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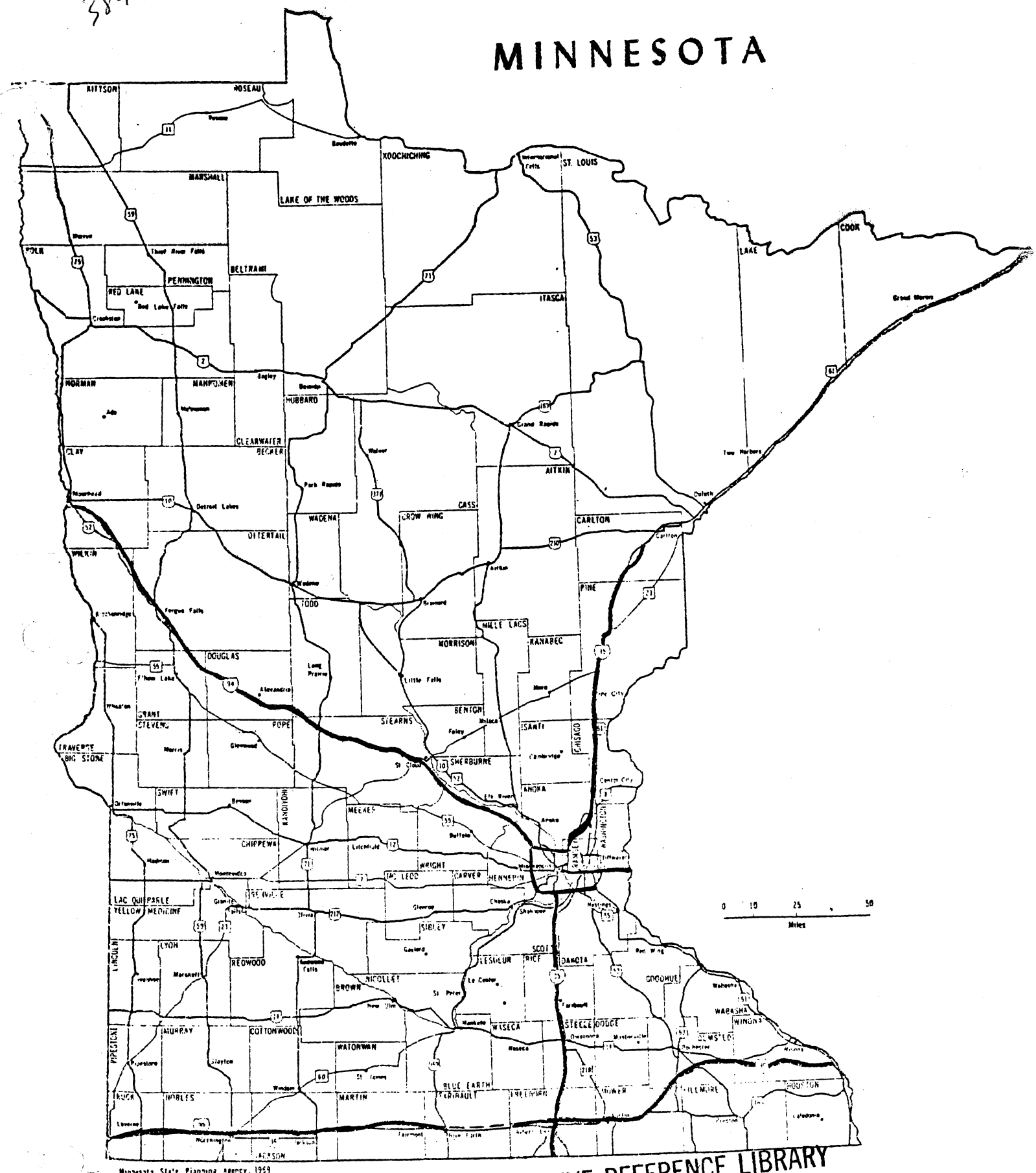

Minnesota State Planning Agency, 1969

UNIVERSITY OF MINNESOTA
TWIN CITIES

Division of Health Care Psychology
Box 393 Mayo Memorial Building
Minneapolis, Minnesota 55455

June 15, 1977

Vera Likins, Ph.D., Commissioner
Department of Public Welfare
Centennial Building
Saint Paul, MN 55101

Dear Commissioner Likins:

At its meeting of May 16, 1977, the State Mental Health Advisory Council unanimously approved the State Plan prepared by Mr. Sarazin. He is to be commended for the high quality of the work, particularly in view of the acute shortage of staff for his office.

The Council has asked to inform you of their concern about that staff shortage. The Mental Health Program Division cannot effectively help you fulfill the functions of the Department with only two people in that program office. Last fall, when I was in Washington on other business, people at NIMH voiced similar criticisms of last year's plan. That is, without great personnel input from your central office, the plan, however excellent conceptually, could not be implemented optimally.

