Minnesota
Department of Human Services

Recommendations For Improving the Adult Mental Health System

February, 1995

Including Summaries of Local and Statewide Task Forces

This report cost approximately $11,500 to produce.

Staff time:	$10,900
Printing/mailing:	$ 600

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I. Introduction

Laws of Minnesota (1993), First Special Session, Chapter 1, Article 7, Section 48, Subdivision 3, authorized formation of a statewide adult mental health task force. This legislation further authorized local mental health advisory councils (LACs) to form local task forces. Both the state and the local task forces were to develop recommendations for improving the state's adult mental health system.

These Laws also required the commissioner of the Department of Human Services (DHS) to submit a report to the Legislature, which summarizes the recommendations of the Adult Mental Health Statewide Task Force and the LACs, and which provides the commissioner's own recommendations. This document meets these requirements.

II. Background

In 1987 the state legislature passed the Comprehensive Adult Mental Health Act. This act defines an array of public mental health services to be implemented in each county, targeted to adults with serious and persistent mental illness or acute mental illness, and emphasizing further development of community-based services. The mission of the act constitutes the primary mental health goal of DHS:

> *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 continues to shape service system development by maintaining focus on the key concepts of comprehensiveness, accountability, effectiveness, efficiency, and unity.

Pursuit of this statewide mission involves various organizations and groups. The three primary organizations in the public mental health system are:

1) the state mental health authority (Department of Human Services), including state-operated services;

2) the local mental health authorities (county boards of commissioners and their administrative agencies); and

3) the service providers contracted by counties.

Each of these organizations makes decisions about how public mental health dollars are spent. Local authorities select those providers with which they will contract for services to their populations. These provider organizations determine the type and amount of services that are provided to each client. DHS disperses mental health grant funds to counties, and is itself a direct service provider through its regional treatment centers (RTCs) and other state-operated services. 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.

Services mandated in the Comprehensive Adult Mental Health Act constitute a comprehensive array, ranging from education and prevention to community-based services to hospital inpatient treatment:

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

Clients receiving community support services (help with housing, employment, etc.), case management, day treatment, or outpatient treatment can receive these services while living in their own home. Residential and inpatient services require institutional housing. Cost of service (per client per year) tends to be higher for residential and inpatient services than for community-based and outpatient services.

The mental health act requires local mental health authorities and providers to develop individual community support plans and treatment plans for their public mental health clients. County case managers monitor progress on these plans along with the client's well being, and assist clients in arranging for needed services.

Approximately $300,000,000 in public funds were spent in SFY 1993 for adult mental health services. About 63% was state money, most of that from appropriations for the RTCs and the state's share of Medicaid (Medical Assistance). Federal funds accounted for about 20% of the total; county funds for about 17%. Inpatient treatment in the RTCs accounted for about 39% of total

public expenditures for adult mental health, inpatient treatment in community hospitals for 19%, community residential treatment for 11%, and outpatient treatment for 11.5%. Community support services, day treatment, and case management together accounted for about 15%.

Some of the funds that flow into adult mental health are "categorical" in nature--that is, they can be used only for a particular type of service. Examples of categorical funds include the state appropriations for the RTCs and state grants to counties for community support services. Other funds, such as Medical Assistance and county social services grants, are more flexible and can be used to pay for a wider range of options.

III. Summary of Local Task Force Recommendations

Mandates

The Laws of Minnesota cited above authorized LACs to organize local task forces to develop recommendations for improving the adult mental health system; in particular, recommendations addressing the practical considerations of implementation. Local task forces were to submit these recommendations to their LACs, which in turn would forward all approved recommendations to the statewide task force and to DHS.

The Laws of Minnesota also required DHS to summarize these local recommendations. This section addresses that mandate.

Local Response

Twenty-four local task forces and LACs, representing 35 counties, submitted reports. These reports contained 480 comments and specific recommendations to improve the adult mental health system.

Content of Reports

DHS used two approaches to summarize the content of local reports. The first approach was designed to group recommendations into more general content areas, and to determine which of these content areas were most frequently mentioned. The second approach was to isolate those recommendations that stated, or implied, that some specific legislative or administrative action should be taken.

