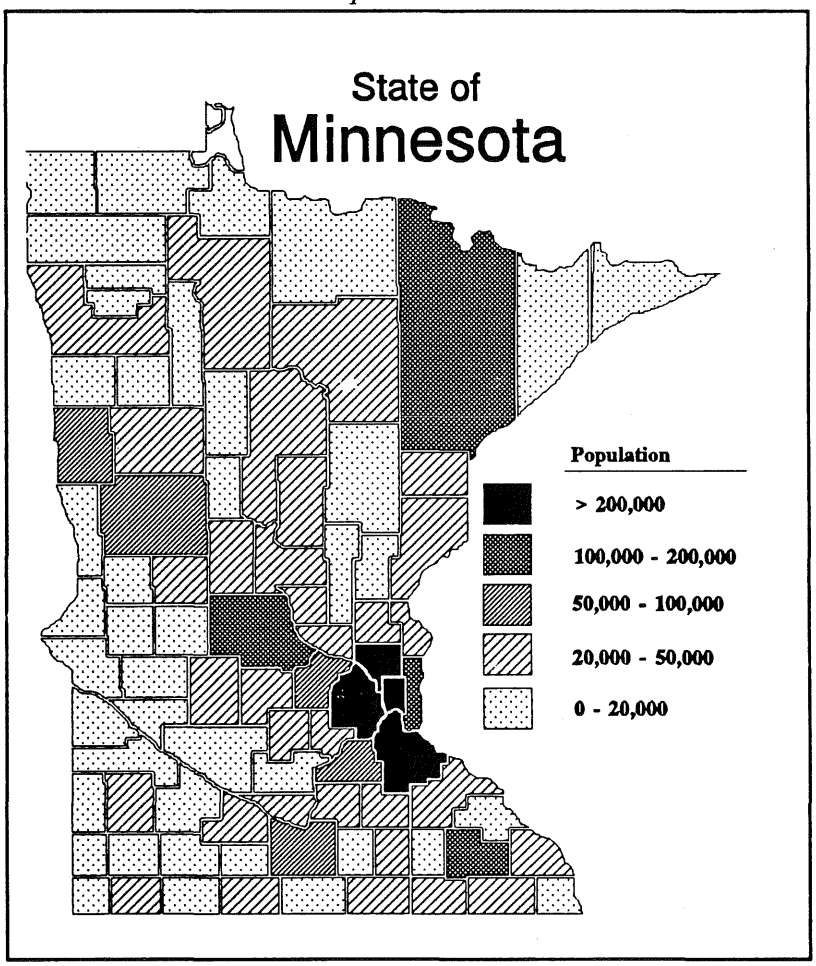
- A comprehensive array of services designed to meet varied needs of the target populations
- Services that are effective in meeting the needs of clients
- Provision of services to all persons in the target population who desire services and who require services from the public system
- Reliance on community-based services to meet the needs of the vast majority of the target populations
- Local systems of care that are integrated across providers and service systems
- Methods for monitoring and assisting development of local services systems
- Involvement of all stakeholders in planning services and in policymaking
- Involvement of consumers in service delivery
- State standards that permit local flexibility while ensuring appropriate and effective care
- State policy that establishes a working partnership between levels of government, providers, consumers and families, and advocates
- Maintenance of clients' rights, dignity, worth, and privacy
- Access to the system that is simple, nonthreatening, and culturally sensitive
- Individualization of care to the fullest extent possible
- High levels of client satisfaction, improved functioning, and quality of life across all programs and services
- Ongoing, reliable methods for assessing levels of service need in the community
- Ongoing, reliable methods for assessing the service needs of individuals
- Funding strategies that promote creative approaches to care and reward effective approaches
- Management techniques that optimize resource utilization

## *Demographics and Target Populations*

Census figures of 1990 indicate that there are approximately 4,375,000 persons living in Minnesota. Of this total, about 3,209,000 are adults and 1,166,000 are children. Children are defined as persons under the age of 18.

Whites constitute the largest racial group--95% of adults and 90% of children. African Americans are the largest minority group among both adults and children, followed closely by Asians/Pacific Islanders. American Indians and persons of Hispanic origin constitute significant minority populations as well.

*FIGURE 4: Population Distribution in Minnesota*




There are 87 counties in the state, ranging in population from 3,800 to 1,033,000. Forty-two counties have population sizes under 20,000, the figure used by the SMHA to define rural counties. The map in Figure 4 displays the population distribution in the state.

**Primary Target Populations**

The state mental health acts define two primary target populations, one for adults and one for children. The primary target population for the adult system is termed "adults with serious and persistent mental illness," or SPMI. The definition for SPMI corresponds to the federal definition for serious mental illness (SMI), and in the remainder of this document, the term SMI will be used to denote this target population. SMI does not include persons with developmental disabilities or chemical dependency, unless these conditions coexist with mental illness. It does include persons

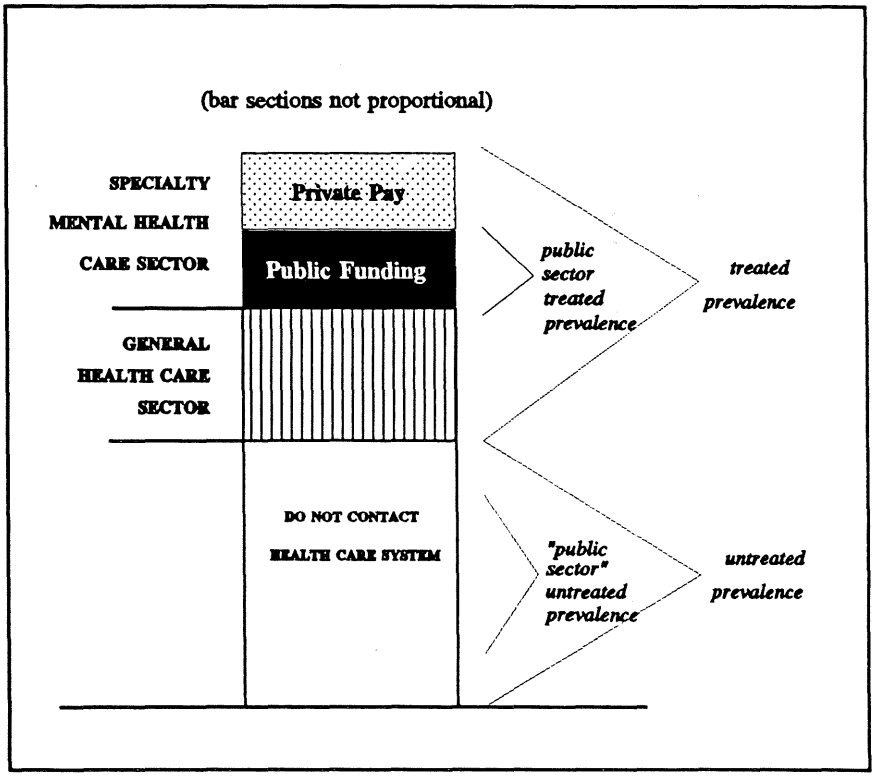
diagnosed with alzheimer's disease.

The primary target population for the children's system is children with serious emotional disturbance (SED). SED does not include children at risk of developing SED, only those with a diagnosis and resultant impairment of functioning.

The state also defines a subgroup of the SED population as "severely emotionally disturbed" (SvED). This subgroup is the primary target population of several of the children's services.

The SMHA uses flat rates to estimate the prevalence of SMI and SED in the state and county populations. For short-term planning purposes, the prevalence of SMI in the adult population is estimated at 1%, or 32,000 adults; the prevalence of SED is estimated at 11.8%, or 130,000 children, and the prevalence of SvED (5%) at 58,000. These rates are based on aging national studies that are widely viewed as under-estimating the true prevalence of SMI. New methods for estimating the prevalence of SMI and SED are expected to be available sometime in 1994. (Note: Minnesota did consider using a newer prevalence rate of 2.8% for SMI, which is based on ECA data from the NIMH; however, this rate relies on diagnosis and functioning criteria that might not coincide with the forthcoming, operationalized federal definition for SMI.)

*FIGURE 5: Prevalence and the Service Sectors*




Not all of the 32,000 adults with SMI, nor all of the 130,000 children with SED, are in need of services from the public sector. The graph in Figure 5 illustrates that some persons in the target population who seek services, as many as 50% by some estimates, receive these services from the general health care sector, while some of those seeking services in the specialty mental health care sector are able to pay for these services from private sources. The precise percentage of the SMI and SED prevalence populations that need services from the public sector is not known; although data from the

National Comorbidity Survey suggest that 64% of persons with "severe mental disorders" have private insurance coverage. The SMHA applies rates to estimate the size of these "public-sector" populations: 75% of the SMI target population and 25% of the SED population. These rates result in a *public-sector SMI population* of 24,000, and a *public-sector SED population* of 32,500.

**Special Populations**

Both the adult and children's systems contain services aimed at the unique needs of special populations. These special populations include:

- persons with dual diagnoses
- persons with SMI or SED from racial or cultural minorities
- homeless persons with SMI or SED
- discharges from the RTCs and from children's residential treatment
- nursing facility residents
- compulsive gamblers
- residents of rural counties
- children at risk of developing SED
- children in detention facilities
- victims of severe 1993 floods.

Persons with dual diagnoses of mental illness and chemical dependency (CD), or developmental disability (DD), appear to represent a relatively small percentage of clients in the mental health system, according to diagnoses submitted with billings for Medicaid reimbursement. These billings indicate that about 3.3% of persons who received mental health services during a year had a CD or DD diagnosis concomitant with a diagnosis of mental illness. Both service providers and advocates in the state, however, feel that the true percentage is much higher--perhaps over 30%. There are few specialized services yet developed for these special populations. The Chemical Dependency Division of the Department of Human Services has received funding for a pilot project to address the needs of the MI/CD population. In addition, one of the state's PATH grant target populations is homeless persons with co-occurring MI and CD.

Homeless persons with SMI, and with SMI co-occurring with CD, are targeted with outreach, screening, case management, and supportive services under the state's Projects for Assistance in Transition from Homelessness (PATH) grant. A 1991 statewide survey of homeless persons estimates that about 5,500 homeless adults with mental illness live in Minnesota. 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. In FY92, $730,000 were expended on the homeless projects.

Many of the most difficult to treat adult clients are in the RTC system. Upon discharge, these clients often need special services to reduce the chances of rehospitalization and to maintain an acceptable quality of life in the community. Similarly, children discharged from residential treatment facilities often have no place to go, no family or community-based setting where they can receive ongoing treatment and support.

Persons with SMI or SED who are from racial or cultural minority groups are of special interest because a system that must provide services to a population that is 95% white runs the risk of creating barriers to access by minorities. The cultural sensitivity of service programs, reflected in the number of staff employed from minority groups and in the number of minority clients being served, is an important aspect of the system.

Applicants to nursing facilities, and residents of those facilities, who have or are expected to have a major mental illness, have constituted another special target population. In SFY 1993, a total of 2,655 applicants and 1,140 residents received Level II preadmission screenings and annual resident reviews under Public Law 100-203. Diversions and relocations from nursing facility care numbered 254.

Another subpopulation of interest is 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.

In rural areas, distance from available services can be an issue, especially where public forms of transportation are not available. There are 42 Minnesota counties defined as rural on the basis of 20,000 or fewer residents; 45 are nonrural.

The number of Minnesota children *at risk* of developing SED is unknown, although estimates based on nationally derived percentage rates indicate that this number far exceeds the number of children *with* SED. Community education services, outreach services, and early identification and intervention services (EI/I) are provided in the public mental health system in order to prevent development of SED. Some school systems are collaborating with county mental health authorities in two ways: a) by allowing EI/I to be based in the schools and contributing funding to these programs, and b) by jointly providing day treatment in some local systems. The fundamental change in schools over the last few years has been an increasing awareness of nonbehavioral forms of emotional disturbance, such as depression.

Many of the children located in detention facilities suffer from serious emotional disturbance and need mental health services.

Finally, severe flooding in 1993 caused over half of the state's counties to be declared disaster areas by the federal government. The state received a grant in August of 1993 to begin provision of mental health services to the populations affected.

## *Services*

Figure 5 lists the services mandated in the Comprehensive 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. A problem facing development of the adult system is extensive reliance on the state-operated RTCs for treatment of this population. These facilities consume a relatively large proportion of total mental health funds. Integration of children's mental health with other systems serving this population is just getting underway, with recent enactment of legislation and funding for local collaboratives.

### Emergency and Crisis Services

Provision of locally available mental health *emergency* services is the highest priority of both the adult and children's mental health acts. Typically, this service takes the form of a 24-hour phoneline with access to a mental health professional. This service represents one form of crisis intervention services, which are designed to prevent hospitalization. Another crisis-related service is crisis assistance, which is one of the components of a community support program, and which focuses on enabling the client to recognize the onset of a crisis.

### Case Management (Adults and Children)

Case management must be provided to any adult with SMI or child with SvED who requests or consents to receive the service. State regulations allow counties considerable flexibility in the type of case management model they employ. State law requires case managers to assist clients in gaining access to a broad array of mental health and other services, including medical, social, educational, and vocational services. Case manager qualifications and procedural and outcome specifications for case management services are defined by state 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.
The primary barrier to effective and equitable case management for all eligible persons in Minnesota is high caseload size. Current caseload sizes for adults and children are too high to

allow enough clients to receive the service, or enough service to be provided to each client. Counties are not ethusiastic about adding case managers to their staff because of tight budgets. Nevertheless, most counties have added case managers during the last three years.

Another barrier to provision of case management is the restrictive nature of reimbursement regulations in the state's Medicaid system and the extensive paperwork that is associated with that system.

(NOTE: The term "case management" in this document refers to *mental health* case management as defined in State Rule 79. A more general form of "social services" case management is also available to mental health clients.)

*FIGURE 5: Services to be Available in Each County*

***Services to Adults and Children***

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

***Services to Adults Only***

- Community Support Services

***Services to Children Only***

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

**Community Support Services (Adults)**

Community support programs (CSPs) include the services of outreach, housing support, day treatment, crisis assistance, employability services, medication monitoring, benefits assistance, psychosocial rehabilitation, and development of independent living skills. Case management and day treatment are also often part of an individual client's CSP. 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" support services. Enhanced housing support services, for instance, represent an intensive (e.g., higher frequency) effort to locate housing and to assist clients in retaining housing.

**Family Community Support Services and Related Services (Children)**

Family community support services (FCSS) include outreach, crisis assistance, medication monitoring, locating respite care, developing parenting skills, developing independent living

skills, leisure and recreational activities, benefits assistance, and help with acquiring financial resources. Related services include day treatment, therapeutic support for foster care, and professional home-based treatment. Both FCSS and related services are designed to help children with SED live and function at home, at school, and in other community settings.

**Integrated Early Identification/Intervention (Children)**

Integrated early identification/intervention (EI/I) services are designed to identify children who are at risk of developing SED, and to arrange intervention and treatment when appropriate. The service is being developed through state interagency funding and federal block grant funding. Communities with EI/I grants are educating child-serving professionals about the mental health needs of children, and are then creating an interagency linkage system that typically relies on the local coordinating council (LCC) as the focal point. Children who are identified as at risk can then be provided a "customized package" of community-based services.

**Traditional Treatment Options (Adults and Children)**

Treatment of mental illness or emotional disturbance is designed to alleviate the clinically manifested symptoms that result in functional impairment and lowered quality of life. Inpatient treatment is provided to adults and children in acute care community hospitals and in the state-operated 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.

Inpatient treatment is designed to stabilize the medical and mental health conditions involved in an acute episode of mental illness or emotional disturbance. The services of inpatient treatment are provided under medical direction in a hospital setting meeting state health standards. The treatment goal is to improve functioning to the point where discharge to residential treatment or community-based services is possible.

Outpatient programs consist primarily of diagnostic and assessment services, psychotherapy, and medication management.

Residential treatment occurs a 24-hour, non-secured residential facility of more than 4 beds. The focus of the treatment is on rehabilitative services, and length of stay for adults averages over 250 days, as opposed to the much shorter 15-20 days in an acute hospital inpatient program. Adult patients of these hospital programs are often referred to residential treatment facilities after their psychiatric conditions have been stabilized.

## Other Supportive Services

In addition to the mental health supportive services, 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. MinnesotaCare's benefits package includes physician's services, vision care, prescription drugs, chiropractic services, lab, X-ray, home health, and immunizations, in addition to mental health treatment services that are covered to the limits established for Medicaid.

Many mental health clients also receive social services, including employment, shelter, and adult protection services.

## Service Capacities

One criterion by which to measure the efforts being made to treat the SMI and SED target populations is the capacity of service. Capacity reflects the amount of resources invested in the service, and is important because it is toward invested resources that clients tend to move.

The capacities of inpatient and residential treatment programs are easily measured, because the units of measure--beds--are real and relatively fixed. Capacities of service programs that are not facility-based--primarily, day treatment and supportive programs--are less easy to measure. These programs tend to expand and contract in flexible response to changes in need and resource levels.

Table 1 shows the bed capacities of inpatient and residential treatment facilities that serve adults and children in the public system.

*TABLE 1: Statewide Service Capacities*

| Service | Measure | Current Capacity | |
|---|---|---|---|
| | | Adults | Children |
| Residential Treatment | beds | 1,600 | 1,160 |
| Inpatient (community) | beds | 950 | 170 |
| Inpatient (RTC) | beds | 1,370 | 70 |

**Priority Services**

The Comprehensive 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. Nevertheless, 1993 witnessed passage of legislation that will result in the transfer of one RTC to corrections. Reduction in the use of inpatient treatment and development of appropriate community alternatives remain priorities of the SMHA.

Other service priorities are implementation of crisis/emergency services in all counties, housing development, and implementation of FCSS and integrated early identification/intervention services for children.