The Council also asked me to bring another concern to your attention: that involves the closing of Hastings State Hospital (and perhaps other institutions). Specifically, by unanimous vote, the Council directed me to convey to you their recommendation that a plan to meeting the need for financing alternative residential and support services be devised before closing any State facility and that decision on the placement of current residents be made on a case-by-case basis.

Respectfully,

For the State Mental Health
Advisory Council

Robert D. Wirt, Ph.D.
Chairperson

RDW/dk

STATE OF MINNESOTA

STATE PLANNING AGENCY
101 CAPITOL SQUARE BUILDING
550 CEDAR STREET
ST. PAUL, 55101

June 16, 1977

Mr. Terry Sarazin
Department of Public Welfare
First Floor
Centennial Office Building
St. Paul, Minnesota

Dear Mr. Sarazin:

On June 15, 1977, pursuant to Section 1524 (c) (6) the Statewide Health Coordinating Council (SHCC) reviewed the State Mental Health Plan. At that time it discussed the major thrust of the plan and its goals and objectives.

As there is not presently an adopted State Health Plan, the Council's review was for comment rather than approval. Finding no major problems with this Plan, the SHCC unanimously voted its support.

Sincerely,

Vernon Sommerdorf

Vernon Sommerdorf, M.D.
Chairman, Statewide Health
Coordinating Council

/ks

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Appendices

Section I

INTRODUCTION

This plan is the Minnesota Department of Welfare's statement regarding the Minnesota Mental Health System. The plan is based upon the Minnesota Statutes 1977, 245.61 - 245.69 and 253A.01 - 253A.20, and 245.70, P.L. 94-63 and the statutory responsibilities of the Department of Public Welfare. This plan provides the framework through which Minnesota Mental Health planning and programming occurs, in accordance with state and local responsibilities.

The focus of this plan is on improving the delivery of services to the mentally ill/behaviorally disabled population of Minnesota. The goal of mental health planning is the provision of a continuum of services to the mentally ill population within each catchment area.

The plan recognizes that resources should be adequate to meet the needs of the residents of Minnesota. At the present time, resources are not sufficiently adequate to do so, but definite advances have been made and are described in this plan. Basic to the development of necessary resources is a clear delineation of responsibility, accountability, cooperation, evaluation and provision of adequate manpower and fiscal resources. This plan endeavors to identify public and private mental health resources, community-based and state institutional mental health resources.

Fundamental to any program of service delivery are the individual needs of the person experiencing emotional distress. The primary evaluative criteria must be how the system responds to those persons for whom the system is developed, and with what effects.

I. GENERAL INFORMATION

A. Purpose:

The Comprehensive Mental Health Services Plan is a mechanism to:

1. Set forth the Minnesota Department of Welfare's policy statement on the Minnesota Mental Health System.

2. Provide a rational basis for the utilization of all available resources in meeting the needs of provision of comprehensive mental health services for residents of this state.

3. Encourage coordination with other state and local, public and voluntary mental health planning activities concerned with enhancing the quality of life for citizens within the communities.

4. Provide for public accountability for the expenditure of federal, state and local matching funds in the provision of mental health services.

5. Formalize the State of Minnesota's commitment to fulfill its obligations for participation in P.L. 94-63.

6. Provide an educational tool and point of reference for both professional and lay persons interested in the Minnesota Mental Health System.

B. 314(d) Plan:

The Minnesota Department of Public Welfare is the mental health authority for Section 314(d) of the Public Health Services Act. The goals for Fiscal Year 1977-78 and the progress report for Fiscal Year 1976-77 are presented in this plan on pages 14-16.

C. Submission:

The Minnesota Department of Welfare herewith submits the State Community Mental Health Plan for Fiscal Year 1977-78 for review by NIMH, in accordance with P.L. 94-63, Title III.

The Minnesota Department of Welfare maintains the authority and responsibility for:

1. The State Mental Health Plan.

2. Annual report to the Secretary of HEW, including:

   a. Progress toward goals
   b. Priority ranking
   c. Amendments, as indicated
   d. Annual inventory of services and facilities.

3. Development of a comprehensive plan every five years.

4. Assurance of public and consumer involvement through:

   a. Notification of the general public
   b. Notification of the service providers
   c. Public availability of the Plan
   d. State Advisory Council.

5. Coordination and consistency with the 314(d) plan.

6. Maintaining a working relationship between the State and Region V, ADAMHA, NIMH.

PERSONS WITHIN THE STATE AGENCY RESPONSIBLE FOR IMPLEMENTING THE STATE MENTAL HEALTH PLAN

Edward J. Dirkswager, Jr., Commissioner, Department of Public Welfare

James J. Hiniker, Deputy Commissioner

Ronald Young, M.D., Medical Director

Wesley Restad, Assistant Commissioner, Residential Services Bureau (operation of state hospitals)

Michael Weber, Assistant Commissioner, Community Services Bureau (all community-based programs and services)

Edward Constantine, Director, Community Programs Division, Community Services Bureau (grants management, coordination of site visits, etc.)