1) *Frequently Mentioned Content Areas*

DHS used a content analysis technique (1) to sort the information contained in the reports into content areas. Efforts were made to ensure that the results of the technique were balanced across all 24 reports and were not over-representing counties who submitted multiple comments in the same area.

Table I displays the frequencies with which the reports mentioned the various content areas. Only the areas most often mentioned are included in the table, led by the need for more housing alternatives (67% of the reports), system and structural concerns (63%), public education/anti-stigma efforts (58%), better coordination of existing systems (50%), enhanced employment services (50%), and transportation services (50%).

Table I
Content Areas Mentioned Most Often in LAC Reports

Description of Content Area	# Reports
Need for more housing	16
Concern about "systems" issues, particularly calls for "flexible Funding"	15
Need for public education re: Anti-stigma	14
Need for better coordination of existing services	12
Need for employment services	12
Need for transportation	12
Need for crisis services	11
Need for more consumer/family involvement	9
Health care reform issues	9
Desires for simplification/alteration of Medical Assistance administration and rules	9

2) *Recommendations for Action*

A second analysis examined those LAC recommendations which state, or clearly imply, that the Legislature or the DHS should consider specific action. This analysis eliminated "recommendations" that were commentary in nature or that were descriptions of problems or issues.

Table II (next page) and Appendix A contain the results of this analysis. Appendix A contains 69 specific LAC recommendations for action, while Table II condenses these 69 recommendations, on the basis of similar content, into 32 recommendations.

Table II also shows the current status of these recommendations. Some are already in state law; some are partially implemented (e.g., in some locations, but not statewide); some are in the Governor's Budget for the 1996-1997 biennium. Those recommendations not checked in any of these three categories have not yet received any state action, but may be studied for future action.

Use of Local Task Force Recommendations

The local task force recommendations have significantly influenced DHS's development of budget and legislative proposals for the 1995 Session. During the spring and early summer of 1994, DHS conducted a number of surveys and focus groups to seek input regarding budget and legislative priorities. Many members of LACs participated in that process; their input drew heavily from discussions within their local task forces. DHS staff, in turn, relied upon that input in formulating budget and legislative priorities. After local task force recommendations were formally presented to DHS in June and July of 1994, DHS utilized much of the detail in those reports as part of the process of converting the earlier priorities into specific budget and legislative proposals. The combined set of local recommendations will continue to be useful as a reference during the 1995 Session, as the Legislature reviews and acts on mental health proposals.

DHS is also using the local recommendations in many other contexts that affect services for persons with mental illness. For example, local input affected development of DHS's annual plan for use of federal mental health block grant dollars. As another example, DHS staff recently used a summary of issues identified in local task force reports in a presentation to the Supreme Court Civil Commitment Task Force. The local recommendations were very useful in helping the Supreme Court Task Force members understand the scope of issues affecting mental health commitments and potential solutions to current problems.

Table II

Recommendations For Action

Recommendation	Already in Law	Partially Implemented	In Governor's Budget *
Housing			
1. Increase MHFA funding for transitional housing subsidies as currently administered through the BRIDGES program.		✓	✓
2. Increase programming and funding for supportive housing services (services to support independent living in the community).		✓	✓
Systems Concerns/Issues			
1. Develop integrated, non-categorical and flexible funding for mental health services administered by a centralized local authority that has the financial responsibility to flexibly manage services and to ensure that the dollars follow the client.		✓	✓
2. Provide counties, or an entity designated by the county, the financial authority and legal responsibility to manage all state and local mental health funds.			
3. Develop an incentive program to reward those counties that use local mental health resources rather than committing consumers to the state hospital system.			✓
4. Amend the Comprehensive Mental Health Act to include an enforcement clause.	✓		
5. For counties that refuse to provide services, decertify the county as the local mental health authority and issue a Request for Proposals for an alternate provider.			
Structural Changes/Issues			
1. Amend the Commitment Act to permit Jarvis hearings to occur immediately following the commitment hearing.	✓	✓	

* The Governor's Budget includes new funding and legislative authority for integrated, non-categorical, flexible funds that can be used to meet the unmet needs identified by LACs. The specific use of these funds will be determined through the local decision-making process, which will include additional input from the LACs.