**Development of New Services**

In recent years the SMHA has taken a demonstration-first approach to developing new and better services--in particular, alternatives to hospitalization for adults, and integrated EI/I for children. In this approach, it is only after programs have demonstrated their effectiveness in pilot counties that efforts at statewide implementation are made.

One important example of this demonstration-first approach is a project begun in 1990 to develop individualized community support services for long-term patients of the Anoka-Metro RTC, who were ready for discharge with intensive community-based supportive services. Most of the program's clients have avoided rehospitalization, and the SMHA has obtained funds to develop similar services as an alternative to Moose Lake RTC inpatient treatment. Housing support programs have been developed and expanded in a similar way, and in 1992 the approach was applied to employment programs, self-help programs, and crisis intervention services as well. Even successful demonstration programs, however, have encountered funding shortages in recent years, delaying statewide implementation.

**Services Integration**

Persons with SMI or SED often contact a variety of public agencies, not only the public mental health system. In order to simplify and streamline the way in which services are received, integration of the efforts made by different agencies to serve the individual is important, and services integration is an important goal of Minnesota's public mental health system.

Several projects now underway will address the issue of further integrating adult services systems. The statewide adult mental health task force will make recommendations to the legislature for policy and funding changes that will improve integration. Several local projects to demonstrate integrated funding and managed care strategies, including counties in the Moose Lake RTC catchment area, are in their planning stages and will begin implementation in 1994. Finally, federal block grant funds will support new efforts to shift RTC resources into community-based services, and in the process establish stronger linkages between these two service bases. Federal block grant money will also be used to initiate several pilot projects for establishing RTC/county/State/private service collaboratives.

Services integration is especially important for children with SED, whose emotional disorders affect functioning in school and at home, and sometimes result in detention in correctional facilities. All of these settings come face to face with the child's emotional disturbance, and each attempts to deal with the phenomenon in its own way, with little or no coordination with the efforts of other agencies. Gains acquired at one stop are often lost or obscured at the next. Legislation passed in 1993 will lead to the establishment of local collaboratives that will bring together health, mental health, educational, social services, and correctional agencies, along with families, to develop mental health delivery systems that are functionally (although not structurally) integrated, and that focus on multi-agency plans of care for children with SED. These collaboratives will receive funding from the state to develop plans for integration.

Some of the key features of the functional integration of local children's mental health collaboratives include:

- multi-agency intake
- multi-agency assessment coordination
- multi-agency care planning
- unified case management
- individualized services

In addition to local collaboratives, several funding integration efforts are already underway. For instance, eight counties are exploring the integration of Medicaid and various state mental health funding streams into a managed care fund. These counties received planning grants in 1993 to move ahead with this project. A large urban county has received legislative approval to integrate their community mental health funds, with the goal of creating a seamless delivery system.

**Prospective Changes to the Service Array**

For both the adult and children's systems, 1994 will see no major changes in the array of services described above. Services that are still unavailable in some counties, or that do not reach a large enough proportion of the target populations, will be further developed. As

mentioned above, the state's efforts to shift utilization away from inpatient and residential services to community support services and home-based services will continue.

## *Needs and Unmet Needs*

"Need" in the state's public mental health system can be viewed in a number of ways, including: a) the number of persons in the target populations who need services, b) the amount of resources needed by the system in order for it to provide all the services needed by the target populations, and c) the structural and procedural components needed to deliver services effectively and efficiently.

Service need can be for services the system already has available, or for services that are *not* yet available. Resources can be measured in terms of dollars flowing into the system, or in terms of invested capacity (see Table 1). Structural needs can be for additional organizational components, such as consumer groups and new funding sources; and procedural needs can include laws, regulations, mechanisms of integration, and administrative systems.

"Unmet need" is the difference between what is needed and what is currently available and utilized. If 10,000 persons need public mental health services, but only 8,000 are receiving these services, then the unmet need is 2,000. Another way to view this difference is in terms of the percentage of the target population that is receiving service: a system serving 8,000 out of 10,000 is meeting 80% of the need, leaving 20% as unmet need. An example of resource-based unmet need might be as follows: if the system requires $100,000,000 to provide services, but only $60,000,000 are flowing into the system, then the unmet need is $40,000,000.

(Need and unmet need can also be viewed in terms of the *effectiveness* of services. This addresses the possibility that a person who is receiving services is not necessarily getting all of his or her needs met. A mere count of persons in service does not provide information on the quality or effectiveness of the service. The SMHA is currently developing technology that will permit measures of effectiveness to be applied to the issues of need and unmet need; this kind of information is not available for this year's plan.)

**Unmet Need: Percent of Target Populations Served**

Table 2 and Table 3 examine unmet need expressed in terms of the extent to which the populations in need are receiving services. They provide estimates of need and unmet need for adults and children respectively.

*Adults*

Table 2 provides estimates of need for each adult service and for the system as a whole (totals). Need is equivalent to the number of adults in the target population who are, or would be, receiving services in the *public sector*; it is not equivalent to prevalence estimates. Note that the total estimated need of the SMI population is based on 75% of prevalence.

For each service in Table 2, the estimated need is computed on the basis of current experience among counties. The number of clients served per 10,000 adult population is computed for each county, and the counties are ranked on this figure. For most services, the 80th percentile figure is used to define the level of need, and this figure is then projected over the state population. For instance, of the 87 counties, 17 (20%) provide CSP to more than 40 adults per 10,000 adult population. When 40 adults per 10,000 is projected over the state population, the resulting level of need is 12,800. For services that have been part of the system for many years, like outpatient treatment, the critical percentile is lowered to 60%. Of course, this estimation procedure assumes that counties are roughly equal in terms of need per 10,000 residents, an assumption similar to that which allows prevalence estimates to be based on a flat rate (see above), and which is subject to the same uncertainties as the prevalence rates. This procedure also assumes that performance can be improved in 80% (or 60%) of counties.

*TABLE 2: Statewide Service Need, Utilization, and Unmet Need: Adults*

| Service | SMI | | |
|---|---|---|---|
| | Est. Need | # Served (SFY93) * | Est. Unmet Need |
| Community Support (CSP) | 12,800 | 7,510 | 5,290 |
| Day Treatment | 4,000 | 3,940 | 60 |
| Case Management | 12,800 | 9,950 | 2,850 |
| Outpatient Treatment | 15,300 | 13,300 | 2,000 |
| Community Residential Treatment | 1,500 | 2,530 | (1,030) |
| Community Inpatient Treatment | 2,200 | 4,360 | (2,160) |
| RTC Inpatient Treatment | 2,500 | 3,180 | (680) |
| TOTALS (unduplicated) ** | 24,000 | 22,970 | 1,030 |

* SOURCE: Community Mental Health Reporting System; MA/GAMC/MNCare Claims System.

** The SMI estimated need figure is based on 75% of prevalence being public sector clients.

Although the overall service need shown on the bottom line of Table 3 suggests that the system is close to serving all adults with SMI who need public services, many clients in the system have needs in addition to the services they are currently receiving. For instance, many adults with SMI who are regularly receiving outpatient treatment also require community support services to continue to live independently in the community. These additional needs are reflected in the larger unmet needs of some of the individual services.

Note that there is no unmet need for community residential and for the two inpatient treatment services. These services are currently being over-utilized, based on the methods employed for estimating need; however, the client counts for all three of these services are down from SFY 1992, which is the desired trend.

In recent years, the rate of admission to the state-operated RTCs has held steady, especially in contrast to much larger increases in overall caseload and in caseloads of other services. The number of long-term RTC patients has declined. The current number of admissions per 100,000 population is 65.7, while the number of patient-days per 10,000 population is 1,367.

The rate of admission to community hospital inpatient programs has increased significantly, despite rigorous controls enacted under Medicaid legislation. Average length of stay appears to be declining, however.

Patient assessment data suggest that one-fourth to one-third of RTC patients are ready for community living, but with further development of individualized community support programs and crisis intervention services, which is now underway, both the number of admissions and the proportion of inpatients awaiting discharge are expected to decrease.

*Children*

Table 3 shows estimates of need and unmet need for children in the SED population. The public sector share of the total SED prevalence (130,000) is estimated at 25%, or about 32,500 children.

The estimates of need for the two populations in Table 3 are produced differently from the adult estimates in Table 2. First, estimates of need for the individual services are produced. These estimates are derived 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." (It is important to point out that the comparision of current utilization of children's services 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 might not equate to the state's definition. The first of these factors tends to underestimate the amount of unmet need in the SED population. Nevertheless, the Friedman method is preferred at this time because the children's system is too immature to support reliance on performance indicators, as is done for the adult

system.)

*TABLE 3: Statewide Service Need, Utilization, and Unmet Need: Children*

| Service | SED | | |
|---|---|---|---|
| | Est. Need | # Served (SFY93) * | Est. Unmet Need |
| Family Community Support ** | 2,800 | 930 | 1,870 |
| Day Treatment | 2,800 | 1,010 | 1,790 |
| Case Management | 5,100 | 2,130 | 2,970 |
| Professional Home-Based Trmt | 2,800 | 480 | 2,320 |
| Therapeutic Support/Foster Care *** | 1,100 | 20 | 1,080 |
| Outpatient Treatment | 20,000 | 20,000 | --- |
| Community Residential Treatment | 150 | 1,380 | (1,230) |
| Inpatient Treatment | 1,000 | 990 | 10 |
| TOTALS (unduplicated) **** | 32,500 | 22,000 | 14,000 |

* SOURCE: Community Mental Health Reporting System; MA/GAMC/MNCare Claims System.

** FCSS other than day treatment, professional home-based treatment, therapeutic support of foster care.

*** This service has been a lower priority than family community support and other community and home-based services.

**** The SED estimated need figures are based on 25% of prevalence being public sector clients.

Note that Table 2 and Table 3 do not include non-client specific services such as community education and early identification/intervention, and do not include clients served by several pre-paid (HMO) Medical Assistance projects. Also note that the negative unmet needs for residential and inpatient services reflect a reliance on this type of care in an environment in which nonresidential alternatives are not yet fully developed. This is especially true for the children's system, where community residential services still constitute the primary type of treatment. When all of the alternative services are in place, the number of residential and inpatient clients should decrease toward the levels of need shown in the tables.

**Unmet Need: Geographic Availability and Accessibility by Special Populations**

The statewide figures of service need and utilization shown in Tables 2 and 3 do not indicate what is occurring in individual counties. County to county variation in need and utilization can be extreme. However, the mental health services defined in the Comprehensive Mental Health

Acts must be made *available* to the residents of all counties, even where the need is small. Table 4 shows the number of counties providing each service. (Certain minimum requirements, such as provision of a service to more than 5 people per 10,000 population, must be met in order for a county to be considered as "providing" a service.) For nonresidential community and home-based services, provision of a service means that it is "available." For inpatient and residential services, non-provision does not necessarily mean that the service is not available; there may simply have been no need for these services in some counties during the year.

*TABLE 4: Number of Counties Providing Each Service in SFY 1993*

| Services | Adults With SMI | Children With SED |
|---|---|---|
| Community Support (CSP) | 82 | |
| Family Community Support | | 58 |
| Day Treatment * | 75 | 30 |
| Case Management | 83 | 72 |
| Early Identification/Intervention | | 20 |
| Professional Home-Based Trmt | | 33 |
| Therapeutic Support/Foster Care | | 10 |
| Outpatient Treatment | 87 | 87 |
| Community Residential Treatment | 83 | 72 |
| RTC Inpatient Treatment | 87 | 50 |
| Community Hosp. Inpatient Treatment | 87 | 83 |

* Some counties have a waiver on the requirement to provide this service.

The extent to which services are available to rural populations and to minority populations are also important aspects of availability. Table 5 suggests that in Minnesota the differences in service utilization between rural and nonrural counties are not dramatic, and could be due to statistical anomalies, reporting errors, etc., rather than to actual differences in service utilization. This suggests that the rural populations are not experiencing more problems in accessing services than are urban counties. (Data on children's services support these conclusions.) To a considerable extent, accessibility of services to rural populations is due to the funding formulas used by the state, which have granted up to 6 times more to rural counties, on a per capita basis, than to urban counties.

*TABLE 5: Rural and Nonrural Adult Clients per 10,000 Population*

| SERVICE | Average Number of Adult Clients per 10,000 Adult Population (1992) | |
|---|---|---|
| | Rural Counties | Nonrural Counties |
| Case management | 28.7 | 29.3 |
| Community support services | 29.8 | 27.4 |
| Day treatment | 14.5 | 13.0 |
| Outpatient treatment | 139.8 | 143.6 |
| Residential treatment | 7.8 | 8.5 |
| Inpatient treatment (community) | 11.1 | 14.6 |
| Inpatient treatment (RTC) | 13.0 | 13.5 |

In Table 6, levels of service utilization by minority populations are compared to their proportion of the general population. The table below indicates that Hispanic clients are somewhat under-represented in all service categories except inpatient treatment, and that Asians are under-represented in case management and CSP. "Over-representation" is evident in many of the cells in this table; although, because some minority populations may be over-represented in the low income groups that are more likely to utilize public services, there is an expectation that some of these groups *should* appear over-represented in the public system.

*TABLE 6: Percent of General and Client Populations from Minority Groups*

| Group | Percent of Adult Population | Percent of Clients in 1992 | | | | | |
|---|---|---|---|---|---|---|---|
| | | Case Management | CSP | Day Treatment | Outpatient Treatment | Residential Treatment | Inpatient Treatment |
| African American | 1.8 | 4.8 | 2.4 | 1.9 | 2.2 | 3.9 | 7.8 |
| Hispanic | 1.0 | 0.6 | 0.5 | 0.7 | 0.7 | 0.7 | 1.4 |
| Asian/ Pacific Is. | 1.0 | 0.8 | 0.5 | 2.6 | 3.3 | 1.2 | 1.2 |
| American Indian | 1.2 | 1.5 | 1.3 | 1.4 | 1.4 | 1.6 | 2.6 |

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.

**Unmet Need: Resource Shortages**

Need and unmet need defined in terms of financing have been estimated for the children's system but not for the adult. The statewide adult mental health task force will examine this issue in 1994 and will report to the SMHA and the legislature on its findings.

The figures in Table 7, for the children's system, are based on the unmet service needs in Table 3. As a result of input from the Children's Subcommittee of the State Advisory Council, most of the figures below are substantially higher than previous estimates.

**Unmet Need: Service Capacity**

Unmet needs can also be viewed from the standpoint of service capacities, equating to the difference between current capacity and model capacity. Model capacities have not yet been developed; however, there is little dispute that the state is over-invested in state-operated inpatient beds (RTCs). As these beds are eliminated from the system, there will be a concomitant rise in need for community inpatient beds, although far fewer community beds will be needed than there will be state-operated beds eliminated. There is also over-investment in residential treatment beds, especially for children. The current capacity of over 1,100 children's residential treatment beds is almost five times the number that will eventually be needed in the state. At the same time, however, there is significant unmet need for family community support programs and other alternatives to residential care.

*TABLE 7: Unmet Financial Need: Children's Services*

| | | Funded | |
|---|---|---|---|
| Family Community Support * | $7,500,000 | $4,000,000 | $3,500,000 |
| Day Treatment | 5,600,000 | 2,000,000 | 3,600,000 |
| Case Management | 14,445,000 | 6,145,000 | 8,300,000 |
| Home-Based Family Treatment | 13,689,000 | 1,254,000 | 12,435,000 |
| Therapeutic Support for Foster Care | 5,100,000 | 1,300,000 | 3,800,000 |
| Early Identification/Intervention | 3,500,000 | 2,000,000 | 1,500,000 |
| Outpatient Treatment | 13,000,000 | 12,000,000 | 1,000,000 |
| Commun Residential Treatment ** | 26,040,000 | 28,000,000 | -1,960,000 |
| Inpatient Treatment | 14,700,000 | 14,700,000 | 0 |
| Subtotal (current funding) *** | $103,574,000 | $71,399,000 | $32,175,000 |
| Less already approved increases (primarily | | $13,000,000 | -13,000,000 |
| Additional Funding Needed | | | $19,245,000 |

* Includes all FCSS other than day treatment, home-based treatment, therapeutic support.

** Includes estimated 8% increased cost per child to comply with proposed higher standards and projected 15% decline in total utilization over the next four years.

*** SFY 93 figure is somewhat less than shown in Figure 11, because not all services are included in this table.

## Unmet Need: Structural and Procedural

The key structural and procedural unmet needs for the adult and children's system are summarized below. Most of these unmet needs are the same for the two systems.

- A method for periodic assessment of service needs in local populations.
- Needs assessments for the RTC patient population and for children in residential treatment.
- Methods for evaluating the effectiveness of services and systems.
- Consumer and family employment in mental health organizations.
- Long-range plans for further system development and improvement.
- More ways to use data and reporting systems in decisionmaking.
- Better methods for estimating the prevalence and incidence of SMI and SED.
- Fewer IMDs.
- More child psychiatrists and other professionals trained in children's mental health.

- Improved outreach to adults and children.
- Integrated funding streams that allow dollars to follow the needs of clients.

## *Financing the System*

This section describes the *sources* of mental health financing in Minnesota, current *levels* of funding (SFY 1993), funding trends over recent years, and fiscal *incentives* in the system.

### 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 contribute to a particular fund. Medical Assistance, for instance, is composed of a federal share (54%) and a state share (46%). State grants to counties sometimes require a county match, such as 10% or 50% of the state grant amount. Some funds are categorical, intended for a particular service or for use with a particular population, and some take the form of block grants that offer a higher degree of local control and flexibility.

Table 8 summarizes the various funding sources for adult and children's public mental health services.