James T. (Terry) Sarazin, Director, Mental Health Program Division, Community Services Bureau (develops the State Mental Health Plan, maintains liaison with federal government, and develops state mental health standards, and policy, etc.)

The Commissioner and Deputy Commissioners provide overall direction, priority-setting, and policy-making authority for the "state agency". They are responsible for the implementation of this plan.

Dr. Ronald Young, a psychiatrist and an ex-officio member of the State Mental Health Advisory Committee, is the Department's Medical Director. He works closely with the Assistant Commissioner for Residential Services on matters of quality care and treatment in the state hospitals. He is also closely involved with the Mental Health Program Division in matters of policy and program development in community mental health.

The Commissioner has delegated responsibility for administration of the 10 state hospitals and two (2) state nursing homes to Mr. Wesley Restad, Assistant Commissioner, Residential Services Bureau. All community-based programs and services are the responsibility of Mr. Michael Weber, Assistant Commissioner of Community Services.

Included within the Community Services Bureau are the operational authorities for carrying out the "state agency's" responsibilities for mental health, alcohol and drugs, mental retardation, social services (Title XX), aging, blind, program licensure of residental and day programs, and management of state grants-in-aid.

Within this Bureau, Mr. Edward Constantine, Director, Community Programs Division, manages the state grants-in-aid for community mental health centers, alcohol and drugs, and daytime activity centers for retarded people. He also coordinates federal site visits to comprehensive centers and manages federal community mental health center construction funds. All grant-in-aid allocation decisions for community mental health centers are made jointly between his office and the Mental Health/Mental Retardation and Chemical Dependency (alcohol and drug abuse) Program Divisions.

Mr. James Sarazin, Director of the Mental Health Program Division, is responsible for the development of the State Mental Health Plan, liaison with ADAMHA, development of state standards for mental health, etc. His office, jointly with the Community Programs Division, makes allocations of state appropriations for community mental health. The same joint decision-making prevails with the Licensing Division on applications for mental health residential licensure under DPW Rule 36 (see Attachment C-2).

The Department is located in the State Capitol complex in the Centennial Building, 658 Cedar Street, St. Paul, Minnesota 55155.

Section II

ADMINISTRATIVE PART

A. State Agency:

The statutory authorities of the Commissioner of Public Welfare relating to mental health are based in several statutes. Minn. Stat. 245.70 specifically designates the Commissioner of Public Welfare as the "state agency" to establish and administer a statewide plan for construction, equipment maintenance, and operation of any facility with care, treatment, diagnosis or rehabilitation of mental retardation and mental illness, which are or may be required by conditions under any federal law.

Minn. Stat. 246.01 states that "the commissioner of public welfare is hereby constituted the 'state agency' as defined by the Social Security Act of the United States and the laws of this state for all purposes related to mental health and mental hygiene."

Minn. Stat. 245.61-.69 provides the statutory authority and responsibility of the Commissioner of Public Welfare for developing and maintaining rules and regulations for community mental health programs.

The scope of the Commissioner's statutory responsibilities and authorities for mental health encompass three major responsibilities:

1. To provide leadership for:

    a. Comprehensive assessment and planning for state and local needs.
    b. Development of needed state and local resources.
    c. The appropriate assessment, modification, utilization, coordination, and evaluation of existing state and local programs and resources.

2. To provide administration, supervision, support and regulation.

    a. Administration of and development of regulations for state hospitals' mental illness programs.
    b. Supervision of and development of regulations for county welfare boards.
    c. Support of and development of regulations for community mental health programs through grant-in-aid contracts.
    d. Administration of costs of care for residential services for emotionally disturbed children.
    e. Licensure of residential services and programs for people who are mentally ill.
    f. Licensure of residential treatment centers and group homes for emotionally disturbed children.

3. To provide assessment, evaluation, and planning for specific services.

The Commissioner has delegated particular authorities and responsibilities to the Assistant Commissioner of the Community Services Bureau, who, in turn, has delegated to the Mental Health Programs Division of the Bureau the authority and responsibility for the development, maintenance and evaluation of the State Comprehensive Mental Health Plan, to address the problems of the mentally ill population, along with other responsibilities.

The Mental Health Program Division is assigned the following responsibilities:

1. Responsibility for the development and maintenance of the State Comprehensive Mental Health Plan. This includes the survey of mental health resources and assessment of needs of the target population, the assessment of the extent and nature of mental illness problems, the definition and evaluation of the current delivery systems and the recommendations for changes pertaining to fiscal, legal, and policy support. Also included is a description of the system relative to the adequacy of services and recommendations of needed improvements, including review, initiation or participation in policy changes.

2. Development of mental health policy for the Department.

3. Establishment of ongoing planning mechanisms for the inclusion of consumers for development, assessment, modification, implementation and monitoring of the system.