Department of Human Services **Mental Health Recommendations**

Recommendation	Already in Law	Partially Implemented	In Governor's Budget *
2. Allow for civil commitments to less restrictive community-based settings.	✓	✓	✓
3. Exclude cost of living adjustments to Social Security payments when calculating eligibility for other programs/services.		✓	
4. Modify the Data Privacy Law to provide clear direction on its intent so that the law can be consistently interpreted and applied throughout the state.		✓	
Employment Services			
1. Provide incentives to private industry to hire individuals with mental illness by funding their Workman's Compensation and medical insurance.			
2. Expand PASS (Plan to Achieve Self-Support) to include other entitlement programs, such as General Assistance.			
3. Provide staff at CSPs and rehabilitation facilities, and job coaches at regional support services programs (RCSSs), for follow-up and long-term support of people placed in jobs.		✓	✓
4. Change current welfare and medical assistance policies to provide an incentive to seek employment without losing benefits or medical assistance until the person has reached a level of self-sufficiency. **		✓	✓
Health Care Reform			
1. Retain the county as the local mental health authority to ensure compliance with the Comprehensive Mental Health Act.	✓		
2. Ensure parity for mental illness and allow for a choice of providers.			
3. Minimum benefit packages should include medication coverage and the same package currently available through Medical Assistance.			
4. Establish employee/employer fund to cover insurance premiums through COBRA period.			

** Current efforts apply only to subpopulations of the serious and persistently mentally ill population.

Recommendation	Already in Law	Partially Implemented	In Governor's Budget *
5. Drop/reduce surtaxes to neighboring state's border cities who serve Minnesota MA clients.			
6. Drop the tax on medications for low income individuals.	✓		
Medical Assistance (MA) Administration/Rules			
1. Disregard spousal income for individuals who have a serious and persistent mental illness.			
2. Study/reconsider using the MA rehabilitation model and make recommendations in this regard.		Day Trmt ✓	
3. Permit payment for case management for persons who have a post traumatic stress disorder.		✓	
4. Return to the use of "six month averaging" rather than the current monthly report where the spend down changes every month.			
5. Reduce case management caseload size by increasing the reimbursement rate and simplifying billing processes.			
Psychiatric Services			
1. Provide loan forgiveness for psychiatrists who practice in a rural area for two years.			
2. Ensure that state medical schools develop substantial residency programs and expertise for practice in community mental health centers.			
3. Within communities of color, identify mental health experts, and, through training, competency testing, or case-by-case review, certify them as mental health case managers and/or practitioners.		✓	
Public Assistance Payments			
1. Allow temporary representative payees for clients during periods of absence from home settings in order to maintain financial security.			
2. Increase income standards and disregards for Public Assistance programs.			
3. Reimburse counties for representative payee services.			

IV. Summary of Statewide Task Force Efforts

The following summary is taken from the *Summary of the Work of the Adult Mental Health Statewide Task Force*. The statewide task force did not submit recommendations.

The 1993 legislation required that DHS convene a statewide task force "to study and make recommendations concerning adult mental health services and funding." Further, the legislation required the task force to:

> *"examine all possible county, state, and federal sources of funds for adult mental health with a view to improving methods of coordinating services and maximizing all funding sources and community support services, and increasing federal funding."*

The legislation also required that the task force be composed of representatives from over 40 specific groups or entities, many with divergent viewpoints and interests. The task force combined these entities into nine stakeholder groups: advocates, consumers, county employees, county governments, cultural minorities, legislators, community service providers, state agencies, and state employees.

The state task force's year-long effort to achieve consensus on significant recommendations proved unsuccessful, as differing stakeholder interests could not be resolved. The task force did produce a report to assist the work of local task forces, and increased among its members mutual understanding of stakeholder positions. The task force discussed many serious problems with the current systems, some of these brought forward by the consumer (mental health client) members of the task force. The task force examined information on mental health problems and reform in other states.