*TABLE 8: Funding Sources for Mental Health Services*

| Source | Abbrev. | Description |
|---|---|---|
| Medical Assistance (Medicaid) | MA | A fund composed of federal, state, and local shares, which pays for medical services, including some mental health services, for low-income persons. (Often referred to by its federal name, Medicaid.) |
| General Assistance Medical Care | GAMC | A state fund for low-income adults not eligible for MA. This includes adults living in Institutions for Mental Disease (IMDs), which include some of the state's adult residential treatment centers. |
| MinnesotaCare | MNCare | State health insurance for low income families and children who are not eligible for MA. |
| Community Mental Health Funds | Comm MH | State allocations and grants for CSP and FCSS services, community residential treatment, early identification/intervention, enhanced housing support, crisis services, and services to homeless persons. |

| Source | Abbrev. | Description |
|---|---|---|
| Community Mental Health Block Grant | CMHS | A federal grant to the state, some of which the state uses to fund demonstration projects. Most funds flow through county governments, and are restricted to programs serving the target populations. |
| Regional Treatment Center Fund | RTC | A state fund for the state-operated RTCs, with a small county match. |
| Group Residential Housing Fund | GRH | A state fund to cover the room and board costs for persons in adult residential treatment facilities. |
| Community Social Services Fund | CSSA | State block grants to counties for social services, including most mental health services. County provide a 50% match. |
| Title XX | Title XX | A federal block grant to the state for social services, including most mental health services, which the state passes on to counties with the CSSA grant. |
| Title IVB and IVE | Title IVB<br>Title IVE | Federal grants for children's social services. Some of these funds and services go to mental health clients. |
| Family Preservation Fund | FPF | State funds to support permanency planning for children. Some go to mental health clients. |

It is the flow of dollars from the state level to counties that is most complicated. Figures 6 and 7 portray these flows for adult and children's services. The names and abbreviations used in the figures, and elsewhere in this document, are explained above in Table 8.

## Current Levels of Funding

Total public mental health funding in SFY 1993 amounted to about $359,000,000. About $280,000,000 of this was for adults; $79,000,000 was for children.

*Adults*

For the adult system, the pie charts in Figure 8 and Figure 9 depict the percentage of total SFY 93 funding from each source and for each service. 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 Minnesota Departments of Education, Corrections, and Jobs and Training, plus direct federal funding through Medicare and the Veterans Administration.

Federal funds amounted to 20.0% of total adult funding in SFY 93; state funds 62.1%; local funds 16.2%. Funding for non-inpatient community services represented 42.1% of total adult funding. RTC and community inpatient treatment accounted for the larger share, 57.9%. (Administrative dollars are not counted in these figures.)

*Children*

Of the $79,000,000 in SFY 93 funding for children, the federal share was 28.4%, the state share was 26.0%, and the local share 42.2%. Figure 10 and Figure 11 indicate how these funds were distributed among sources and services. Figure 11 shows that non-inpatient community services represented 80.7% of children's funding, largely for residential treatment. RTC and community inpatient treatment accounted for only 18.8%.