   Programs and services are evaluated by the Mental Health Program Division and the Department of Public Welfare Office of Evaluation by:

   a. Program review and consultations with community and state residential mental health programs.
   b. Site visits to community mental health programs.
   c. Review and consultation on grant-in-aid application for community mental health centers, social service plans, human service board plans, license applications in regard to services for the mentally ill population.

4. Initiating development of standards for mental health programs.

5. Planning and evaluation of mental health programs in conjunction with other state departments, as appropriate.

6. Review of other state plans which are developed with the Department and submitted to the federal government, to determine the impact on mental health programs and services, such as Title XIX, Title XX, Aging, Alcohol and Drug plans.

STATE MENTAL HEALTH ADVISORY COUNCIL

		Representing	Governor's Economic Reg.	HSA	Length of Term
P	Robert Wirt, Ph.D., Director Division Health Care Psychology University of Minnesota Box 393 University Hospitals Minneapolis, Minnesota 55455 612/373-1910	University of Minn., Director of Health Care Psychology	11	5	3
P	Robert Hiller, Assistant Commissioner Community Health Service Department Minnesota Department of Health 717 Delaware Street SE Minneapolis, Minnesota 55440 612/296-5384	Dept. of Health	statewide	5	3
P.	James Janacek, M.D. Suite 1202 Lowry Medical Arts Bldg. St. Paul, Minnesota 55102 612/227-2144	Psychiatry	11	5	3
	Harvey Caldwell, Chief Executive Officer Moose Lake State Hospital Moose Lake, Minnesota 55767 218/485-4411	State Hosp. Hosp. Admin.	3	2	3
P	Harriet Mhoon, Director Social Services Department Anoka State Hospital Anoka, Minnesota 55303 612/421-3940	Member, Metro Health Brd., (HSA), Governor's Council on Aging, Statewide Health Coordinating Council	11	5	3
P	Edmund Schnettler, Director Central Minnesota Community Mental Health Center 1321 - 13th Street N. St. Cloud, Minnesota 56301 612/252-5010	Minn. Assoc. of Comm. MH Progs.	7W	4	2

	Representing	Governor's Economic Reg.	HSA	Length of Term
James E. Fischer Executive Director Minnesota Sheriffs' Ranches, Inc. Box 249 Austin, Minnesota 55912 507/433-8873	Minn. Council of Residential Treatment Centers	10		1
James Logan, Director 8224 Penn Avenue S. Minneapolis, Minnesota 55431 612/881-3354	Minn. Care Home Assoc.	11	5	2
Helen Reardon, Deputy Director West Central Community Serv. Center 1125 SE Sixth Street Willmar, Minnesota 56201 612/235-4613	Psychiatric Nurse	6E and W	3	3
Honorable Cedric Williams County Judge Meeker County Courthouse Litchfield, Minnesota 55355 612/693-2459	County Courts	6E	3	3
C 2117 Eleanor Avenue St. Paul, Minnesota 55116 612/699-0132	Marion Flesch	Emotions Anony.	11	5
Kevin Kenney, Legislative Analyst House Research Department Minnesota House of Representatives Room 17 - Capitol St. Paul, Minnesota 55155 612/296-5044	Legis. Staff; Psych., Former Employee of a State Hosp. & of 2 Community Mental Health Centers	statewide		3
Steven Mosow, Asst. Director Health Planning State Planning Agency Capitol Square Building 550 Cedar Street St. Paul, Minnesota 55101 612/296-3321	Health Planning	statewide		3

		Representing	Governor's Economic Reg.	HSA	Length of Term
C	William McFadzean 430 Baker Building Minneapolis, Minnesota 55402 612/333-3239	Businessman, Active in State & National MH Assoc. Affairs	11	5	2
C	Mrs. Virginia Dayton 900 Old Long Lake Road Wayzata, Minnesota 55391 612/473-8314	Member of Carter Mental Health Comm., Active in Civic Organs., including Hennepin Co. Health & Welf. Council	11	5	3
	Mrs. Mary Kinkade R.R. #1 Ada, Minnesota 56510 218/784-7346				
	Lee Cook 5016 - 13th Ave. So. Minneapolis, MN 55417 612/823-2692	Native American, Active in Local Civic Activities	11	5	1
C.	Mrs. Polly Mann Route 1 Marshall, Minnesota 56258 507/532-5201	Countryside Council	8	6	3
	Ms. Aileen Maki 825 East Fourth Street Apt. 302 Duluth, Minnesota 55805				
C	Mrs. Virginia Greenman 148 Prospect Boulevard St. Paul, Minnesota 55107 612/227-4068	Member Mental Health Assoc. Board of Directors, Citizens League	11	5	3
	Mrs. Patricia Solomonson 2325 Hansen Lane South St. Paul, Minnesota 55075 612/451-3264	MH Advocates Coalition, SLIC, MH Assoc.	11	5	3

		Representing	Governor's Economic Reg.	HSA	Len. of Term
C	Edward Murphy 900 Midwest Plaza East Minneapolis, Minnesota 55402 612/335-1101	Attorney, CPA, Citizen Concerned with MH problems	11	5	3

Ex-Officio: Ronald Young, M.D.
Medical Director
Minnesota Department of Public Welfare
Centennial Building
St. Paul, Minnesota 55155
296-3058

B. Advisory Council:

The rising concern for consumer protection and input has had its effect on the mental health services delivery system. With the changing focus of treatment for the mentally ill from isolated large institutions to smaller community-based treatment programs, the need for community involvement in the planning, development and operation of mental health programs became more evident. Both the federal and state governments have recognized this need and legislated a requirement for community involvement in the planning and operation of community mental health centers.