County-based local mental health advisory councils (LACs) were encouraged by the legislation to form local task forces. As with the state task force, these local task forces were to include representation of specific interest groups. They were to forward their recommendations to the state task force and to the Department of Human Services. Twenty-four local task forces, representing thirty counties, submitted over 600 recommendations. The combined population of these thirty counties totals 75% of the state's population.

The inability of the state task force to reach consensus on recommendations should not diminish the importance of improving the adult mental health system. Many task force members believe that the mental health system needs reform, and that the barriers preventing this from occurring should be removed. The task force could not agree on how to reform the current systems.

V. Recommendations of the Commissioner

The Department of Human Services recognizes that efforts must be directed toward systemic changes in the delivery of mental health services to address the following salient issues:

1. Categorical funding streams for mental health services result in a system driven by funding rather than by client needs;

2. Restructuring of the mental health delivery system must be consistent with the managed care philosophy of Minnesota's health care reform;

3. The mental health system should develop models of care that avoid fragmentation of service delivery and ensure continuity of care throughout the array of needed services;

4. There must be greater availability of services that are culturally appropriate to individuals and minority populations;

5. In small, rural areas of the state, mental health services may need to expand across county boundaries;

6. New strategies need to be developed for the purchase of mental health services that improve access and service coordination, without cost shifting.

DHS concurs with the themes expressed in the reports of local task forces. DHS's recommendations for a specific strategy to begin restructuring the service system are contained within the Governor's Budget for 1996-97. See Appendix B for the primary adult mental health initiative in the Governor's Budget. The Governor's Budget also contains initiatives in welfare reform and health care reform that could address LAC recommendations.

REFERENCES

(1) Sellitz, Jahoda, Deutsch and Cook, 1951. *Research Methods in Social Relations*. Holt, Rinehart and Winston, Toronto.

Appendix A

Local Advisory Councils' Recommendations For Action

Although all of the 480 LAC recommendations merit serious consideration, many are statements of need or general principles and do not indicate what action is recommended or who should be responsible for implementing the recommendation. In this analysis, DHS has attempted to identify those recommendations which state or clearly imply that the legislature or the Department of Human Services should take specific action. One hundred and sixty-six recommendations appeared to meet these criteria. Many of these call for actions which DHS could initiate under existing authority. Some have already been implemented; others will be carefully considered as future plans are developed.

Following are 69 of those 166 recommendations, which appear to have the greatest significance for legislative consideration, based on the following criteria:

1) Two or more local task forces state (or support) a recommendation which addresses the same need in a similar manner, and

2) Implementation of the recommendation would be likely to require legislation or rule changes, and

3) No other recommendation has been made which would have contrary implications. (For example, a recommendation to expand a specific program and a recommendation to reduce that same program would be offsetting.)

Case Management

Case management caseloads should be reduced to thirty. Funding to accomplish this could be made available by increasing the case management reimbursement rate and simplifying the billing process for MA reimbursement. (Anoka)

Provide the means for counties to hire more case managers and lower caseload sizes by (a) raising the current reimbursement rate for Rule 79 case management so that rates are brought more in line with actual costs, and (b) simplifying the billing system so that less detail is required, thereby allowing for more billable time. (Hennepin)

The state should pursue changing Rule 79 Case Management Billing to using a monthly bundled rate. (Ramsey)

Coordination

Data privacy laws often exclude families and hinder professional collaboration. Interestingly, the laws have a more restrictive effect in the area of mental health and are interpreted/applied differently throughout the state. The legislature should modify the Data Privacy law to provide clear direction on its intent, so that the law can be consistently interpreted and applied throughout the state. Secondly professional education programs should be conducted on how to include families and collaborate while still protecting the client's right to privacy protected in the data privacy law. (Carver)

Data privacy laws need to be reviewed and modified to prevent privacy issues and treatment plans from coming into conflict. (St. Louis)

Commitment

Jarvis procedure should be done at the same time as commitment hearing, so there is not such a long time before medication is given. (Otter Tail)