*FIGURE 6: State Funding Flows for Adults*

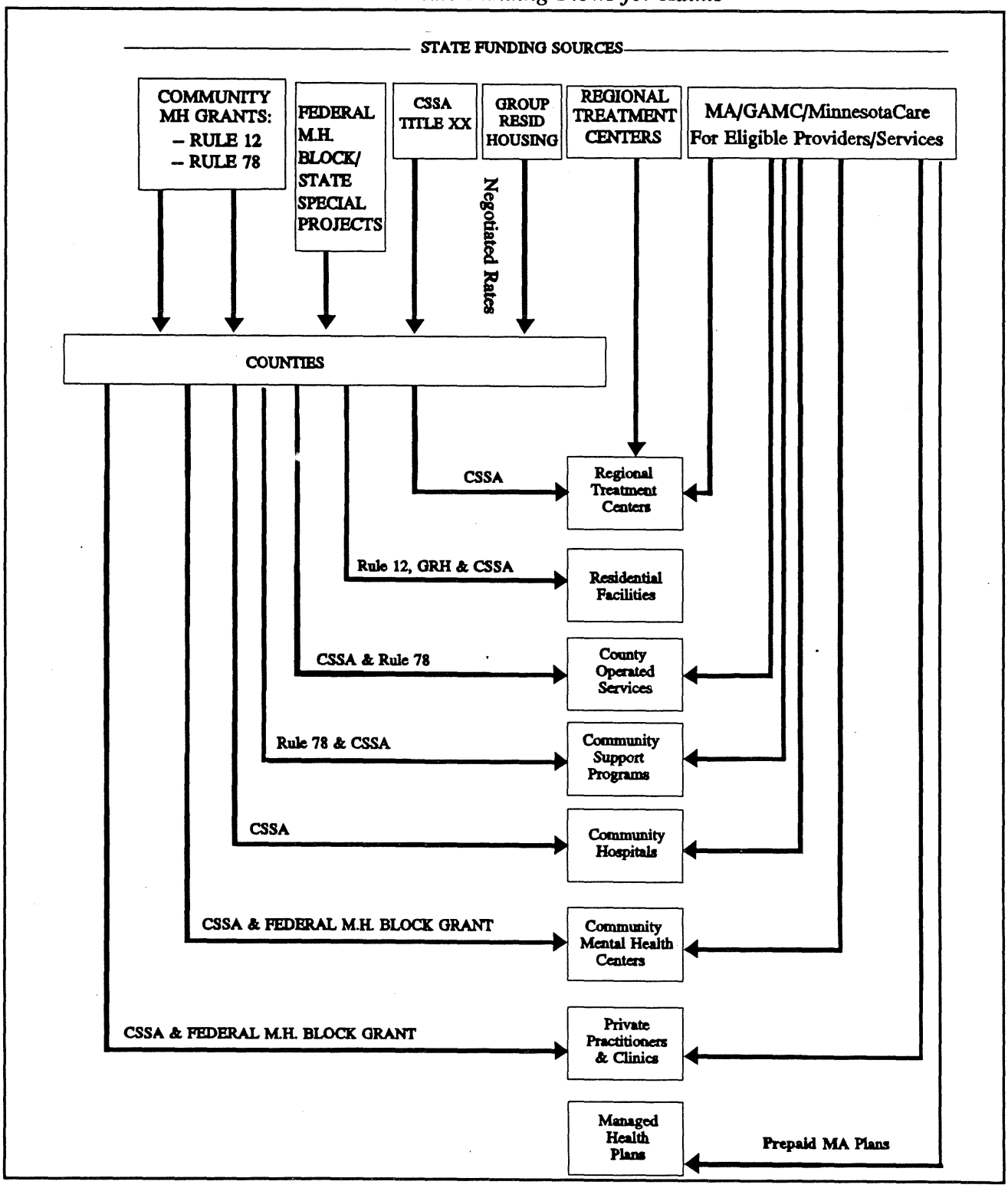


*FIGURE 7: State Funding Flows for Children*

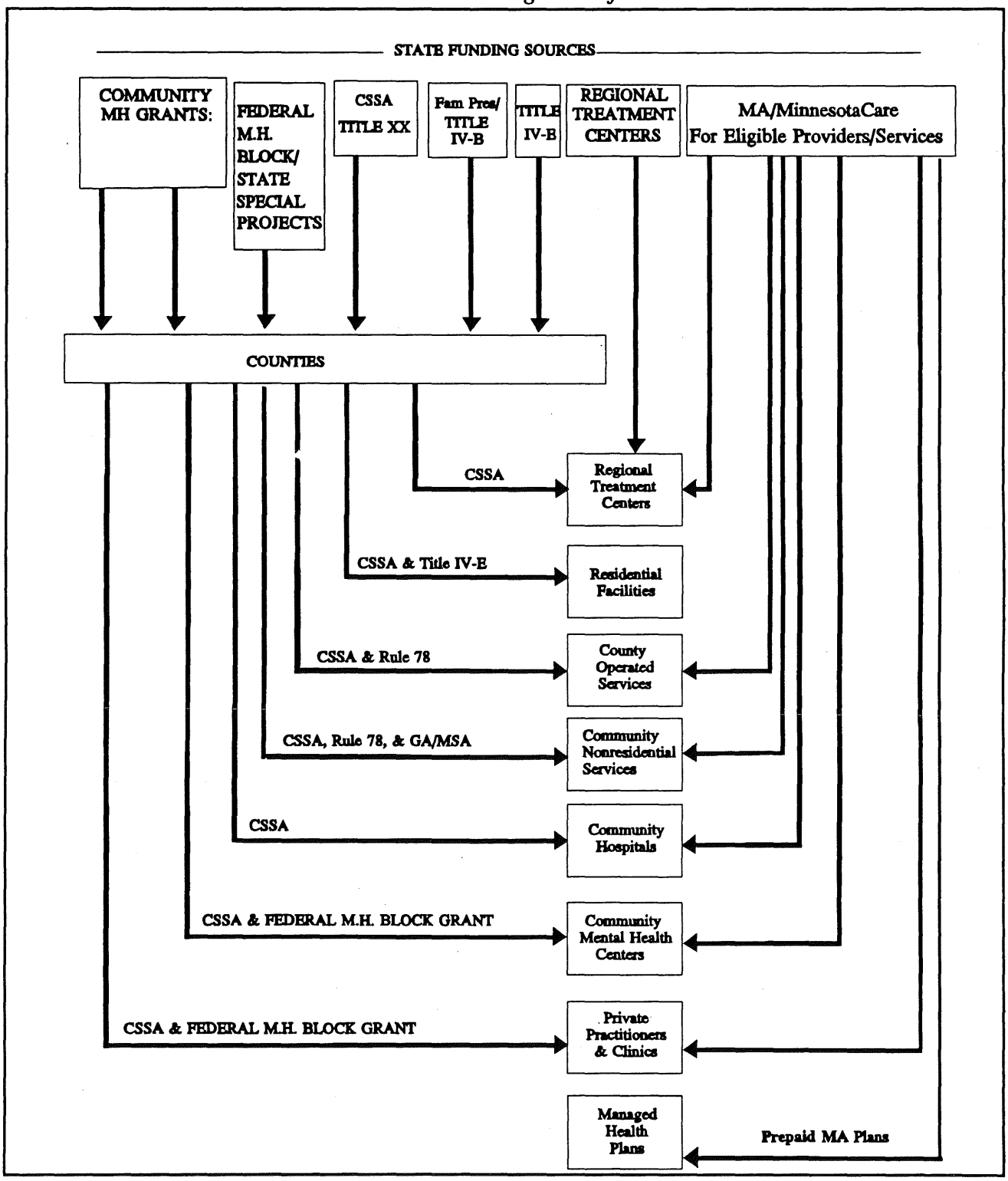


*FIGURE 8: Percent of SFY 1993 Funding From Each Source: Adults*

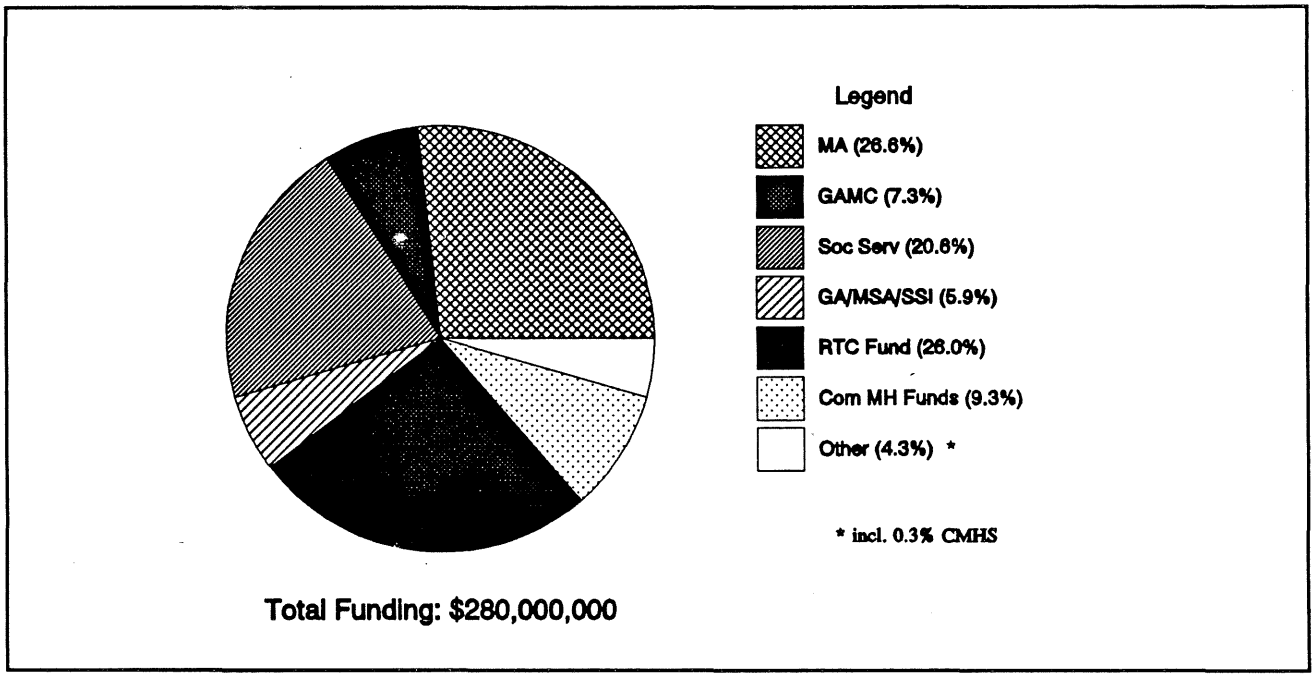



*FIGURE 9: Percent of SFY 1993 Funding For Each Service: Adults*

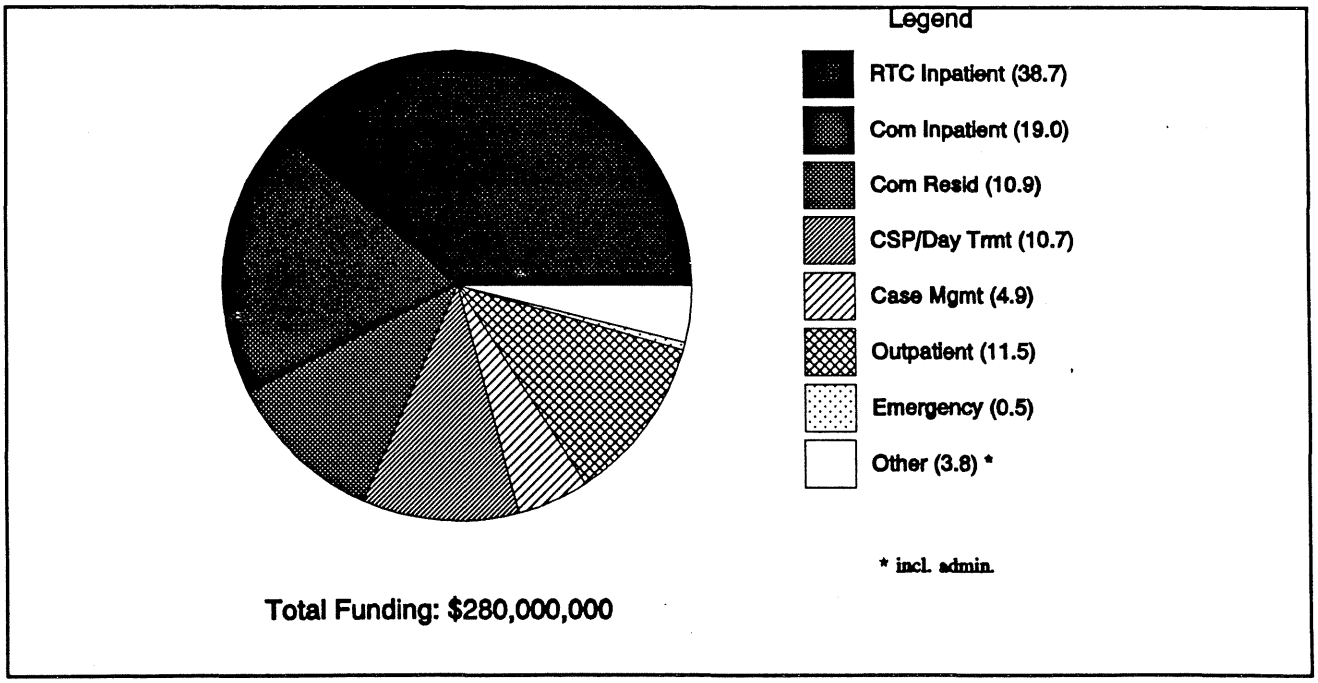


*FIGURE 10: Percent of SFY 1993 Funding From Each Source: Children*

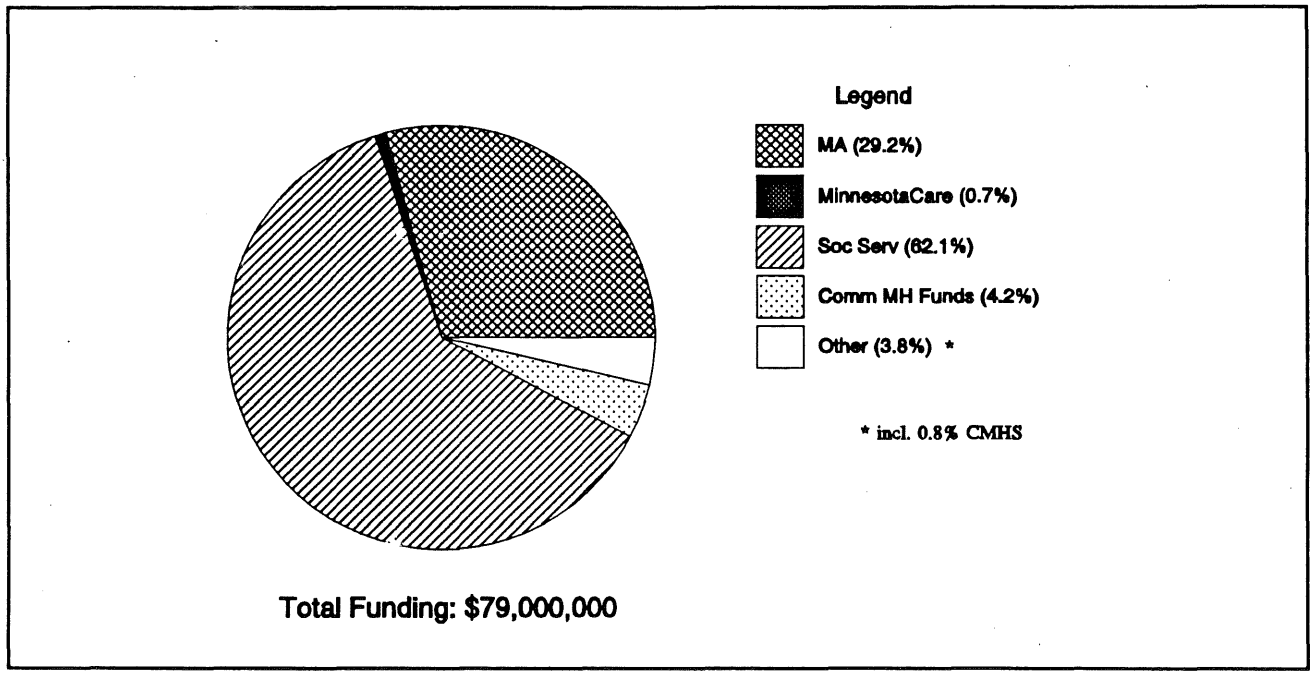
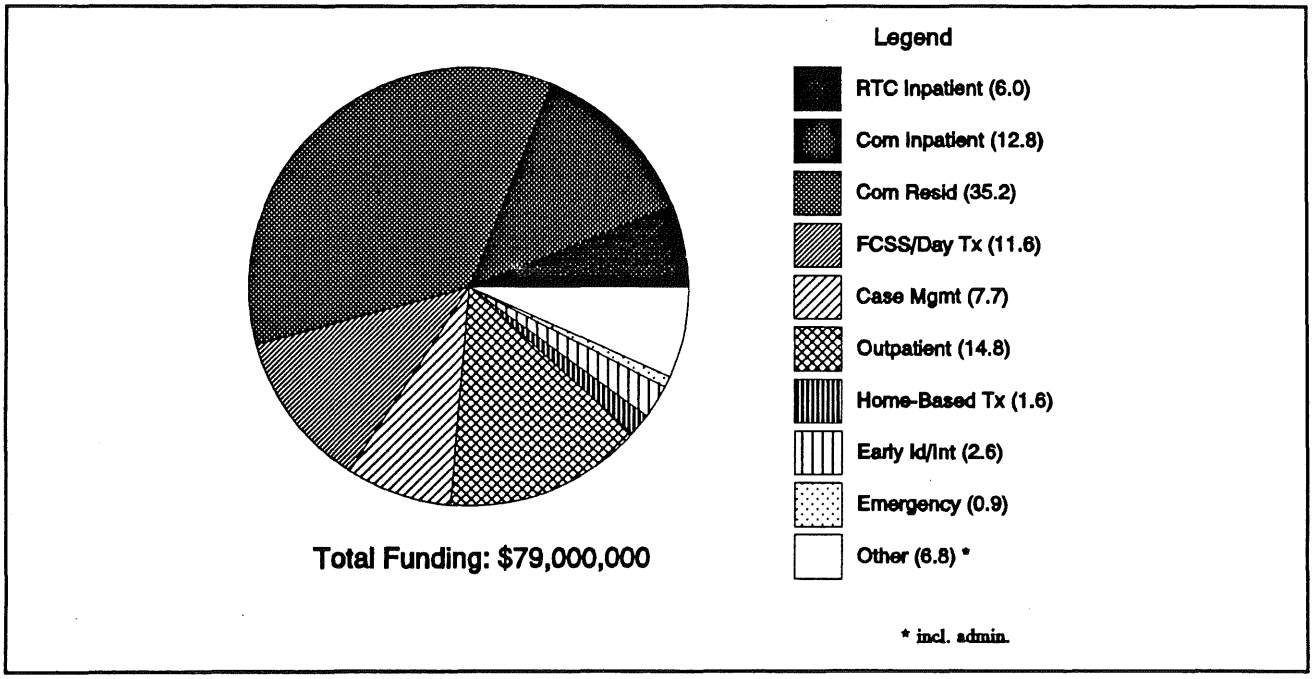



*FIGURE 11: Percent of SFY 1993 Funding For Each Service: Children*



## State Funding Trends

Trends in state funding for the overall public mental health system are displayed in Table 9.

*Table 9: Trends in State Funding for Adult and Children's Services*
(dollars in thousands)

| Adult | SFY 1987 | SFY 1989 | SFY 1991 | SFY 1993 | Change 87-93 |
|---|---|---|---|---|---|
| Community Nonresidential | $ 41,526 | $ 58,112 | $ 69,475 | $ 87,329 | $ 45,803 |
| Community Residential | 26,272 | 28,098 | 29,999 | 30,540 | 4,268 |
| Community Inpatient | 27,084 | 31,975 | 36,151 | 52,773 | 25,689 |
| RTC Inpatient | 55,670 | 72,085 | 92,328 | 108,359 | 52,689 |
| Other * | 640 | 1,392 | 1,354 | 1,162 | 522 |
| Subtotals | 151,192 | 191,662 | 229,307 | 280,163 | 128,971 |
| **Children's** | **SFY 1987** | **SFY 1989** | **SFY 1991** | **SFY 1993** | **Change 87-93** |
| Community Nonresidential | 11,743 | 16,434 | 21,417 | 36,332 | 24,589 |
| Community Residential | 17,000 | 20,200 | 23,800 | 27,908 | 10,908 |
| Community Inpatient | 7,945 | 7,150 | 6,302 | 9,964 | 2,019 |
| RTC Inpatient | 2,320 | 3,059 | 4,270 | 4,724 | 2,404 |
| Other * | 71 | 536 | 144 | 369 | 298 |
| Subtotals | 39,079 | 47,379 | 55,933 | 79,297 | 40,218 |
| TOTALS | $ 190,271 | $ 239,041 | $ 285,240 | $359,460 | $ 169,189 |

* Includes community education and prevention, training, administration.

For adult services, the largest dollar increase since SFY 87 has been for RTC expenditures ($52.7 million), while the largest percentage increase has been for community non-residential (108%). The 79% increase for all community adult mental health expenditures ($128,499,000) is less than the increase for RTC expenditures alone (95%). This means that RTC expenditures are now a larger share (39%) of total adult mental health expenditures than they were in SFY 87 (37%).

A large part of the increase in RTC-MI expenditures is due to 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) in the RTCs have undergone significant downsizing. Persons with mental illness were 36% of the average daily population in FY 87, vs. an estimated 52% in SFY 93.

For children's services, the largest dollar increase and the largest percentage increase has been for community non-residential ($24.4 million, equaling an increase of 208% from SFY 87 to SFY 93). Children's mental health services have been predominantly county-funded, whereas adult services have been mostly state-funded. This is still true in SFY 93. The average state share for children's services has increased from 23% in SFY 91 to 26% in SFY 93, with most of the new state funds targeted to community non-residential services.

**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 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. 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.)

**Fiscal Incentives and Comparative Costs**

The state funding system has been criticized 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 12 and 13 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 10 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 10 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.

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 10: Estimated FY92 Total Cost Per Adult Day by Residential Setting*

| Program or Service | Setting | | |
|---|---|---|---|
| | RTC | Community Residential | Intensive Supported Housing |
| RTC | $236.33 | 0 | 0 |
| Case Management | 3.10 | 3.10 | 3.10 |
| Room and Board | 0 | 28.82 | 21.00 |
| Adult Community Residential | 0 | 31.34 | 0 |
| CSP/Day Treatment | 0 | 7.08 | 50.00 |
| Outpatient Treatment | 0 | 2.20 | 2.20 |
| Pharmacy | 0 | 4.11 | 4.11 |
| Periodic Hospitalization | 0 | 3.00 | 3.00 |
| Non-MH Medical Services | 0 | 2.80 | 2.80 |
| State Administration | ** | 0.14 | 0.14 |
| TOTALS | $239.43 | $82.59 | $86.35 |

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

*FIGURE 12: Federal, State, and County Shares for Selected Adult Services*

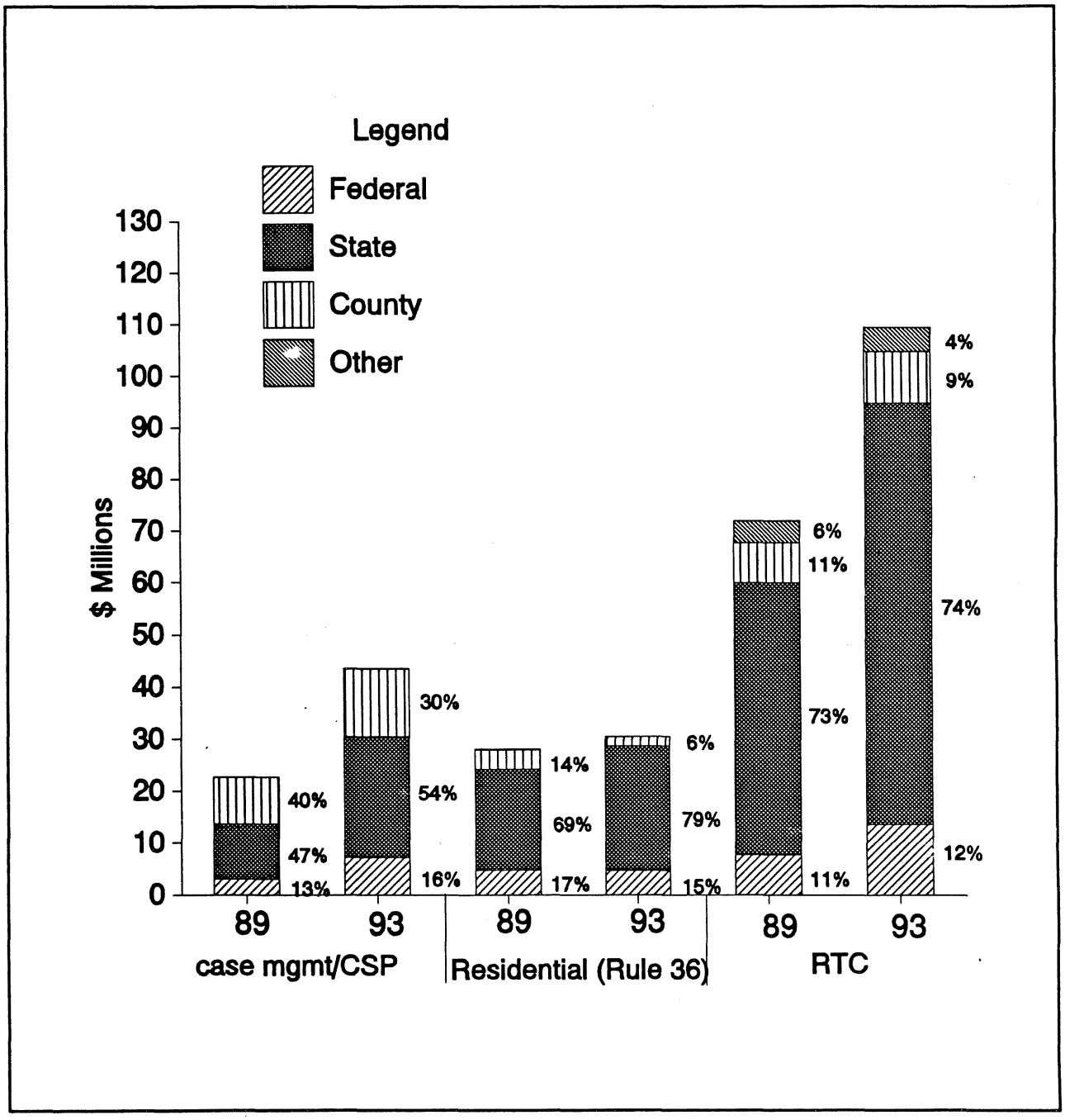
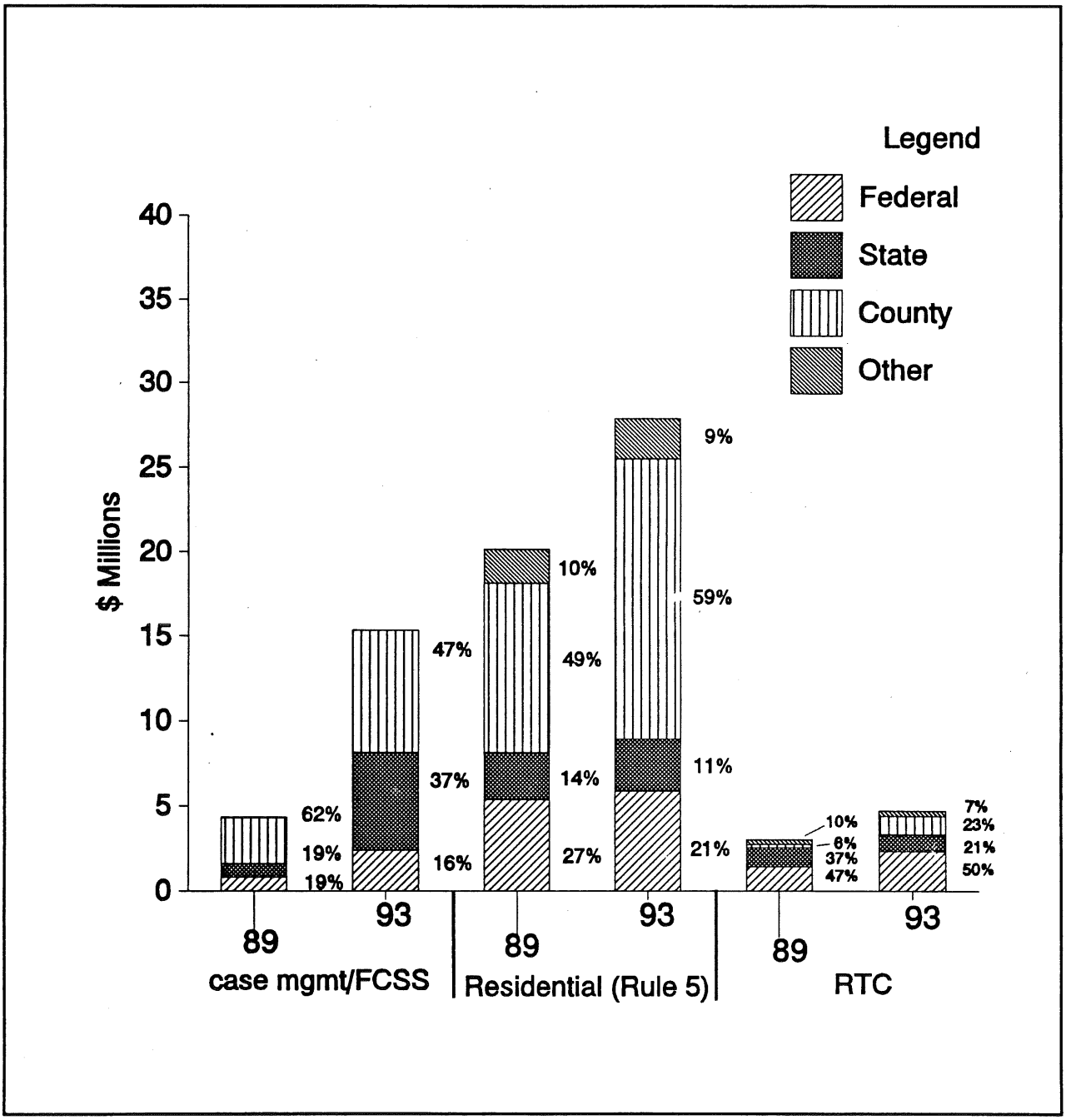


*FIGURE 13: Federal, State, and County Shares for Selected Children's Services*



## *Human Resources*

This section describes the types and distribution of mental health human resources in the state. Excluded are staff of provider organizations that do not serve any public clients.

It is not possible at this time to clearly and meaningfully distinquish those disciplines employed in serving adults and those employed in serving children, nor is it possible yet, using survey data, to project the numbers working in each discipline within the various types of mental health organizations. This information should be available in next year's report.