The 1975 Amendments to the Public Health Service Act (P.L. 94-63) mandates that the state mental health authority shall:

> "Provide for the designation of a state advisory council to consult with the state agency in administering such plan."

Additionally, Minnesota State Statutes (245.61 - 245.69) requires that the State Department of Welfare, being the designated state mental health authority, shall comply with all federal regulations necessary to establish eligibility for federal monies for mental health programs. Included in this mandate is the authority to:

> "Designate or establish a state advisory council, with representation as required as a condition of eligibility for benefits under any federal law, to consult with him in carrying out the purposes of this act."

In keeping with these mandates and a philosophy committed to community involvement, the Minnesota Department of Public Welfare has assembled an advisory council composed of consumers, providers and planners of mental health services.

The function of this council is to provide a consulting forum that reviews, comments upon, and makes recommendations to the Minnesota Commissioner of Public Welfare regarding the development and administration of the State Mental Health Plan. It is intended that such a council will assume an advocacy role for consumers of mental health services, assuring that the needs of the population are recognized and met and that planning is directed toward this end. Additionally, the council addresses the issue of quality assurance and assesses the planned programs and services against the best available standards for high quality of care. The combined expertise of this council will provide assistance to the Commissioner in assessing the mental health needs of the population and setting planning and funding priorities in compliance with these identified needs. The council will be staffed by the Mental Health Program Division of the Department of Public Welfare.

The council has been meeting at least four times per year for the purpose of reviewing the State Mental Health Plan, commenting on its progress toward achieving its desired goals, recommending policies and actions, and reviewing the quality of programming. The council itself does not have decision-making authority, but makes recommendations to the state mental health authority concerning such decisions.

To date, the council has met on April 26, June 7, September 13, November 9, 1976, and January 11, March 18, May 16, and June 28, 1977. The Department hereby provides assurance that the council will meet at least four times annually, as required by P.L. 94-63. Council recommendations to the Commissioner will be acted upon within 30 days.

P.L. 94-63 requires that the state advisory council be composed of four categories of members, half of whom are chosen by some type of public process. The advisory council members shall include at least 51%, and not to exceed 60%, state residents who are nonproviders of mental health services. The remaining percentage of the council shall be composed of state residents who are direct or indirect providers of service. Service providers are defined as those persons, professional and nonprofessional, who directly provide mental health services or administer mental health programs.

Indirect providers of service include persons with fiduciary interests in mental health programs, persons who issue insurance to cover mental health services, persons involved in research or education relating to mental health services or the spouses of these persons.

The four categories of members include persons concerned with planning, operations or use of community mental health centers or other mental health facilities who are: 1) representatives of nongovernment agencies; 2) representatives of state agencies; 3) those concerned with service needs who are consumers, including clients and their families; and 4) providers of service. The total membership of the council reflects representation from the social and economic classes, linguistic and racial groups and geographic areas of the state.

At its meeting on May 16, 1977, the council unanimously approved this plan for Fiscal Year 1978, subject to the items covered in the discussion. The topics addressed in the council discussion have been included in this plan.

C. Reports:

The Department of Public Welfare shall make such reports in the form and containing such information as the Secretary may, from time to time, reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports.

The Department of Public Welfare will retain on file, for a period of at least one year beyond participation in the program, all documents, accounting records, and control related to any expenditure and will take such steps as are necessary to assure that sponsors retain, for a period of at least two years after final payment of federal funds, all financial records and documents related to expenditures for the project.

Under Section 314(d) of the Public Health Service Act, as revised by P.L 94-613, the Special Health Revenue Sharing Act of 1975, federal funds will continue to be made available to the state health and mental health

authorities. If the two authorities are separate, as they are in Minnesota, the federal statute required that the state mental health share be at least 15% of the total state allotment. For Fiscal Year 1978, which runs from October 1, 1977 through September 30, 1978, Minnesota will receive approximately $237,000.

Departmental priorities for the use of the money have been to support efforts toward deinstitutionalization and/or the integration of human services. During Fiscal Year 1976-77, the Department used this money to make the following awards:

$15,000 to the Southwestern Mental Health Center, Inc., Luverne, which, in turn, contracted with the Community Programs Information System, Inc., for the preparation of a plan for the establishment and initial operation of a management information system for the state's community mental health centers.