Amend the Commitment Act to permit a Jarvis hearing to occur immediately following a commitment hearing. Appoint a guardian ad litem at the commitment hearing for those patients who might qualify as "incompetent consenters" and for whom guardian consent would be sufficient, especially in cases where substituted judgement can provide a more humane and less costly alternative to repeated court hearings. Clarify the circumstances under which emergency administration of neuroleptic medications could occur, allowing treatment providers to begin such medications for up to 14 days or until a court hearing, whichever occurs first. [Note: these recommendations have been incorporated into Senate File 1694 (Sen. Don Betzold), which will be reintroduced in February 1995. The Task Force recommends support of this bill as written.] (Hennepin)

Revise statutes so that patients can be "committed to treatment" in settings that are less restrictive than RTCs. (Hennepin)

Employment

Provide incentives to private industry to hire individuals with mental illness by funding their Workman's Compensation and medical insurance. (Anoka)

Provide funding to counties to develop job maintenance resources so that the focus on employment moves beyond job placement to job retention. Provide staff at CSPs and rehab facilities, and job coaches at the Regional Community Support Services programs (RCSS's), for follow-up and long-term support of people placed in jobs. (Hennepin)

The PASS (Plan to Achieve Self-Support) has been very successful for people who are receiving SSI; GA recipients should have a similar option. The PASS focus should be expanded to include part-time, contracted and temporary employment opportunities. (Ramsey)

Flexible Funding

That the county, or an entity designated by the county, have the financial authority and legal responsibility to manage all state and local mental health funds. This would include authority to allocate Regional Treatment Funds to pay for community-based services and/or community-based inpatient psychiatry services. (Dakota)

In order to avoid cost shifting, it is important to put all funding streams together, including those for MA, GAMC, MinnesotaCare, ISN's and RTC's. (Kandiyohi, Chippewa, Lac Qui Parle, Meeker, Renville, Swift)

Develop an incentive program to award those counties (like Sherburne) that use local mental health resources rather than committing consumers to state hospital system. (Sherburne)

Increase funding available to county's for enhancing their local mental health delivery system. (Sherburne)

Make flexible funding and services that follow the client available to all consumers who meet the SPMI criteria, similar to the Combined Fund. (Hennepin)

Develop integrated, non-categorical and flexible funding for mental health services. Inpatient dollars, including community hospital and RTC dollars, should be combined with funding for community-based services. Combined funding would necessitate the establishment of a centralized local authority which would have the financial responsibility to flexibly manage services and to ensure that the dollars follow the client. (Hennepin)

Consolidate the following sources of funding: RTC, Rule 12, Minnesota supplemental Aid, CSP, CSSA, Housing Support, Crisis, Employability, grant funds, General Assistance Medical Care, and MA. Pursue a mechanism by which HUD-Section 8 money could be included in this fund. We wish to strongly state that to consider consolidation of funding sources, excluding the RTCs, would seriously undermine the intent and potential improvements to the system in terms of accountability and flexibility. (Carver)

Ensure that counties maintain legal responsibility for the delivery of services and designate them as the entity with the authority to access the consolidated fund. (Carver)

In addition to consumer care and treatment needs, allow use of integrated and flexible funding to cover: (a) Expenditures for basic needs when they are not sufficiently addressed through Economic Assistance programs, (b) Support services to families such as parenting skills training; psychoeducation; family counseling; and respite care and financial assistance for caregivers; and (c) Rental assistance and housing supports to facilitate transitions between residential programs and independent living situations. (Hennepin)

Housing

Increase MHFA dollars for transitional housing subsidies that consumers can access through their CSP programs. Transitional dollars are identified as housing subsidies such as the "Bridges Program". These dollars allow consumers to rent a home or an apartment in the community of their choice and receive a rent subsidy while they are on a waiting list for HUD-funded federal subsidy. (Blue Earth)

Increase the number and use of vouchers for Section 8, Bridges, and similar programs; correspondingly, decrease reliance on traditional "negotiated rate" approaches to housing. (Ramsey)