### Direct Service Staff

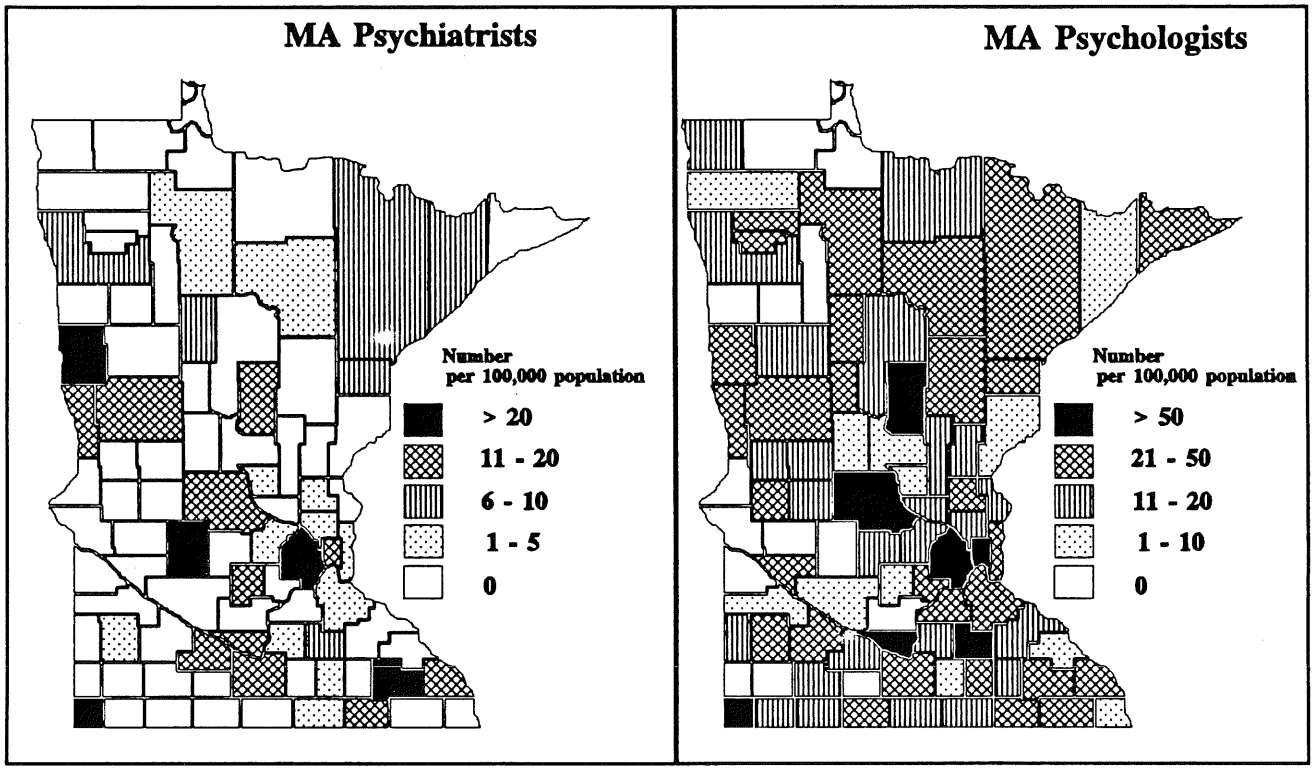
Table 11 represents the breakout of human resources data that will be available in the 1995 report. At the present time, only a few of the statewide figures are available, as shown in the table. Counts of psychiatrists and psychologists include only those registered for MA reimbursement.

*TABLE 11: Direct Service Staff by Provider Type*

| Staff Discipline | OUTPATIENT CLINIC | RESIDENTIAL TREATMENT | PSYCHIATRIC HOSPITAL | GENERAL HOSP | FREESTANDING CSP/DAY TRMT | MULTISERVICE ORGANIZATION | COUNTY HUMAN SVCS | STATEWIDE |
|---|---|---|---|---|---|---|---|---|
| Psychiatrists | | | | | | | | 530 |
| Other physicians | | | | | | | | |
| Psychologists-PhD | | | | | | | | 1,157 |
| Psychologists-MA | | | | | | | | 1,190 |
| Social worker | | | | | | | | |
| Registered nurse | | | | | | | | |
| Case managers | | | | | | | | 250 |
| Other MH | | | | | | | | |
| Other medical | | | | | | | | |
| Other | | | | | | | | |

The geographic distribution of psychiatrists and psychologists are displayed in the maps in Figure 14. These distributions are based on 1991 Medicaid data. Eighty-eight of the total of 530 psychiatrists indicate that they serve children.

*FIGURE 14: Geographic Distribution of Public Sector Psychiatrists and Psychologists*




## SMHA Staff

The SMHA currently employs 30 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. Six of the community programs staff are children's specialists.

## *Management Information Systems*

The SMHA and many local organizations (providers and counties) underwent extensive information system development during the period from 1987 to 1993, 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.

### State Systems

The SMHA implemented the Community Mental Health Reporting System (CMHRS), which collects client and services data from over 250 provider organizations. 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 the CMHRS, the SMHA extracts mental health data from the state's Medicaid Management Information System (MMIS) and from the RTC system. Together with the CMHRS, these extracts provide the SMHA with the capability of meeting most of its routine information requirements, and most special requests from outside sources. Other data collection methods, such as county plans, fiscal reports on categorical grants, program evaluation instruments for pilot projects, and a provider organization and staffing survey (OIS), address other information requirements of the SMHA. Undergoing piloting in late 1993 is a consumer outcome survey that will provide data on the effectiveness of community programs.

From its various 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. These reports are also integrated into the local planning process and into the processes of statewide policymaking. The reports to counties and providers enable local, immediate corrections to be implemented without direct state intervention.

The SMHA is the recipient of a "phase 2" MHSIP (Mental Health Statistics Improvement Project) grant from the Center for Mental Health Services, which will develop procedures by which counties and providers can more directly access the SMHA's databases to obtain routine and custom reports on-line. This grant will also help the SMHA develop methods for integrating data-based information into its TQM decisionmaking processes.

### County and Provider Systems

Counties are also designing new management information systems. One project is being funded

and managed by a group of counties that are interested in implementing a PC-based, distributed system that will support the entire array of county human services functions. A second project, funded by the state legislature and managed by the Department of Human Services, is developing a design for a new county system that will have ongoing support from the Department. These two systems, when developed, will provide MIS to all but a handful of the state's 87 counties.

There is less uniformity of data systems among provider organizations than among counties; however, many of the provider systems are fully capable of generating management information. Most of the CMHCs operate data systems on modern, sophisticated minicomputers or on distributed PC networks. The RTCs are also computer based and are currently developing a new MIS that will be capable of sharing data among RTCs, and between the RTCs and the SMHA central office. Residential treatment providers are less sophisticated; most still rely on paper-based data collection filing systems.

**Data Privacy**

Data privacy is ensured through the state's Data Privacy Act, which restricts release of data on individuals to the system of care and requires all agencies to employ data security procedures. It further requires that informed consent be obtained prior to release of data on mental health clients, and that all providers request consent of their clients. Data collected by the SMHA from local providers and from consumers does not contain the name or address of the client, but instead makes use of a coded identifier.

# Chapter II

# Progress Made in 1993

This chapter summarizes the extent to which Minnesota was able to accomplish the objectives it had set for its public mental health system in 1993. Adult and children's objectives are presented separately.

It is important to point out that the progress reported here represent accomplishments of the entire system, including all of the state and local organizations discussed in Chapter I. Although it is the Department of Human Services that produces this report, credit for improvements in the adult and children's systems is widespread.

All statistical information in this chapter refers to clients and services in the public mental health system only, as defined in Chapter I. The most current data available are used, and can be assumed to be for SFY93 unless stated otherwise. It should be noted here that information about services refers to those services defined in state law and regulations. Some counties provide additional services of similar type and name, but not meeting all regulatory requirements. These "additional" services are not included in this report.

## *Major Accomplishments*

The first priority for 1993 was development of a plan for transfer of the 200-bed Moose Lake Regional Treatment Center to the Department of Corrections. The state legislature authorized the SMHA and the counties of the Moose Lake region to carry out this plan, including development of enough alternative services to meet the needs of those mentally ill patients discharged from the facility. The approved budget for the plan spends more for the array of Moose Lake alternatives than was being spent for the Moose Lake RTC. Furthermore, funds diverted from the RTC as a result of the transfer cannot be used for purposes unrelated to care and treatment of the target population.

The second priority for 1993 was to explore the possibilities for integrated services systems, including managed care systems. Sixteen counties were funded as pilots; these projects are exploring various options for future expansion of integrated systems.

To integrate the children's system, legislation was passed to fund development of local children's collaboratives. Prospective collaboratives, consisting of those agencies that regularly provide services to children, such as health, mental health, education, social services, and corrections, submitted proposals to the SMHA in the summer of 1993, and 8 of these proposals received startup funding by the end of the year.

There were other important accomplishments in 1993.

- Children's services experienced a 24% increase over 1992 funding (incl. MA and state grant increases).
- 65 local coordinating councils received funding for integrated early identification services for children.
- The targeted reduction in adult residential treatment days per year was exceeded by almost twice the target amount.
- The target for case management hours per child client per year (15) was exceeded (24).
- Coverage of adult case management and day treatment by MA/GAMC exceeded targets.
- Adult CSP and housing support grants were integrated
- A cultural diversity task force to assist the SMHA in developing a cultural agenda was created.
- Reduction in the number of IMDs far exceeded the targeted reduction.
- Program standards for family community support services were developed.

The following pages of this chapter, in the form of tables, summarize progress made in 1993 on specific objectives for that year. There were 54 of these objectives for the adult system; 37 for the children's system. Progress is discussed in terms of measurable indicators of progress; in some cases, progress may also have been made that could not be measured. Wherever possible, the discussion of progress includes a comparison to status in SFY 1992.

## *Progress on Adult Objectives*

| No. | Objective | Measurable Progress |
|---|---|---|
| 1 | Programs that extend services to homeless adults with SMI. | Of the 5,500 estimated homeless adults with SMI living in the state, 12% (683) received case management and 18% (1003) received housing support services. Data for the previous year are not available. |
| 2 | Programs that extend services to rural populations. | In the state's 42 rural counties, 31% (1,060) of the estimated 3,460 adults with SMI received case management in SFY93. This is a significant increase from the SFY92 figure of 18%.<br><br>The state has supported this objective by providing higher levels of funding for rural counties than for nonrural counties. Most state funds for adult community support programs are based on a formula which allocates to each county the greater of $41,000 or $2.10 per capita (based on the county's adult census). A similar formula for children's grants allocated to each county the greater of $22,000 or $2.25 per capita (based on child census). This has meant that sparsely populated counties have received on a per capita basis up to 6 times more state grant support for adult community support than have urban counties; up to 10 times more for children's community support. |
| 3 | Counties provide CSP services to a significant segment of their SMI populations. | In SFY92, about one-half of the 87 counties provided CSP services to more than 25% of their estimated SMI populations. This percentage showed no increase (48%) in SFY93. |
| 4 | Counties provide enhanced housing support. | Ten counties received funds from enhanced housing support grants in SFY92; thirty-one received these funds in SFY93, which was 37% of the 87 counties. Enhanced housing support grants were to be used by counties to supplement housing support activities that are a part of the basic CSP. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 5 | Alternative crisis services models being piloted. | Six crisis intervention pilot projects are now serving clients. These projects, funded by the federal block grant, were designed and developed in SFY92 and became operational in SFY93. Crisis intervention services are designed to offer the kinds of immediate help a person in mental health crisis needs to re-establish equilibrium. The priority of the SMHA is to develop more comprehensive and responsive crisis services in the counties, by looking for innovative approaches. Examples of the types of services eligible for funding include: a) 24-hour crisis telephone, b) walk-in services, c) mobile crisis outreach, and d) residential crisis services. |
| 6 | Counties provide emergency mental health services. | Sixty-nine (79%) of the 87 counties reported to the SMHA the number of mental health emergency contacts they received in 1993. The 18 counties that did not report do indicate in their mental health plans that they are providing the service. |
| 7 | Consumer self-help projects are pilot tested. | There were no self-help projects funded in SFY92. In SFY93, the SMHA funded a total of 13 projects for the purpose of empowering consumers. Ten of these projects were self-help projects; three were employability projects. These projects meet a recommendation of the state advisory council (SMHAC) that more efforts be made to empower consumers. |
| 8 | Continue specialized supervised apartment living training (SALT) programs for adults with MI and hearing impairment. | This program was refunded in 1993. The SALT Program provides supportive housing services to individuals who have a mental illness and hearing impairment. The program employs staff who have signing and interpretation skills as well as expertise in working with persons with mental illness. Some of the services provided by this program include: independent living skills development, benefits assistance, case coordination, social and recreational services. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 9 | Levels of expenditure adequate to support the full array of community services in each county. | In SFY92, 41.9% of spending for the adult system was for community-based, non-inpatient services. This figure remained virtually unchanged in SFY93, at 41.8%. Although RTC inpatient expenditures accounted for about 1.0% less of total expenditures in SFY93 than they had in SFY92, the share of community inpatient expenditures, which is paid almost exclusively by Medicaid for this target population, increased by nearly the same amount. Because of a state budget deficit during 1993, there were no new state appropriations for community programs. Cuts in some of these programs were threatened, but did not occur, and the 1993 legislature did approve the SMHA's plan to close one of its 6 RTCs and to transfer most of the funding for this RTC to community alternative services by 1995. |
| 10 | Medical Assistance funds a significant share of services. | Fifty-five percent of case management units of service were paid through the MA/GAMC system. Virtually all day treatment was paid through the MA/GAMC system, and 74% of outpatient treatment was paid through this system. These figures apply to the SMI target population only. |
| 11 | Medical Assistance funds a full range of medical and dental services to adults with SMI. | The objective was to provide the wide range of medical coverage available in MA to as many clients in the system as possible who are eligible for these insurance programs. Sixty-one percent of clients with SMI received some MA/GAMC/MNCare services in SFY93. This indicator could not be computed from available data in SFY92, so a comparison is not possible. |
| 12 | Approved county mental health plans that meet local needs. | In previous local planning cycles, instructions issued to counties by the SMHA did not collect sufficient information about the needs assessment methods used, and did not require plan objectives to be explicitly linked to identified needs. This year, the SMHA instructions did include these elements. The instructions include expanded data requirements for needs assessment, and objectives based on client outcomes that are linked to needs assessment findings and to service utilization statistics. The SMHA issued supporting statistical information to counties, and also released to counties the specific criteria that would be used to approve local plans. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 13 | Recommendations from the State Advisory Council for state plan objectives and resource allocations. | The formal recommendations of the SMHAC are included with the Department's application for the federal mental health block grqant. The council reviewed the 1994 plan objectives included in that application. |
| 14 | Recommendations from local advisory councils on local service system plan objectives and resource allocations. | 82% of counties reported that their LACs contributed recommendations for their local mental health plans. There are a few counties, mostly small rural counties, where LACs are still having difficulty maintaining strong membership and conducting business. The SMHA recently hired an LAC liaison person to assist these counties. |
| 15 | Public comment on the state's one-year plan. | Prior planning cycles had limited opportunities for review of issues and comment on plan content. Review was limited to members of the SMHAC. This year, the review-and-comment process was expanded to include more participants. The SMHA requested comment from counties, providers, advocates, and consumers, as well as members of the SMHAC. Persons receiving the document were asked to make it available to any interested parties. The SMHA received comment in three ways: in writing, by phone, and by attendance at a special, day-long meeting. |
| 16 | Crisis services employ RTC staff. | One of the six projects now providing services employs staff of one of the RTCs. A second project uses a shared services agreement with an RTC. (See Objective #5 above.) |
| 17 | Greater integration of mental health funds. | State Rule 78 was revised to integrate basic CSP grants to counties with enhanced housing support grants and alternative disposition (ADP) grants. Counties now make one application for this more flexible pool of funds. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 18 | Managed care pilots. | No managed care system is yet in place, but significant progress has been made. Planning and development of integrated funding and managed care systems are carried out locally in Minnesota, with standards, consultation, and technical assistance provided at the state level. Three large urban counties have begun integrating their community mental health funds (excluding Medicaid). These services systems will not be managed care systems initially, but will have established a fiscal basis for managed care. Two of these counties have already tested managed care systems for Medicaid (MA); however, these systems did not include the target population of SMI.<br><br>A cluster of 8 rural counties is now planning a managed care system for mental health that would involve a "carve-out" of mental health funding, and has requested a federal Medicaid waiver. The Department of Human Services has developed a managed care policy that will guide development of these systems in counties and statewide.<br><br>Still needed are pilots for integrating RTC funding with community-based services funding. |
| 19 | More programs that assist RTC discharges in making successful transition to community services. | Sixty additional persons were discharged from the Anoka-Metro RTC with specialized services. These discharges represent 13.2% of the total 455 discharges at the Anoka-Metro RTC, where the program of enhanced, individualized community services was implemented on a demonstration basis. The group of 60 discharges had a much higher length of stay in the hospital than the other discharges, and had a higher than average risk of rehospitalization. Only 10 of the 60 (16%) were rehospitalized following discharge, compared to a much higher recidivism rate for the other discharges. About 45% of the demonstration group were discharged to independent living with supportive services, rather than to residential treatment facilities. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 20 | Membership of local advisory councils includes all mandated categories. | Twenty-six (87%) of the thirty councils contacted in 1993 indicated that their membership meets all requirements specified in law. Data for 1992 are not available.<br><br>Law requires local advisory councils to have at least one member from each of the following categories: a) consumers, b) mental health professionals, c) family member of person with SMI, and d) CSP representative. Survey data indicated that consumer representation is the most difficult to maintain of the four groups. In addition to the required categories, many councils had members from law enforcement, public health, vocational rehabilitation, court services, clergy, and the community at large. |
| 21 | A statewide information system that meets the information requirements of the SMHA. | The percentage of information requirements of the SMHA that are being met had increased from 30% in 1989 to 60% in 1990 and to 70% in SFY92. A new analysis in SFY93 indicates that nearly 90% of needs are being met. The 10% of needs not yet being met fall mostly into the areas of client outcomes, demographics of provider staff, and MA eligibility. This percentage will rise in the future, however, as outcomes become more central to the information system. |
| 22 | Enhanced capability to evaluate service provision. | Consumer satisfaction, level of functioning, and quality of life data collection forms were mailed to housing support clients as a test of a client outcomes measurement system. |
| 23 | Outcome standards for programs. | As a first step in developing outcome standards, instruments for measuring outcomes in CSP, Enhanced Housing Support, Case Management, and Day Treatment programs were developed. These instruments contain scalar items measuring client satisfaction, level of functioning, and quality of life. Analysis of data from these surveys will define expectations for program performance. The SMHA will also make these instruments available to counties and providers for self-evaluation. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 24 | A method for estimating prevalence of SMI in county populations. | The state did not implement a new method for producing prevalence and incidence rates. The SMHA instead decided to wait for new methodology from the Center for Mental Health Services for making these estimates, which would allow adjustments to the composition of local populations. |
| 25 | A new state Rule that defines program standards for CSPs and FCSS providers. | Prior to 1993, there was no organized effort to redefine programs standards for CSPs and FCSS. The SMHA formed a task force to rewrite these standards (proposed Rule 15); however, only the children's (FCSS) standards were rewritten before work on the Rule was suspended. The project was suspended until the relevance of the defined standards to new developments in managed care approaches and in Medicaid reimbursement policies are clear. |
| 26 | Technical assistance is made available to all case managers. | Over 30 structured case management training sessions were conducted by the SMHA during 1993. Seven regional meetings were held to train case managers and county supervisors in case management policy and procedures. Additional training was conducted at two major statewide conferences: the Minnesota Social Services Association Conference and the Community Support Programs Conference. In September, the SMHA also conducted three-day case manager training at 6 sites around the state. |
| 27 | Fewer MI beds in the RTC system. | The SMHA, counties, and other regional entities coordinated development of a plan to eliminate MI beds from one of the RTCs. The plan involved transfer of all 200 MI beds at the Moose Lake RTC to the corrections system, while 75 beds are to be added to one of the other RTCs in order to continue inpatient services to the Moose Lake catchment area. The net reduction in RTC MI beds will be 125. The legislature approved the plan and passed funding legislation in 1993.<br><br>(Due to the large number of sexual offenders being referred from the corrections system to human services, however, 100 new forensic beds will be built for people with psychopathic personalities.) |
| 28 | Programs that incorporate elements of cultural sensitivity. | The SMHA had intended to focus on minority staffing in mental health programs but was unable to collect the data due to staff shortages. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 29 | The statewide RTC inpatient population is regularly evaluated for readiness for community services. | Biennial evaluation of RTC patients with mental illness was done in 1989 and 1991, but not in 1993 due to a shortage of resources and the startup of the Moose Lake closure project, which includes development of a new set of patient evaluation instruments. |
| 30 | Adults with MI are not being inappropriately admitted to nursing facilities. | There were no persons with mental illness admitted to a nursing facility, who were not in need of nursing facility care. Minnesota employs pre-admission screening of potential nursing facility placements, pursuant to P.L. 100-203, and aimed at diverting those with mental illness into mental health programs, unless the medical care available in the nursing facility is needed by the client. There were 89 diversions made in SFY93. |
| 31 | Adults with MI who appropriately reside in nursing facilities are re-evaluated to determine if their mental health needs are being met. | Since 1988, the year before annual screenings of nursing facility residents began, all residents of these facilities have been screened for mental health service needs. As a result of these screenings, 110 residents for whom nursing facility care was not appropriate have been moved out of the nursing facilites and into less restrictive community settings with mental health services. Of 41 long-term residents identified as needing mental health services within the nursing facility setting, all are receiving these services. In addition, over 1,100 residents are re-evaluated annually to ensure their mental health needs are being met in the facilities. |
| 32 | Client choice in housing. | Study of a random sample of 50 housing project clients around the state found that 80% had moved into their preferred type of housing after nine months in the program. |
| 33 | The average caseload size for case managers is small enough to promote quality service. | Unable to determine this year. |
| 34 | A significant number of adults with SMI will receive CSP or Day Treatment services. | The percent of adults with SMI who were receiving CSP or day treatment services in SFY92 was 47%. This percent appeared to decrease to 42% in SFY93. However, the SFY92 figure was based on a counting procedure that is different from that used for the SFY93 figure. The key difference is that the SFY93 count uses a new, statewide client identifier code, whereas the SFY92 count could accurately unduplicate clients only for specific providers (single data sources). |