Community Programs Information System, Inc., is a nonprofit corporation, the members of which are board members or staff of the community mental health centers in the state.

The plan is almost completely written and will be submitted to prospective public and private funding sources for financial assistance in implementing the system across the state.

$15,000 to the Hennepin County MH/MR/CD Department, which has contracted with Multi-Resource Center, of Minneapolis, to open and operate supervised apartment living units for persons who have experienced mental illness problems. The first units will be open by July, 1977, in Minneapolis. The Hennepin County Welfare Department has committed itself to provide ongoing funding for this project.

$12,000 to the Tri-County (now Blue Earth County) Human Services Board to enable the Minnesota Valley Mental Health Center, Mankato, to open a day treatment center for persons who have had mental illness problems.

$12,000 to the Range Area Human Resource Board, Inc., Virginia, to provide day programming for isolated senior citizens in its catchment area. Three local organizations serving senior citizens have offered to provide this service on a contracted basis.

$8,000 to the Carver County Mental Health Program Board to begin a prevention program of education for parents of young children.

$3,200 to the Zumbro Valley Mental Health Center, Inc., Rochester, to provide specialized mental health services to hearing impaired people.

In addition, the Department uses some of these funds to support 10 positions:

The Assistant Director and secretary in the Mental Health Program Division;

Two secretaries in the Residential Services Bureau;

Two staff members in the Staff Development Unit;

Two staff members in the Office of Evaluation whose responsibility is consumer satisfaction surveys (including mental health);

The assistant to the Department's Medical Director (psychiatrist); and

One residential licensing consultant.

Those staff not assigned directly to the Mental Health Program Division or to the Medical Director are working in positions that have their impact primarily at the local level (e.g., Staff Development) or, if they have duties other than mental health, are more than compensated for by others doing mental health work (e.g., residential licensing where assignments are geographic rather than by disability. Residential licensing staff, for instance, issue programmatic licenses for chemical dependency and mental retardation facilities, as well as those for mentally ill people).

The Fiscal Year 1977 Plan reported that Mr. R. David Ragan, a federal employee on loan to the Department under the Intergovernmental Personnel Act, was partially supported with 314(d) funds. During the period from January 1, 1977 to May 30, 1977, when Mr. Ragan returned to federal service, he was Assistant Director of the Minnesota Board on Aging. During that period, he was partially supported by Aging funds. No 314(d) funds were expended on his behalf after December 31, 1976.

As required under Title I of P.L. 94-63, the state must provide assurances, to receive 314(d) funds, that employees of state institutions will be protected in the event that their jobs are eliminated as patient populations decline. (See the section on State Hospitals for these assurances.) Minnesota does not anticipate a problem in this regard with the closing of the Hastings State Hospital.

The 1977 session of the Legislature, which ordered the closing of the Hastings State Hospital, authorized that its staffing complement be reallocated to the nine remaining state hospitals. In addition, the Legislature authorized the Department to add 100 new positions to the complement of the remaining state hospitals. Thus, all those employees of the Hastings State Hospital who wish to transfer to another state hospital will be assured of a job.

The Department will maintain its priority on deinstitutionalization in Fiscal Year 1978. The combination of 314(d) funds and state appropriations for this purpose will assure continued progress in this area.

D. Annual Review:

The Department of Public Welfare shall review the state plan at least annually, and shall incorporate the results of the review in the annual submission of the state plan. The plan shall be reviewed by the state advisory council and its comments included at the time of submission to the Secretary for approval.

Plan Availability and Amendment Procedure: At least 30 days prior to submission to the Secretary, the state plan, or any modification, will be publicized by the Department of Public Welfare. The state plan and related documents shall be readily available and accessible for examination and comment by interested persons prior to submission and during the period they are in effect.

A copy of the proposed plan was published June 1, 1977. This copy will be retained and is available for review at any of the community mental health centers in the state and at the Department of Public Welfare, Mental Health Program Division, Centennial Office Building, St. Paul, Minnesota, until May 1, 1978. Comments and suggestions for amendments may be made to the Mental Health Program Division. Notice of the availability of the plan was given to the media on June 2, 1977.

A copy of the final plan, which covers the period from October 1, 1977 to September 30, 1978, can also be reviewed at any community mental health program or state mental illness hospital.

E. Personnel Administration:

Methods of personnel administration have been established and will be maintained in the state agency and in local agencies administering the state plan in conformity with the Standards for a Merit System of Personnel Administration, 45 CFR Part 70, and any standards prescribed by the U.S. Civil Service Commission pursuant to the Intergovernmental Personnel Act of 1970. Laws, rules, regulations, and policy statements, and amendments thereto, effectuating such methods of personnel administration, are a part of the plan. Citations of applicable state laws, rules, regulations, and policies which provide assurance of conformity to federal Merit System Standards and to any standards issued by the U.S. Civil Service Commission are available for review and determination of adequacy. Amendments to the list will be submitted whenever necessary. Copies of the material cited and of similar local materials maintained by a state official responsible for compliance by local jurisdictions will be furnished to the Regional Office upon request. Statements of acceptance of the federal standards by official local agencies administering the state plan will be obtained in accordance with instructions of the Department of Health, Education, and Welfare, and will be submitted for review and determination of adequacy.