Health Care Reform

...retain the LMHA as the responsible authority to ensure compliance with the Comprehensive Mental Health Act. (Blue Earth)

Mandate to all insurers that mental/behavioral/emotional disorders be covered as any other illness. Lifetime caps, co-payments, and other financial/service limitations should be no different than other diseases. (Carver)

Passage of laws to equalize mental health and physical health insurance. (Houston)

Mandated coverage by insurance companies of brain diseases including the chronic ones. (Rice)

Clients must have a choice of providers. By choice, we mean that the providers are geographically accessible, that if preferred provider networks are utilized by an insurance entity, that they include enough mental health providers of each professional category so that the ability to choose is meaningful, and that clients be able to access mental health providers freely, without another professional being used as a gatekeeper. (Carver)

Minimum benefit packages should include medication coverage and some rehabilitative services. (Carver)

Reform needs to be structured so that it protects, not destroys, the integrated community programs that have developed since passage of the Comprehensive Mental Health Acts. This would need to include but not be limited to ensuring that the community-based providers who are now part of the integrated programs such as CSPs, be included in the preferred provider networks. (Carver)

Assure that people who are enrolled in managed care plans have, at a minimum, the same benefit package available to them as they have under the current MA plan. (Hennepin)

Because of the significant role of neuroleptic medications in relapse prevention, supplement their purchase through a state fund or treat them as a public health (prevention) cost and include them in a global health care budget. (Hennepin)

We are concerned that the managed care provider "case manager" will be denying services without ever having met the person for whom they are making decisions, a situation which happens currently with managed care providers. We also believe there may be a weakening of the role of the Rule 79 Case Manager. Assure that people with serious mental illness have access to someone who will help them with the appeal process if they are denied a service. (Hennepin)

Develop legislation to establish employee/employer fund to cover insurance premiums through COBRA period. (Houston)

Increase MA reimbursement to agencies so it is more attractive for them to service MA clients. Also, drop/reduce surtaxes to neighboring state's border cities who service MN MA clients. Drop tax on medications to lower income persons. (Becker)

Medical Assistance Administration

Increase enhanced supported service dollars such as the waivered service dollars that individuals with development disabilities receive. This would also be a viable model for persons with mental illness. (Blue Earth)

Disregard spousal income when applying for medical assistance for individuals with serious and persistent mental illness. (Houston)

Propose legislation recommending the immediate development of a medical assistance waiver program for individuals with serious and persistent mental illness. (Houston)

Study/reconsider utilizing the Medical Assistance (MA) rehabilitation model and make recommendations. (Carver)

Establish a fund to allow payment for or prior authorization of MA-reimbursable services during the benefit application process. (Hennepin)

Increase funding levels for Home Health Care and Personal Care Attendants (PCAs). Reimbursement is currently too low, making it "too risky" for the agency to provide this service. (Hennepin)

Minnesota mental health law and Medical Assistance standards should be amended to permit payment for case management services for post traumatic stress disorder. Appropriately provided services could significantly reduce the disability of this population. Services should be provided by individuals who are culturally sensitive and skilled in the language of individuals who are from other countries. Ramsey County is currently experiencing high rates of need for services by refugees of war from other countries and not all of these services are funded by Medical Assistance. (Ramsey)

Expand the definition of SPMI to include the diagnosis of PTSD. It is particularly relevant to include PTSD in the definition since it appears that risk for sustained maladaptive symptoms is greater and more prevalent for persons from diverse ethnic and cultural heritage, especially where poverty is involved. Such inclusion would allow the client with PTSD to receive case management and other services for persons classified as SPMI. Although PTSD apparently does not have a biological basis, as do most of the other SPMI diagnoses, the severity and persistence of symptoms as dysfunctional behavior can be markedly maladaptive. Diagnosis alone would not be the major criterion for service eligibility, but rather the diagnosis in combination with a measure of functioning reflecting severe impairment in major life areas. (Hennepin)

Put a ceiling on MA spend-downs, which is more realistic for people on fixed incomes. (Becker)

...return to the use of the "six month averaging" rather than the current monthly report where the spend down changes every month. (Blue Earth)