| No. | Objective | Measurable Progress |
|---|---|---|
| 35 | Outreach services contact a significant number of adults with mental illness. | There were no reliable data on numbers of outreach contacts prior to 1993. Statewide, there were 78 contacts per 1000 estimated adults with MI in 1993. |
| 36 | CSP crisis assistance services are provided to a significant number of adults with mental illness. | Data collection systems could not be modified this year to allow collection of data on this objective. The current system produced mixed counts of individual clients of this service (1,482) and distinct "contacts" (58,661), which could not be added together. |
| 37 | Increased employment among CSP clients. | Measurement of progress on this objective was based on the assumption that the CSP Consumer Outcome Survey would be implemented in SFY93, and that the results of that survey would establish a baseline for future progress measurement. The CSP Survey was not implemented, however, because of recent developments in technology for outcomes measurement. (See Objective #23 and #38.)<br><br>The SMHA, in conjunction with the Department of Jobs and Training, has made significant progress in developing and funding 9 new community-based employment projects for persons with SMI. It has also funded 3 self-help (consumer operated) employment projects during the past year. In order to improve discharge planning and employment outcomes for persons in the Anoka-Metro RTC, the SMHA negotiated with DJT for addition of a new vocational counselor at the facility. |
| 38 | Clients are satisfied with their community support programs. | The SMHA decided not to implement the CSP Consumer Survey in 1993, which included a data collection form for consumer satisfaction. Staff cutbacks were one reason for the delay; however, the primary reason was that information collected from other states and from private companies indicated that there was considerable progress being made in developing new client outcomes measurement technology in mental health, and that it made more sense to wait on the new technology than to implement a system that would soon have to be scrapped. The SMHA is particularly interested in implementing a set of outcomes management tools that will be useful in a managed care system. |
| 39 | Reduced hospitalization among CSP clients. | See # 38. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 40 | Emergency services contact a significant number of adults with mental illness. | Data reported by counties indicate that the number of contacts statewide, per 1000 adults with MI, was 35. A comparative figure for SFY92 is not available. |
| 41 | A significant number of adults with SMI receive mental health case management. | In SFY92, 28% of the state's estimated SMI population received case management services (as defined in Rule 79). This percentage increased to 31% in SFY93.<br><br>This objective drew attention to the need for more of this service in some counties. Still, 33 of the 87 counties have not met the statewide target, and this objective will be continued in 1994. |
| 42 | The amount of case management per client is adequate to meet clients' needs. | The average number of hours per client in SFY92 was 13. In SFY93, it rose to 14.2. The state is concerned that although case management is reaching deeply into the SMI population, the number of hours of service being received by clients is too low and threatens the quality of the service. The low number of hours per client is directly related to high average caseload sizes throughout the state. This objective is continued in 1994. |
| 43 | A significant number of adults with SMI receive housing support services. | The number of enhanced housing support clients statewide was 31 per 1000 adults with SMI. A comparison figure for SFY92 is not available. The enhanced housing support programs reached 1,003 clients in SFY93. There are an estimated 32,000 adults with SMI living in the state.<br><br>In 1994, the state grants for enhanced housing support services will be merged with grants for "basic" CSP services. |
| 44 | Interagency agreements that combine SMHA funds with other state or federal funds to provide mental health services. | The SMHA and the Department of Jobs and Training pooled $320,000 for employability programs. The SMHA transferred $1,300,000 to the Minnesota Housing Finance Agency in order to maximize federal funding and to shift the housing subsidy program to the agency with greatest expertise. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 45 | Hold steady expenditures for RTC inpatient treatment. | RTC total expenditures increased 3.6% from SFY92 to SFY93. However, these expenditures computed per 10,000 adult population, adjusting for a 0.9% increase in population (from 3,208,000 to 3,496,000), actually fell from $326,000 to $313,000 from SFY92 to SFY93.<br><br>Inflation--the Consumer Price Index--increased 3% during SFY93. In constant SFY92 dollars (adjusted for this inflation rate), the RTC expenditures increased only 0.5%, not 3.6%. The RTC percentage of total mental health expenditures decreased during the year, from 33.5% in SFY92 to 31.5% in SFY93. |
| 46 | Reduced use of RTC inpatient treatment. | There was a 3% reduction in RTC inpatient days from SFY92 (459,827) to SFY93 (445,594). |
| 47 | Legislative approval to reduce the number of RTC MI beds. | The state legislature passed legislation mandating the closure of the 200 bed Moose Lake RTC, and transfer of the facility to the Department of Corrections.<br><br>(This objective is virtually identical to Objective #27, except that it could be viewed as a performance indicator for objective #27.) |
| 48 | Consolidated grant applications. | Three state grant applications were combined into a single form. The Rule 78 (CSP) grant application now includes information from the former Housing Support Grant and the Alternative Disposition Plan (ADP) Grant, which allows funding for all three programs to be awarded through a single application-review process. |
| 49 | Interactive video technology used in providing technical assistance to counties. | Interactive video was used 12 times to provide technical assistance and training, and for planning purposes. The SMHA conducted 4 meetings with RTC and county personnel in the Moose Lake RTC region through interactive video. These were planning meetings. Technical assistance and training were provided through this medium on 8 other occasions: once to train counties in developing client outcome-based objectives, three times in downlinked conferences of consumers and providers that involved 39 sites and over 1200 people in the state, and four times as co-sponsored human services management conferences. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 50 | Reduced use of residential treatment. | The number of resident-days per 10,000 in CY91 was 1,389. This decreased to 1,249 in CY92. In SFY93 the figure increased to 1,349. The "dip" in CY92 appears to have been due to reporting anomalies (late reporting by several facilities), and this led to a projected trend that did not in fact exist. |
| 51 | Fewer IMDs. | The number of IMDs in SFY92 was 20, and the number of beds in these facilities was 895. By the end of SFY93, the number of IMDs was 16 and the number of beds was 853. The percentage reduction in the number of IMDs was 20%.<br><br>Over the past four years the state has steadily reduced the number of adult residential treatment facilites with 16 or more beds (IMDs) in favor of smaller group-homes and scattered-site supported housing. These reductions create a more community-based nature to the service and allow residents to receive Medicaid reimbursement. |
| 52 | Increased residential eligibility for MA. | There was an 11% increase over SFY92 in the number of clients in residential treatment facilities who received MA/GAMC coverage for ancillary services. In SFY92, 986 residents received these services. This number increased to 1,092 in SFY93, while the overall number of residents in each of the two years was virtually the same. |
| 90 | Increase the number of adults with SMI receiving services. | The number of adults with SMI receiving services in SFY92 was 22,600. This number in SFY93 was 22,970, a 1.6% increase. The increase from SFY92 to SFY93 was roughly equal to the increase from SFY91 to SFY92. |
| 91 | Stop the rate of increase in use of inpatient treatment facilities. | The number of adults with SMI receiving inpatient treatment in SFY92 was 7,950. The number in SFY93 was 7,540. This includes treatment in the RTCs as well as in community hospitals. Development of more CSP and day treatment programs has assisted in stopping the growth of inpatient treatment. |

## *Progress on Children's Objectives*

| No. | Objective | Measurable Progress |
|---|---|---|
| 53 | Increase in overall funding for children's mental health services. | There was a 24.2% increase over SFY92 funding for children's services. Increases in the federal block grant to the state, a significant portion of which is used for children's services, and increases in the use of MA/MNCare as a funding source for some services, helped to increase total funding even though the state was experiencing a budget crisis. There was also a significant increase in the use of state block grant funds to counties (CSSA) for children's mental health. |
| 54 | A significant share of overall funding for children's programs is for family community support and home-based services. | In SFY92, 12.0% of total children's funding was used for FCSS and professional home-based family treatment. In SFY93, this percentage increased to 13.2%. |
| 55 | Medical Assistance funds a significant share of services. | In CY92, 30% of case management units of service to children were billed to MA. In SFY93, this figure was 33%. The SMHA has provided special training to county staff to increase billings for these services, and has automated county data systems to produce these billings. |
| 56 | Medical Assistance funds a full range of medical and dental services to child clients with SED. | The objective was to provide the wide range of MA/MNCare medical coverage to a significant proportion of clients in the system. Because the MA/MNCare data system does not have enough information to identify children with SED, and because techniques for matching records in the community mental health database (CMHRS), which does have this information, to the MA/MNCare database are not yet reliable, progress could not be measured. |
| 57 | Programs that extend services to homeless children with SED. | Although there were plans to modify the state's system of data collection for homeless persons to include children, that modification was not made in SFY93. It was not possible to measure progress on this objective. |
| 58 | Programs that deliver services to children in the corrections system. | Of the 1,861 children entering the corrections system in SFY93, in the 12 pilot counties, all were screened for possible emotional disturbance. Of those screened, 191 (10%) received a professional mental health assessment, and of these, 179 (9.6%) received treatment. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 59 | Counties provide family community support services to a significant segment of their SED populations. | The percent of counties providing FCSS to at least 10% of their estimated SED populations was 2% in SFY92 and increased to 15% in SFY93. The SMHA provides funding to each county for provision of these services to the SED population. Many of these grants are still small, provided solely through state appropriations; however, beginning in 1994, MA will fund these services as well, which should provide a needed "boost" to implementation. |
| 60 | Counties provide mental health case management to children with SED. | As of the end of SFY93, 74 (85%) of the state's counties were providing mental health (Rule 79) case management to children with SED. This compares to 50% in CY91. In both CY91 and SFY93, however, some counties provided the service to fewer than 3 clients per 10,000 population. The SMHA continues to provide technical assistance to counties that need help in providing mental health case management. |
| 61 | Parent-to-parent support is available for parents of a child with an emotional disturbance. | The number of support groups increased from 8 in SFY92 to 21 in SFY93, with an average referral rate in each group of 30-40 per month. The agency funded to operate this program also issues a newsletter with over 300 subscribers. |
| 62 | A multi-agency fund available to local coordinating councils (LCCs) for implementation of integrated identification and intervention services. | Sixty-five counties received a total of $1,622,000 in grant funds for SFY93 to implement integrated early identification/intervention services. These grants were developed in 1992 as a joint effort of the SMHA and the state departments of Corrections, Education, and Health, blending funds at the state level. The SMHA funds include federal block grant dollars that were added in 1993. The grant requirements are flexible to the needs of local systems, allowing counties to direct the dollars where most needed to build EI/I capacity. For some counties this will mean providing these services, for others it will mean further developing collaborative efforts of their LCCs in the first year. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 63 | Approved county mental health plans that indicate the counties will make all possible efforts to meet local needs. | In previous local planning cycles, instructions issued to counties by the SMHA did not collect sufficient information about the needs assessment methods used, and did not require plan objectives to be explicitly linked to identified needs. This year, county plans were required to include these elements.<br><br>All 87 county mental health plans were approved by the SMHA by the end of 1993. |
| 64 | Recommendations from LCCs on local service system plan objectives and resource allocations. | 80% of counties reported that their children's advisory councils contributed recommendations for their local mental health plans. As with local adult advisory councils, children's advisory councils are still undergoing development in some counties and are not yet ready to play active roles. |
| 65 | Managed care pilots for children's services. | Of the eight children's collaborative projects approved by the SMHA in 1993, two involve a managed care approach to service delivery.<br><br>State legislation passed in 1993 provides funding for planning local children's collaboratives. These collaboratives are to integrate funding streams for children's services and are allowed to embrace managed care models of service delivery. |
| 66 | Local interagency agreements that implement coordinated education and service plans for individual children with SED. | Thirty-nine counties (45%) that provide day treatment to children with SED have implemented agreements with school districts for provision of this service. The development of local collaboratives in 1994 will greatly expand interagency agreements and will result in implementation of multi-agency service plans for children. |
| 67 | Greater consolidation of mental health funds. | State grant application procedures were simplified to allow counties to apply for three grants in a single application. One application form (the biennial county mental health plan) consolidated state FCSS grants with federal block grants dollars for integrated services planning and integrated service delivery. Although this combined application integrated information, it did not integrate the funds themselves. The passage of new legislation for local children's collaboratives in 1993 will permit much greater integration of funding streams. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 68 | Membership of local advisory councils meet legal requirements. | Twenty-three (88%) of the twenty-six councils contacted indicated that they had at least one family member on the council. Data for 1992 are not available. Data suggest that obtaining and retaining consumer and family membership is more difficult than for some of the other mandated membership categories. |
| 69 | Membership of local coordinating councils includes all mandated categories. | Fifty-one (96%) of the fifty-three councils contacted indicated that their memberships meet the principal membership requirements. Only about 50% are thusfar able to meet all of the additional requirements.<br><br>The principal mandated categories of membership include: mental health, health, education, corrections, and social services. Additional categories include American Indian and vocational services representation. These councils are still undergoing their initial development in many counties, assisted by funds from the federal block grant. |
| 70 | A statewide information system that meets the information requirements of the SMHA. | See # 21. |
| 71 | Enhanced capability to evaluate service provision. | No statewide methods were developed for collecting EI/I consumer outcome data; however, draft forms were developed for FCSS. Counties were required to develop client satisfaction instruments for the EI/I grants, and the extent to which this occurred is unknown. |
| 72 | A method for estimating prevalence of SED in county populations. | The state did not implement a new method for producing prevalence and incidence rates, but instead decided to wait for a new federal methodology for making these estimates, which would allow adjustments to the composition of local populations. |
| 73 | Reliable methods of needs assessment being used in counties. | 72% of LACs and 70% of LCCs conducted local needs assessments as part of the county planning process, according to data submitted by counties to the SMHA.<br><br>The needs most often cited by these groups include: more day treatment for children, especially for the younger children; respite care; community education about emotional disturbance; and greater cooperation and collaboration among service agencies. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 74 | A state rule for residential treatment, which establishes standards for treatment. | The revised Rule 5 has been drafted and will be promulgated in April, 1994. The revised rule incorporates standards of treatment and staff qualifications. |
| 75 | Programs demonstrate increased sensitivity and responsiveness to persons of color and diverse cultural backgrounds in the community. | Fewer than 5% of counties use special mental health consultants for children of minority cultural backgrounds. Counties are not making use of special consultants because they feel the state law is too prescriptive, and in many cases would force them to use consultants from outside the county who are not familiar with the families in need or with local issues. The SMHA will propose a change in the law in 1994. |
| 76 | SMHA staff with diverse cultural background. | As of December, 1993, five (17%) of the professional staff positions in the SMHA's Community Mental Health Division were filled by persons from minority cultural backgrounds. The SMHA will continue to recruit persons from minority backgrounds. |
| 77 | A task force to advise the SMHA on issues related to cultural diversity. | The cultural diversity task force was created in 1993 and met each month during the year. It is composed of about 30 members. Cultural minority membership is as follows: African American (6), Hispanic (5), Asian (9), American Indian (5). |
| 78 | The average caseload size for children's case managers is small enough to promote quality service. | The state's data collection process for this objective was not implemented until January, 1994, and so progress cannot be determined. Data from 1992 showed that the average caseload size in the state was 18:1. State regulations require each county to achieve a ratio of 15:1 by January, 1994. |
| 79 | Advocacy services are available to parents with children in the mental health system. | The state-contracted provider of this service responded to more than 3,700 individual telephone requests for information and assistance--an average of over 300 requests per month. The SMHA contracts PACER (Parent Advocacy Coalition for Educational Rights) Center, an independent organization, to provide individualized advocacy services. In addition to responding to individual requests, PACER provided training to parents interested in serving on local advisory councils (LACs). Training focused on the parent's role in planning and accessing services. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 80 | A significant percent of unmet need for FCSS will be met. | 29% of the SFY92 unmet need for FCSS received the service in SFY93. In SFY92, there was an estimated statewide need for FCSS among the SED population of 2,800. There were only 160 clients that year, resulting in an unmet need of 2,640. In SFY93, 770 additional children out of the 2,640, or 29%, were reported as recipients of FCSS. Some of this increase was due to improved reporting. |
| 81 | A significant percent of unmet need for case management will be met. | 34% of the SFY92 unmet need for children's case management received the service in SFY93. In SFY92, an estimated 5,100 children with SED in the state needed case management. There were 600 clients that year, resulting in an unmet need of 4,500. In SFY93, 1,530 additional children out of the 4,500, or 34%, received case management. |
| 82 | Integrated Early Identification and Intervention services contact a significant number of children with SED. | Data collection systems could not be modified this year to allow collection of data on this indicator. Although there were 17 counties providing EI/I services through special state grants, there was no requirement that these projects report to the SMHA the number of children identified as SED. |
| 83 | A significant percent of unmet need for professional home-based treatment will be met. | In SFY92, the estimated number of families needing professional home-based family treatment was 2,800. There were 260 clients receiving the service, leaving 2,540 as unmet need. In SFY93, 220 more clients were added, which was 8.7% of the unmet need. |
| 84 | The amount of case management per client is adequate to meet clients' needs. | The SFY92 figure for average number of hours per client was 14.8. The SFY93 figure was 18.9. |
| 85 | Integrated funding for children's mental health services. | Eight plans for local children's collaboratives were approved by the SMHA, all of which include integration of funding between the mental health system and one or more other services systems, primarily education. |
| 86 | Interactive video technology used in providing technical assistance to counties. | Interactive video was used on 12 occasions to provide technical assistance and training, and for planning purposes. The planning, TA, and training events discussed under Objective #49 of the adult report also covered children's services. |