Private and public autonomous agency's boards, such as community mental health centers, develop their own personnel policies.

County welfare departments and human service boards are covered by Merit System personnel policies. State facilities are covered by Civil Service Personnel Policies and Practices for the State Agency Staff.

The Minnesota Merit System is an organizational unit within the Minnesota Department of Public Welfare.

F. Standards of Maintenance and Operation:

The Department, as the state mental health authority, has developed administrative standards for community mental health centers in the form of DPW Rule 28 (see Appendix).

The Office of Evaluation, in conjunction with the Community Programs Division and the Mental Health, Mental Retardation, and Chemical Dependency Program Divisions will develop a plan, in 1977-78, for state sponsored site visits to mental health centers. The program and administrative standards will provide the basis for the site visit surveys.

The 1977 Legislature reduced the Office of Evaluation's Field Review Division by seven positions. The implications of this cut on the Department's ability to carry out its planned site visits is not yet known. One likely result is that fewer site visits can be conducted each year.

Personnel from the Community Programs and the program offices, including mental health, regularly participate in federal site visits to comprehensive community mental health centers. When state site visits are begun to the remaining centers which are not comprehensive, the same offices of the Department will participate, along with the Office of Evaluation.

Participating staff are, and will continue to be, personnel who are familiar with the needs of their respective disability groups and appropriate treatment/rehabilitation methods, are experienced in the management of grant-in-aid programs, or are experienced in monitoring and evaluating local programs.

The Department has not yet formulated a policy on the newly emerging accreditation standards for community mental health centers being promulgated by the Joint Commission on Accreditation of Hospitals (JCAH). It can be anticipated that, when this form of accreditation is available to all potentially eligible centers, the Department will encourage local boards to qualify, but that it will leave such decisions to each local board.

The Department has not yet decided how JCAH accreditation will relate to state or federal site visits. When accreditation becomes widely available in the state, a thorough review of all of these monitoring and evaluation mechanisms will be done and the Department will formulate policy and procedures in this area.

One precedent is departmental policy in regard to residential treatment facilities for adults with mental illness problems. Prior to the exclusion by the 1977 Legislature of inpatient psychiatric hospitals from program licensure under DPW Rule 36, the Department policy was not to duplicate those items covered in JCAH accreditation surveys. Instead, the DPW licensure review addressed only those items not adequately covered in JCAH surveys, e.g., discharge planning and aftercare.

The standards will address the following areas:

1. Effective functioning of all essential elements of P.L. 94-63 and Minn. Stat. 245.61-.69 for comprehensive centers and of Minn. Stat. 245.61-.69 for state supported centers.

    a. Mechanisms assuring response to community needs, services for those unable to pay, continuity of care in coordination with providers.

2. Policy direction, organization, administration and staffing program.

3. Clinical Record and Administrative Statistics System.

4. Evaluation of patient care and program management.

5. Environmental support of programs accessibility, space and safety.

6. Protection of patient rights.

State established procedures for the determination of compliance with standard set and enforcement of standards.

Periodic review and revision of standards at least every five years.

It has not been a goal of the State of Minnesota, necessarily, to cover the state with comprehensive community mental health centers, since that decision is best made at the local level. The Department has always assisted local communities interested in developing comprehensive centers, and will continue to do so.

For those communities which elect not to pursue this course, or which do not meet federal catchment area minimum population requirements, the Department will continue to assist them in meeting the service needs of their residents in other ways that meet the spirit, if not the letter, of P.L. 94-63. For example, as mentioned in the description of the Carver County Catchment Area, the county has no inpatient psychiatric beds and does not expect to have any in the foreseeable future. The county will, however, pay for needed psychiatric hospitalization out of the county when individuals have no other means of payment. The Department considers that this service is available to Carver County residents, even though the county will be too small to support a comprehensive center for many years to come.

Standard setting will be flexible to accommodate a variety of ways of providing the essential services that take into account local priorities, state and local ability to pay for services and facilities, geographic distances, density of population, etc.

In addition, the Office of Evaluation is now field testing a survey instrument for use in monitoring county welfare departments. The mental health component was developed by the Mental Health Program Division in cooperation with the Office of Evaluation.

The legislative cut in staff of the Office of Evaluation, mentioned previously, has just occurred at the time of this writing. A planned survey of the Otter Tail County Welfare Department, in Fergus Falls, scheduled for late May, 1977, has been postponed until staff adjustments have been made and work schedules have been readjusted. Staff from the Mental Helath Program Division and the Residential Services Bureau participated in developing the survey instruments and would have participated in the survey.