Medical Services

Provide loan forgiveness for psychiatrists who practice in rural areas for two years. (Lincoln, Lyon, Murray, Redwood, Yellow Medicine)

Provide loan forgiveness for mental health professionals that practice in rural communities for two years. (Lincoln, Lyon, Murray, Redwood, Yellow Medicine)

Ensure our three medical schools in Minnesota develop substantial residency programs and expertise, as well as recruit sufficient medical students, to prepare for practice in community mental health centers and provide incentives for these graduating physicians to go into rural areas to practice. (Blue Earth)

Cultural Diversity

Advocate for more county, state and federal funding for Reservation Mental Health Services. Provide incentives for psychiatric service on Reservation. Highly prioritize

Reservation mental health service at county, state and federal levels. Provide more funding to counties to provide contracted psychiatric services. (Becker)

Mental health services need to be culturally appropriate. (Kandiyohi, Chippewa, Lac Qui Parle, Meeker, Renville, Swift)

Need to be more sensitive to and integrate with resources that deal with persons of color, persons of different cultures, persons with hearing impairments and with English as a second language. (Olmsted)

Within communities of color, identify mental health experts and, through training, competency testing, or case-by-case review, certify them as Mental Health Case Managers or Mental Health Practitioners or both. (Hennepin)

To implement this recommendation, the case management rule will most likely need to be changed to include a waiver. (Hennepin)

Public Assistance

Income standards and disregards should be increased for Public Assistance programs and the level of General Assistance funding increased. (Anoka)

To improve consumer's understanding of Public Assistance programs, a comprehensive, easily understood Benefits Assistance manual/flow chart should be developed for consumers of mental health services. (Anoka)

We would propose that cost of living adjustments to Social Security payments be excluded when calculating eligibility to other programs and services. This could also be accomplished by increasing the eligibility for other programs by the amount of the Social Security cost of living increase. The cost of living increase would be disallowed when calculating other benefits governed by either state or federal authority. (Blue Earth)

..we would propose that the first $100 of earned income (by gainful employment) be similarly disallowed from calculating eligibility for all other government assistance programs. This would result in persons with mental illness being able to increase their standard of living by $100 by involving themselves in an activity that also has a high probability of further facilitating their recovery from mental illness. This in turn may serve to save other tax dollars which would otherwise go for treatment or crisis intervention related to one's mental illness. (Blue Earth)

Change welfare and medical assistance policies so that people with disabilities have an incentive to make money without losing benefits or medical assistance until they have reached a level or recovery where they can be truly self-supporting. (Carver)

Increase the income limits for SSI, SSDI, and MA. (McCleod)

MA Waivered services funding should be available for adults with mental illness and Medical Assistance should reimburse counties for representative payee services. (Anoka)

Allow temporary representative payee for client during period of absence from home setting to maintain financial security. (Lincoln, Lyon, Murray, Redwood, Yellow Medicine)

Supported Independent Living

Continually increase funding for independent living skills services. (Anoka)

State and local housing agencies need to explore and expand housing options similar to Clay County's SILS program. (Clay)

Recognizing that persons with mental illness emancipate from their families but have needs to learn how to cope in the community an in independent living, a SILS type program funded by state dollars would be an asset to resources already available. (Olmsted)

Increase programming in the areas of affordable housing, and supported housing (services are provided to support independent living). (Carver)

Staffing Issues

Encourage flexibility for program planning and employees, steps need to be taken to equalize the salary levels between publicly and privately operated facilities and between inpatient and outpatient programs. (Carver)

Establish parity in staff wages and other program funding between state-operated programs (RTCs and future SOCS) and community residential programs. (Hennepin)

That pay equity be achieved for staff working in community support programs comparable to governmental staff with similar experience, education and job responsibilities. (Dakota)

Structural (system) Issues

Amend the Comprehensive Mental Health Act to include an enforcement clause. (Carver)

Modify the state's response to counties that refuse to provide service. Rather than withhold funds, which only hurts clients, decertify the county as the mental health authority and put out "Request for Proposal: for an alternate provider. (Carver)