| No. | Objective | Measurable Progress |
|---|---|---|
| 87 | Hold steady the use of residential treatment. | In SFY92, the state had 11.2 child residential clients per 10,000 child population. This figure increased to 11.9 in SFY93. Both the SFY92 and SFY93 figures were computed from 1990 census data. This does not allow for an increase in the child population between the two years, which would have the effect of lowering the SFY93 indicator figure from 11.9 to something closer to the SFY92 figure. |
| 88 | Fewer residential treatment days. | In SFY92, the number of treatment days per 10,000 child population was 1,630. This figure *increased* to 1,730 in SFY93, a 6% increase. Although the SFY93 figure is not adjusted for an increase in population from SFY92, such an adjustment would not erase the increase in utilization of residential treatment. These services continue to be over-utilized, while FCSS and home-based treatment are making modest progress in penetrating the target population. |
| 89 | Increase the number of children with SED receiving services. | In SFY92, 17,300 children with SED were served in the public system. This figure rose to 22,000 in SFY93, a 27% increase. Increases in client counts occurred across nearly all children's services in SFY93. In some cases, including the total count of 22,000, some of the increase was due to more complete reporting. |

# Chapter III

# State Mental Health Plan For 1994

This chapter outlines Minnesota's mental health plan for 1994. It is composed of objectives that are organized according to ten requirements specified in federal law (P.L. 102-321). While the objectives are established to address identified unmet needs in the mental health system, they are done so with an eye to the fiscal, political, and other "realities" that are likely to exist during the period covered by the plan. Not all unmet needs are addressed in this one-year plan.

(NOTE: This plan does not present information about specific performance levels, targets, or operational measures for the objectives, or about what actions will be taken to achieve them. This information is available in workplans and other documents of the Department's Mental Health Division--see inside of back cover for address.)

## *Federal Requirements for State Plans*

| No. | Requirement |
|---|---|
| I. | The State shall provide for the establishment and implementation of an organized community-based system of care for individuals with serious mental illnesses or emotional disturbance. |
| II. | The State plan shall contain quantitative targets to be achieved in the implementation of such system, including numbers of individuals with serious mental illness or emotional disturbance residing in the areas to be served under such system. |
| III. | The State plan shall describe services, available treatment options, and available resources to be provided to individuals with serious mental illness or emotional disturbance to enable them to gain access to mental health services, including access to treatment, prevention, and rehabilitation services. |
| IV. | The State plan shall describe health and mental health services, rehabilitation services, employment services, housing services, educational services, medical and dental care, and other support services to be provided to individuals with mental disorders with federal, state, and local public and private resources to enable such individuals to function outside of inpatient and residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Education of the Handicapped Act. |
| V. | The State plan shall describe the financial resources and staffing necessary to implement the requirements of the plan. |

VI. The State plan shall provide for activities to reduce the rate of hospitalization of adults with serious mental illness or emotional disturbance.

VII. The State plan shall require the provision of case management services to each person with a serious mental illness or emotional disturbance who receives substantial amounts of public funds or services.

VIII. The state plan shall provide for the establishment and implementation of a program of outreach to, and services for, individuals with serious mental illness or serious emotional disturbance who are homeless.

IX. The state plan shall describe a system of integrated social services, educational services, juvenile services, substance abuse services, which together with health and mental health services should be provided in order for children and adolescents with serious emotional disturbance to receive care appropriate for their multiple needs, including services to be provided by local school systems under the Education of the Handicapped Act.

X. The plan shall describe the manner in which mental health services will be provided to individuals residing in rural areas.

# Adult Plan for 1994

| I | Implementation of an organized community-based system of care. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| A glance back at Figure 2 and Table 2 in Chapter I suggests areas in which the community-based system can be improved. Although the state-mandated array of services is available in all counties, the extent to which the community-based services penetrate the target population, and the extent to which these services are adequately coordinated and effective, are additional dimensions to county services systems that in most cases require further development. As Table 2 shows, case management and community support services fall short of need at the present time, while residential treatment is being overutilized.<br><br>Also needed in the adult system are better mechanisms of coordination among provider agencies, more active participation among all stakeholders in planning and policymaking, more flexible and outcome-based state regulations, and increased individualization of services. Some services, such as crisis intervention, should perhaps be added to the "comprehensive" array of services mandated in each county.<br><br>Objectives under this criterion have been developed under the assumption that there will be no shift of funding in 1994 from the RTC system, where there is over-investment of resources, into the community system, where more services are needed, other than what occurs as part of the Moose Lake RTC transfer. | #1<br><br>#2<br><br>#3<br><br>#4<br><br>#5 | Assessment of the service needs of all patients of the Moose Lake RTC, prior to discharge.<br><br>A method for evaluating the effectiveness of the Moose Lake RTC closure.<br><br>Active consumer participation on local mental health advisory councils.<br><br>Recommendations of local task forces for improving the adult system of care.<br><br>County mental health plans that are targeted to identified local needs. |

| II | Quantitative Targets. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| Case management and CSP services should reach more persons with SMI. Along with this, use of residential and RTC inpatient treatment should be reduced.<br><br>Improvements in data collection systems will occur during the next year as counties and providers continue to upgrade their data processing technology; however, the focus will be on further development of techniques for measuring service effectiveness. | #6 | Better statistical information available to counties on client characteristics, service utilization, and expenditures. |
| | #7 | CSP Consumer Outcome Survey instrument implemented statewide. |
| | #8 | A larger percentage of the SMI population receives services. |
| | #9 | An accurate method for estimating prevalence of SMI in county populations. |
| | #10 | Reduced utilization of RTC inpatient treatment. |
| | #11 | Reduced utilization of residential treatment. |
| | #12 | Fewer IMDs. |

| III | Service Availability and Access. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| There is a general availability of all of the community-based services around the state, with a few isolated exceptions. There is evidence that some counties are not providing the full array of CSP component services. The resources needed to ensure provision of these components are discussed under Requirement V An objective for ensuring that case management is provided in each county is included under Requirement VII.<br><br>The Hispanic and Asian populations may be experiencing widespread barriers to access.<br><br>Discharges from the Moose Lake RTC will require individualized community support services in order for the closure of this facility to be successful. (Counties in the catchment region of this facility, in partnership with the SMHA, are currently developing a state-of-the-art mental health delivery system in this predominantly rural area.)<br><br>Victims of severe flooding in 1993, most of whom will not be members of the SMI target population, will nevertheless require public services, including educational, preventive, crisis, and treatment services. | #13<br><br>#14<br><br>#15<br><br>#16<br><br>#17<br><br>#18<br><br>#19 | All CSP component services are provided in each county.<br><br>Staff positions at the SMHA that are responsible for monitoring and communicating the needs of consumers.<br><br>Expansion of individualized services to Moose Lake RTC discharges, which improve access to an array of MH services, including CSP services.<br><br>Definition of special services for adults with SMI who have a concurrent chemical dependency diagnosis.<br><br>A significant percentage of compulsive gamblers and their families receive treatment.<br><br>The general public and mental health professionals will become more aware of the issues associated with problem gambling.<br><br>Victims of flooding receive crisis counseling and other mental health services as needed. |

| IV | Supportive Services. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| There is unmet need for CSP component services in some counties, which is covered by Objective #13. | #20 | Counties provide basic CSP services to a significant segment of their SMI populations. |
| Beyond basic community support services as defined in state regulations, many counties still need more intensive services, especially for persons discharged from hospital treatment. Basic support services might be available on a weekly basis; however, discharges often require daily services in order to avoid readmission. Persons with tendencies to become "system-dependent," and to give up on employment, need more intensive employability services. | #21 | Clients obtain housing of their choice. |
| | #22 | Innovative housing subsidies programs are implemented as demonstration projects. |
| | #23 | A strong statewide consumer network. |
| Persons who either are living or want to live in the community continue to have problems finding safe, affordable, low income housing. Waiting lists for Section 8 are long and it can take as long as 3 years for a person to receive a certificate. In some parts of the state, 80% of those on waiting lists are believed to be SMI individuals. | | |

| V | Resources. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| As suggested in Chapter I, the level of overall funding for adult mental health appears adequate, given current estimates of target population prevalence. However, distribution of that funding does not agree with the values of the system of care that include emphasis on community-based services. Almost 40% of all funding goes to RTC inpatient treatment, while in many counties the community support programs are inadequately funded and cannot support the full array of CSP component services.<br><br>There are shortages of psychiatrists in rural counties in the state, as illustrated in Chapter I, Figure 14. It is widely believed that there are statewide shortages in direct services staff from minority backgrounds, but data are not yet available to establish the magnitude of these shortages.<br><br>Case managers need additional training, particularly in the area of billing Medical Assistance, and emergency health services personnel need mental health training. | #24<br><br>#25<br><br>#26<br><br>#27<br><br>#28<br><br>#29<br><br>#30 | Medical Assistance funds most case management services.<br><br>Additional funding for community-based services in the Moose Lake RTC region.<br><br>Integration of housing support, OBRA/ADP, and basic CSP funding streams.<br><br>Piloting of initial phase of adult mental health integrated funding systems.<br><br>A rural psychiatric residency training program in the Moose Lake region.<br><br>Adult mental health case managers receive refresher training.<br><br>Emergency medical personnel are able to recognize problems due to mental illness. |

| VI | Rate of Hospitalization. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| A significant percentage of inpatients could be converted or diverted into community-based programs. These alternative programs need further development around the state. | #31<br><br>#32<br><br>#33 | More crisis intervention programs.<br><br>Fewer admissions to the RTCs.<br><br>Lower readmission rates at all RTCs. |

| VII | Case Management Services. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| The system needs to provide more hours of case management per client, and it needs to acquire more case managers. | #34 | Case management services are provided to a significant number of adults with SMI in each county. |
| Surveys of case managers suggest that the state's regulations of this service are too restrictive and are a disincentive to its provision; however, there will be no modifications to these regulations proposed this year. | #35 | More hours of case management per client. |

| VIII | Services to Homeless Persons in Target Populations. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| There are still many homeless adults with MI who can benefit from mental health services, but who are not yet being served. However, PATH funds for 1994 will not be increased. As a result, one service that is not expected to increase in the next year is outreach. There were 700 new outreach contacts made in SFY93, and this number is expected to remain at that level, or perhaps decrease in favor of increased referrals. | #36 | More homeless persons with mental illness receive state-funded mental health services. |

| IX | Integration of Services. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| More integrated service delivery systems. | #37 | Projects demonstrating integrated funding of local service systems. |
| | #38 | State Adult Mental Health Task Force recommendations for improved integration of services. |

| X | Services to Persons in Rural Areas. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| Rural psychiatry is one specific area of need that is often mentioned by mental health professionals and organizations in the state. | | See #28 |

# Children's Plan for 1994

| I | Implementation of an organized community-based system of care. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| The full array of community-based services is not available in many counties. The extent to which the community-based, nonresidential services are penetrating the SED target population on a statewide basis can be seen in Table 3 of Chapter I. There is significant unmet need for all of these services.<br><br>Table 7 in Chapter I shows that there is a large shortage of funding for the children's system. | #39<br><br>#40<br><br>#41 | Measures of client outcome.<br><br>Consumer participation on local mental health advisory councils.<br><br>County children's mental health plans that target identified local needs. |

| II | Quantitative Targets. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| Increased capacity in terms of more case managers and more FCSS programs is needed. Gains in target population penetration are expected in all community-based, nonresidential services. Along with this, reductions in the use of residential and RTC inpatient treatment are expected.<br><br>Improvements in data systems will also occur during the next year as counties and providers continue to upgrade their data processing technology (see Objectives #6 and #7). The focus of the SMHA will be on development of the means for measuring service effectiveness and on increasing the use of data in periodic reports to counties and providers. | #42<br><br>#43<br><br>#44<br><br>#45<br><br>#46 | Expanded statistical reports to counties, including statistical information on client characteristics, service utilization, and expenditures.<br><br>Larger percentage of the SED population receives services.<br><br>A method for estimating prevalence of SED in county populations.<br><br>Reduced utilization of residential treatment.<br><br>A long-range objective to reduce the capacity of residential treatment. |

| III | Service Availability and Access. | |
|---|---|---|
| Unmet Need | No. | Objective |
| Community-based, nonresidential services are not available in some counties. An objective for increased availability of home-based treatment is included below. An objective for ensuring that case management is provided in each county is included under Requirement VII; and an objective for increased availability of FCSS is included under Requirement IV. | #47 | Increased availability of home-based treatment services. |
| | #48 | Increased availability of day treatment services. |
| | #49 | Reduction in use of out-of-state residential treatment facilities. |
| Early identification and intervention services must begin to channel children with SED into the system of care. | #50 | Staff positions at the SMHA that are responsible for monitoring and communicating the needs of consumers. |
| Children with both emotional disturbance and developmental disability need specialized services, and children with SED who display violent or destructive behavior need specialized residential treatment. Also in need of special services are dually diagnosed parents with poorly developed or poorly maintained parenting skills. | #51 | A significant number of children with SED, or at risk of SED, are being contacted through early identification and intervention services. |
| | #52 | Victims of flooding receive crisis counseling and other mental health services as needed. |
| Children who were victims of severe flooding in 1993 need crisis counseling and other special services. | #53 | A plan to meet the special needs of children with SED and DD. |
| There are large shortages in funding for professional home-based family treatment, case management, FCSS, and therapeutic support for foster care, as shown in Table 7 of Chapter I. | #54 | Pilot project demonstrating that parents with MI and CD diagnoses can learn sufficient parenting skills to avoid out of home placement. |

| IV | Supportive Services. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| The need for more family community support services is covered under Requirement III. There are no other needs identified for this Requirement. | #55 | Family community support services (FCSS) are available in every county. |

| V | Resources. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| The level of overall funding for children's mental health services is far below the level of need, particularly for supportive and home-based services. Distribution of community-based funding is also part of the problem of underfunded supportive and home-based services, with too much of the financing going for residential treatment.<br><br>Integration of funding across all agencies serving children with emotional disturbance is seen as essential to development of integrated services systems. | #56<br><br>#57<br><br>#58 | Medical Assistance is the primary funding source for case management services.<br><br>State Medical Assistance Plan includes reimbursement for FCSS and therapeutic support for foster care.<br><br>Children's case managers receive refresher training. |

| VI | Rate of Hospitalization. | |
|---|---|---|
| **Unmet Need** | **No.** | **Objective** |
| Even though the percentage of psychiatric inpatients in the state who are children has been relatively low--5% in the RTCs and 12% in community hospitals--the state needs considerable further development of alternative services. These needs are addressed under other Requirements in this plan. | | See Objectives #47, #48, #55. |

| VII | Case Management Services. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| The system needs to provide case management to more clients. It also needs to provide more hours of case management per client, and it needs to acquire more case managers.<br><br>Surveys of case managers suggest that the state's regulations of this service are too restrictive and are a disincentive to its provision. | #59<br><br>#60<br><br>#61 | Increased availability of case management services.<br><br>Case management services are provided to a significant number of children with SED in each county.<br><br>More hours of case management per client. |

| VIII | Services to Homeless Persons in Target Populations. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| Based on the estimates of homeless children with emotional disturbance and on the numbers of homeless persons receiving services, it can be safely assumed that there are many homeless children with SED who can benefit from mental health services, but who are not yet being served. Shelters are a key point of contact, and staff of these shelters need more education in how to recognize and refer children with SED. | #62 | Shelters for homeless children and their families are able to recognize the need for mental health services. |

| IX | Integrated Services. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| Integration of services to children is an important factor in the development of the children's system. This integration should encompass services delivered in the educational, health, corrections, and social services systems, in addition to the mental health system. Formal mechanisms of system integration, which include integration of funding, have not yet been established, although funding for the planning of these systems was begun in September, 1993. | #63 | Local children's mental health collaboratives that integrate funding and service delivery. |

| X | Services to Persons in Rural Areas. |
|---|---|

| Unmet Need | No. | Objective |
|---|---|---|
| Rural areas have a shortage of children's mental health professionals. | | (See Objective #28 in the Adult Plan.) |

# Chapter IV

# Special Reports

This chapter contains two special reports, both required by legislation. The first is a report on the public-academic liaison initiative; the second on a demonstration project to test the feasibility of permitting MSA recipients who have mental illness to live with another person without loss of MSA benefits.