Appendix B

Adult Mental Health Programs in the Governor's 1996-97 Budget

F.Y. 1996 - 97 BUDGET INITIATIVE

AGENCY:	Human Services, Department of (DHS)
PROGRAM:	Community Mental Health and State-Operated Services
BUDGET ACTIVITY:	Mental Health Programs
MANAGEMENT ACTIVITY:	State Mental Health Grants - Adults
ITEM TITLE:	Regional Adult Mental Health Service System Improvements

	Dollars in Thousands			
	F.Y. 1996	F.Y. 1997	F.Y. 1998	F.Y. 1999
Expenditures: ($000s):				
General Fund				
State Mental Health Grants - Adults	$150	$2,500	$2,500	$2,500
Revenues: ($000s):				
General Fund	$-0-	$-0-	$-0-	$-0-

Requires Statutory Change? Yes __X__ No _____
If yes, statute affected: MS 245.461

GOVERNOR'S RECOMMENDATION:

The Governor recommends an increase in the budget base of $150,000 in F.Y. 1996 and $2,500,000 in F.Y. 1997. This funding will be used for regional adult mental health service system improvements. As a result of this proposal, innovative ways to integrate state, county and community mental health programs and resources into a new mental health service delivery system will be planned and piloted in regions across the state. This proposal is part of the department's life skills self-sufficiency initiative.

RATIONALE:

Under the present system, persons with serious and persistent mental illness are often unserved or under served in community resources. Categorical funding has forced clients to accept a full service "package" regardless of need and has contributed to a heavy reliance on institutional care that is not well integrated with the community-based system. Restructuring the mental health system to more fully integrate persons with serious mental illness across the full array of community vendors will expand service options within existing expenditures and direct resources to specific client needs.

The Department of Human Services (DHS) will explore strategies to assure the delivery of needed services to persons with mental illness statewide. Using the data available from the DHS studies, each region will have the opportunity to design a state-local-private partnership that will best meet the needs of the area. The pilot projects will allow for new relationships to develop among state and local agencies and public and private vendors.

Various models of a community-based mental health service system will be planned in partnership with all public and private mental health providers in each region. Conveners of the planning effort will be the counties, as the local mental health authority.

Pilot projects for systemic change must: 1) provide an expanded array of services from which clients can chose which are appropriate to their needs; 2) be based upon purchasing strategies that improve access and coordinated services without cost shifting; 3) incorporate existing state facilities and resources into the community mental health system infrastructure through creative partnerships with local vendors; and, 4) utilize existing categorical funding streams and reimbursement sources in creative ways. This proposal will make new funds available to each pilot project to fund gaps in service, to assist in restructuring the delivery system, and to provide new funding for housing subsidies to be administered through the MHFA. Criteria for allocation of new funds will include size of population to be served and the ability of proposed projects to meet the objectives described above.

PROGRAM OUTCOMES:

Pilot projects funded under this proposal will provide valuable data and evaluation information on improving services to clients while controlling costs. Pilot projects will also evaluate new roles for state operated services continuing to focus on client needs.

This proposal includes housing subsidies for adults with serious and persistent mental illness. As a result of this housing subsidy, persons with serious and persistent mental illness will receive a bridge subsidy until they become eligible for a federal housing subsidy. This will increase the number of persons with serious and persistent mental illness who can live in affordable, decent housing in the community and who are able to maintain themselves in the community rather than confront long stays in treatment or become homeless.

The focus of this proposal is systemic reform in the state-operated, county and private mental health system. The direction is consistent with national trends away from facility-based services toward services that allow consumers to choose their own housing and receive services that are integrated with the community.

This proposal includes a transfer of $500,000 from current community residential services to these new projects. The transfer will require closure of 2 to 3 Rule 36 adult residential community programs or conversion of those programs to non-Rule 36 status. Criteria are being developed to choose from programs with low utilization or in locations where other services or new funds for alternative services are available.

LONG-TERM IMPACT:

Changes to the mental health service system will be piloted to meet client needs, forge partnerships among all appropriate vendors, and direct funding in an efficient and effective manner.