## *Public-Academic Liaison Initiative*

Minnesota Statutes § 245.4861 directs the Commissioner of Human Services to work in collaboration with higher education organizations to promote research, education and training opportunities for mental health professionals.

The Department of Human Services, in partnership with representatives from the Governor's Office; University of Minnesota School of Medicine, Department of Psychiatry; University of Minnesota - Duluth Medical School; Human Development Center; and the Minnesota Department of Health is working to establish a program in rural psychiatry in the Duluth area.

The Rural Psychiatry Program grows from a long-standing interest between the University of Minnesota, Department of Psychiatry and the other members of the planning group to take collaborative action to address the chronic shortage of psychiatric services in rural Minnesota. The planned closing of the inpatient psychiatric facility at Moose Lake Regional Treatment Center gives an additional sense of urgency to address these needs in northeast Minnesota.

The proposed program will add a rural psychiatry residency option to psychiatry residents attending the University Medical School at the Twin Cities campus. Residents will live and work in community-based settings in northeast Minnesota, gaining valuable experience and exposure to rural practice. Faculty for this program will have appointments to the University of Minnesota - Duluth and, in addition to their instructional duties, will provide clinical services to support both state operated and community programs in the region.

This program will attract and train persons interested in rural practice settings and as such should be provide a valuable recruiting resource for rural Minnesota. It is anticipated that this program will expand to include other mental health disciplines and provide a solid base for ongoing research in rural service delivery models.

## *MSA Shared Housing Demonstration Project*

The Laws of 1992, Chapter 513, Article 8, Section 55 required the Commissioner of Human Services to establish a demonstration project in Hennepin County that would test whether:

> "...allowing full MSA grants for certain persons with mental illness who share housing can be effective in helping those individuals avoid costly mental health treatment..."

Minnesota Supplemental Aid (MSA) is a public assistance program for persons who are blind, aged, or disabled. Those recipients who qualified to participate in the shared housing project would be allowed to receive the full MSA assistance amount that they would have received if they lived alone. The project would include a study to determine whether there indeed appeared to be benefits to this program that would outweigh the added cost to MSA.

The benefits to be examined focused on use of the more costly mental health treatment services. Would persons enrolled in the project and allowed to live with someone else, without a reduction in MSA support, in essence "pay the system back" by utilizing less of these services? Of particular interest was use of hospital-based inpatient treatment.

The project enrolled its first client in October of 1992, is still in operation, and will be reviewed for continuation during the 1994 session of the legislature.

**Summary of Findings**

The findings of the project to date are as follows.

- There are factors related to the project that tend to limit enrollment to a small percentage of otherwise eligible clients.

- There does not appear to be a clear association between living with another person and reduced mental health service utilization--i.e., lower cost of treatment.

- The impact of statewide expansion of this program would not appear to be significant, either in terms of the number of people who would enroll or the additional MSA expenditures that would result from enrollment.

The research design originally developed to test the question about whether living with a another

person had an effect on the use of costly mental health services (e.g., inpatient treatment) had to be abandoned due to the factors that limited enrollment. This situation is explained in more detail below.

Only 17 clients enrolled in the pilot program in its first 15 months of operation. The average additional MSA cost for the program was $840 per month, or about $600 per client per year. It is possible, however, that the impact of the program would have been much larger had the project included an aggressive effort to identify and recruit eligible clients, and perhaps a roommate-locating service. Neither of these features was designed into the project nor budgeted.

(There is another factor that could result in higher enrollment, which lies outside the scope of this demonstration project. A few Hennepin County MSA recipients with mental illness who are living in shared housing were qualified for the higher single household standard by means of an allowed variance from policy. Should these additional clients have been enrolled in the demonstration project instead, the number of enrollees and costs could have, according to county estimates, perhaps doubled.)

Although the research findings do not indicate an association between living with another person and reduced hospitalization, the Department believes that MSA policy should be responsive to a variety of housing needs and preferences, and should not present a barrier for persons with mental illness to living with other people if there is reason to believe that, in this small number of cases, there will be benefits to the person's mental health. The Department recommends that this project be continued in Hennepin County until the 1995 session of the legislature makes a decision on policy amendments.

**Background**

The 1987 Comprehensive Adult Mental Health Act established a state policy that persons with serious and persistent mental illness should be served in the least restrictive, most appropriate setting. However, the state continues to spend over $150 million per year for placement of adults with serious and persistent mental illness in regional treatment centers, community residential facilities, and acute care hospitals. A number of clients and mental health advocates have contended that many people could be served more effectively in nonresidential settings if:

1) appropriate financial assistance were available to clients for independent living; and

2) someone were living with the client to help the person recognize early signs of destabilization, so that the person can take measures to alleviate or prevent a crisis.

MSA is currently structured in a way that discourages recipients from living with anyone else. If the recipient chooses to live with someone else, the monthly assistance level is reduced from

$502 to $387. Table 12 describes the MSA standards of assistance effective January 1, 1994. These standards represent levels of *need*, not amounts actually received by clients. Most MSA clients will mental illness receive SSI benefits which are deducted from the MSA standards.

*TABLE 12: MSA Assistance Standards*

| Living Arrangement | Shelter | Basic Needs | Total |
|---|---|---|---|
| Living Alone | $ 124 | $ 383 | $ 502 |
| Living with Another | $ 93 | $ 294 | $ 387 |
| Difference | $ 31 | $ 81 | $ 120 |

**Eligibility Criteria**

To be eligible for this project, a Hennepin County MSA recipient would have to meet two criteria: a) he or she would have to have a mental illness, and b) he or she would have to obtain the certification of a physician (psychiatrist) that living with another person would be beneficial. Included in the second criterion is the judgment of the physician that living with another would not subject the client to abuse or exploitation.

Two "softer" but also necessary criteria for eligibility were a desire on the part of the client to live with another person, and the belief by the client that such a living arrangement would help him or her cope with mental illness.

All these criteria are important because, along with other factors, they had the effect of reducing the number of MSA recipients who have been enrolled in the program.

**Method of Enrollment**

Staff of the Department of Human Services, Hennepin County staff, members of the Hennepin County Local Mental Health Advisory Council, and representatives of the advocacy and consumer community in the county, jointly developed the general method of enrollment, including the procedure by which MSA clients were notified of the program (a letter), and the procedure by which physicians could certify the presence of mental illness and the probable benefit of shared housing (a letter and a form). This group also developed the original research design for studying the project's effects on service utilization.

The project design relied heavily on self-identification by MSA recipients. All active MSA recipients in Hennepin County received the letter notifying them of the program and of the

eligibility criteria, including certification mental illness. It was left up to the recipient to obtain certification and to contact the county.

Operational procedures for enrolling clients in the program were defined by Hennepin County. County financial workers, case managers, and community support program (CSP) workers coordinated enrollment. County workers would have to carefully examine each case to ensure that enrollment in the program would not have negative effects on the client, such as loss of eligibility for other programs, that would outweigh any possible benefits from this program.

County staff reported that the letter introducing the shared housing program to MSA recipients proved to have little success in recruiting participants. (The letter stated that the duration of the program could be limited to two years, and this might have discouraged some individuals. More importantly, the expectation presented in the letter, that persons with serious mental illness take the initial steps toward enrollment without direct assistance, almost certainly reduced participation.) Most of those eventually enrolled in the program received direct assistance from county staff. Some were in situations where they needed additional financial help; some had already moved into shared housing, only to discover that their MSA benefits were in jeopardy as a result.

Finally, enrollment was affected by the co-existence of other programs operating in Hennepin County, which serve the same population, and which were able to obtain the single household MSA standard for some of their clients living in shared housing, without enrolling them in the demonstration project.

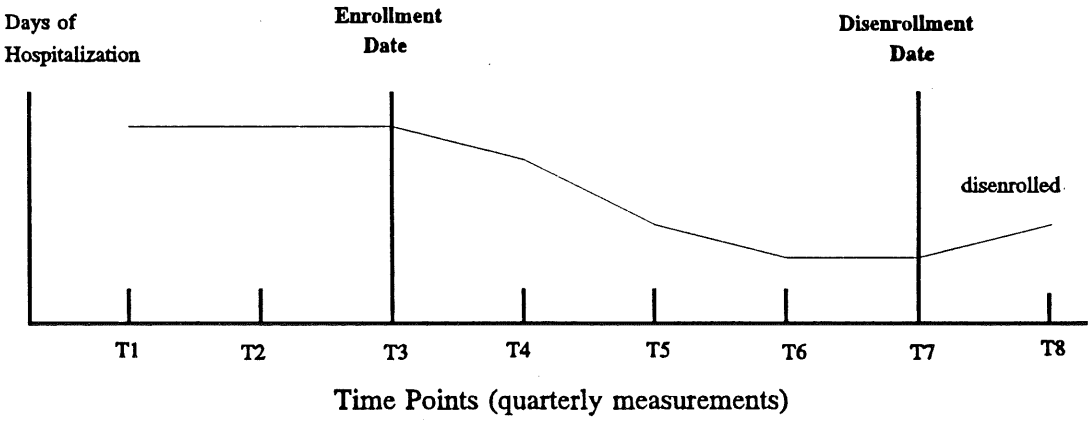
**Original Research Design**

The original design for studying the effects of shared housing on service utilization relied on using persons enrolled in the program as their own control group. Under the belief that a substantial number of the people enrolled would have been living alone prior to enrollment, the design simply involved comparing patterns of service use during the period of time while in the program to a period of time, of equal length, prior to enrollment. The anticipated pattern would show a drop in the use of costly services such as inpatient treatment during the period of enrollment. The graph in Figure 15 shows what this effect might have looked like.

Factors that contributed to a small enrollment in the program made this original research design impossible. Only 17 persons had been enrolled as of January, 1994, and of these only one had been living alone prior to enrollment. Persons already living in a shared housing arrangement found it much easier to enroll in the program, because they did not have to go through the additional, usually difficult, steps involved in finding a roommate and possibly moving.

*FIGURE 15:*

*Anticipated Results: The sample used fewer days of hospitalization for mental illness while enrolled in the program than while living alone.*




## Second Research Design

In an effort to answer the question that the original research design would have attempted to answer, a second design was employed. This design made use of data already collected as part of the Medical Assistance (MA) Billing System, rather than data collected on MSA Shared Housing Project clients.

The original question was whether living with another person (one person only) appeared to affect use of services in a way that would reduce costs. In the original design, a new factor was introduced--shared housing--and some effect on service use would be observed (hypothetically). This study question had to be modified somewhat under the second design. The second design could only look for a "relationship" between shared housing and service use, not offer any evidence that one may have caused the other.

The second design consisted of identifying a sample of MA recipients with serious mental illness who lived alone, matching these clients with another sample of MA recipients with serious mental illness who, in this case, lived with another person, and then comparing the patterns of service use of these two groups over a period of time. Significant differences in service use between the

groups would indicate a relationship between this variable and the type of living arrangement.

The existence of a *relationship* would not, however, imply a cause-and-effect relationship, although it would not rule that possibility out, either. This was regarded as the best "fall-back" strategy, given that the original design was unworkable.

**Research Data**

Two measures were chosen for service utilization: the *number of clients receiving services* and the *units of service*. Units of service would effectively equate with costs. (Accurate expenditure data were not available through the MA system other than for inpatient treatment. Those data that were available--charge data, except for inpatient--were nevertheless examined and proved to display the same patterns as units of service. Units of service was deemed a more direct and reliable measure.)

The mental health services examined included: a) inpatient treatment, b) outpatient treatment, and c) day treatment. Each of these services is billable under MA.

MA recipients were selected into GROUP A (living alone) if their MA eligibility data indicated that they lived with no other adult and with no children. GROUP S (shared housing) consisted of MA recipients whose MA eligibility data indicated that they lived with one other adult and with no children. GROUP S consisted of persons living with a spouse or a roommate. Selection into either group required that the person be an adult and have a diagnosis of serious mental illness.

GROUP A and GROUP S clients were matched on the variables AGE, SEX, DIAGNOSIS, and COUNTY. This eliminated the effects that these variables might have on the observed differences in the measures of utilization.

The study period ran a full year from January through December of 1993. (It should be pointed out that because of delays in billing MA, which can be up to twelve months, not all service data were included in the study; but the large majority of services received would have been entered into the MA system, and delays in billing could be expected to affect each group equally.)

**Research Results**

Table 13 shows the results of the comparisons between the two study groups. The difference for inpatient treatment units is the most statistically significant; that for outpatient treatment represents virtually no difference at all.

*TABLE 13: Units of Service Per Client During CY 1993*

| | Sample Size | Inpatient Treatment | | Outpatient Treatment | | Day Treatment | |
|---|---|---|---|---|---|---|---|
| | | n | mean days | n | mean hours | n | mean hours |
| GROUP A (alone) | 205 | 23 | **10.8** | 107 | **490** | 35 | **63** |
| GROUP S (shared) | 205 | 34 | **16.8** | 108 | **480** | 21 | **91** |
| difference | | | **6.0** | | **10** | | **28** |
| signif. test | | | t < .10 | | t < .94 | | t < .24 |

Note that, for the shared-housing group (GROUP S), the proportion of clients receiving inpatient treatment is 17%, and for the living-alone group (GROUP A) is 11%. This pattern is reversed for day treatment, which would be expected, since day treatment is often viewed as a less costly option to hospital admission.

It should be pointed out that this study did not take into account the *preferred* type of housing of those selected into the two sample groups. A comparison between the two groups composed only of persons who prefer the living arrangement they have might produce different results.

### Other Results

In the first 15 months of the project, 32 persons met all qualifications, including certification by their physician. This represented less than 1% of Hennepin County's MSA caseload. Of the 32 who qualified, only 17 were enrolled. Reasons cited for nonenrollment were inability to find a roommate and loss of interest in the program.

The increase in MSA benefits for these 17 enrollees amounted to $840 per month, or an average of about $50 per person. Because most enrollees were already living with another person, they received only minor adjustments to their MSA benefit when they entered the program.

### Discussion and Findings

The results of the research on Medical Assistance clients and the relationship of shared housing to use of less inpatient treatment do not support the existence of this relationship. The shared-housing group had a higher percentage of individuals using inpatient treatment during the year, and a higher mean days of inpatient treatment, than did the group that lived alone. These findings do not support statewide implementation of the program on the basis of obtaining the kind of benefit defined here--less use of costly services.

On the other hand, statewide implementation would not be expected to significantly increase

MSA expenditures. The 17 enrollees in Hennepin County projects to fewer than 100 statewide enrollees. Hennepin County's average additional MSA cost per client of $50 per month, or $600 per year, projects to less than $60,000 per year for the state.

For a small number of individuals, the program might indeed prove highly beneficial. In the assessment of Hennepin County staff, based on interviews with these clients, they are highly sensitive to everyday problems and are helped immensely by being able to share their concerns with another person.

Despite its apparent benefits to a small number of individuals, there were obviously some important factors that caused most people who could have qualified for this program to pass it up. The key factor may have been one of self-selection: client preference for living alone. Those persons who were living alone and preferred living that way would not find the program useful; their MSA benefits would not be increased. Another self-selection factor might have been a stigma issue. The county reported that many clients "had a problem with the MI label."

Lack of understanding of the program might also have contributed to the low number of enrollees. The way in which the program was designed required MSA recipients to identify themselves as eligible, and then to follow the procedures necessary to become officially qualified. This could have been too optimistic an expectation.

Finally, the county also cited inability to locate a roommate as a barrier to enrollment. The project did not include a service that would aggressively assist qualified individuals in finding someone to share housing, nor did it include assistance with moving.

**Recommendations**

Although the research findings do not indicate an association between living with another person and reduced hospitalization, the Department believes that MSA policy should be responsive to a variety of housing needs and preferences, and should not present a barrier for persons with mental illness to living with other people if there is reason to believe that, in this small number of cases, there will be benefits to the person's mental health. The Department recommends that this project be continued in Hennepin County until the 1995 session of the legislature makes a decision on policy amendments.