While the focus would have been on the performance of the county agency, particularly on its mental health services, its relationships with the Fergus Falls State Hospital, the Lakeland Mental Health Center, and the county court would also have been addressed.

The Department is in the process of revising DPW Rule 28, which governs its relationships with community mental health centers. When completed, this rule will be promulgated and will be the standard against which they will be monitored and evaluated. (See Goal Statement for the timetable for promulgation.)

C. State Plan Administration Funds

No funds are currently available for this purpose under Section 227 of the CMHC Act and no funds are being requested by the Department for its administrative costs. The state will absorb the costs of plan development and administration.

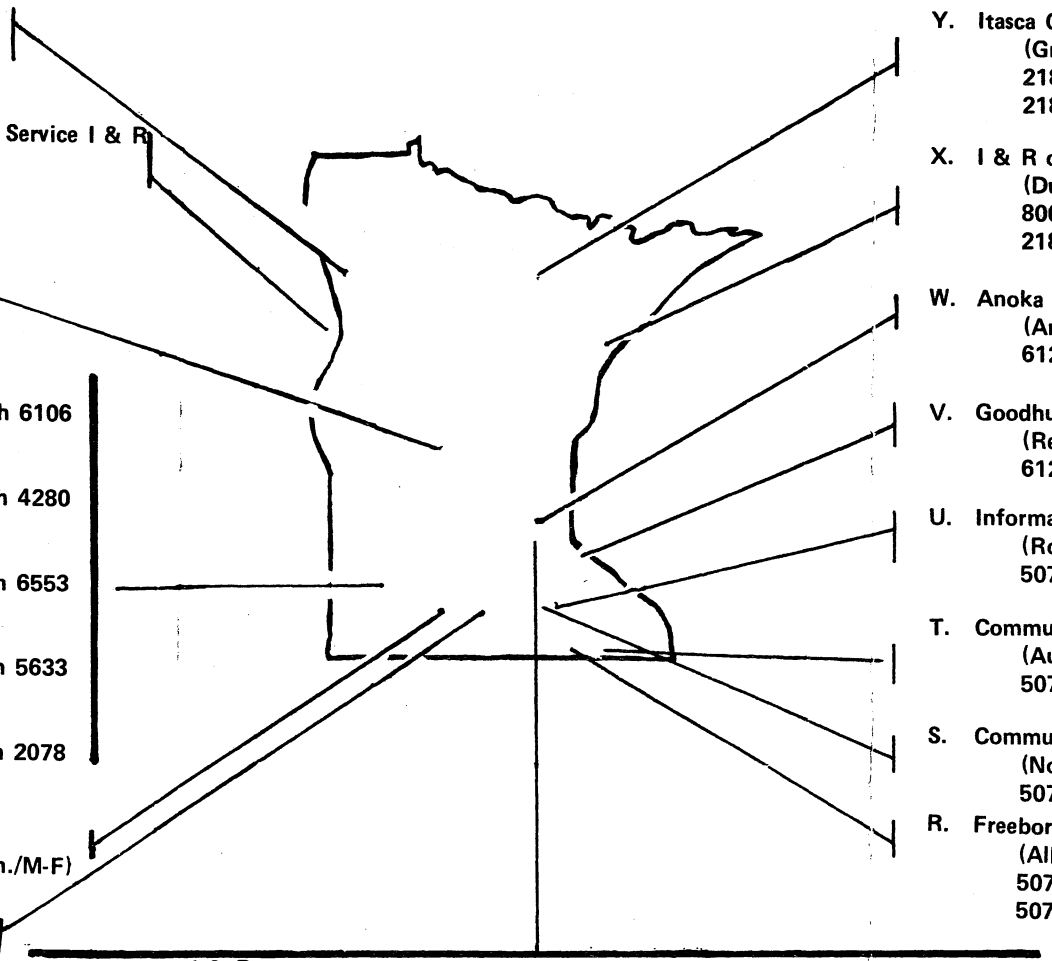
Information and Referral

During the past year, the Department developed a computerized statewide information and referral system that was compatible with existing local and regional I & R systems. The project was initiated with a federal grant from the Administration on Aging. During the past year, a dozen state agencies contributed to the completion of the project. From the outset, it was designed to include all human service agencies, including mental health.

The 1977 session of the Legislature did not see fit to fund the state level project, so it was terminated as of June 30, 1977. What remains are the local I & R services, as shown on the following page. Mental Health services are included in the local listings. Most, but not all, of the state will continue to be covered. Coverage of the remainder of the state will be a matter of local initiative.

All of the community mental health centers and county welfare/social service agencies will continue to provide I & R services, including mental health.

Minnesota Information and Referral Centers



A. Northwest Regional I & R
(Crookston)
218/281-4444

B. Volunteers for Community Service I & R
(Fargo, N.D.)
701/293-3222

C. I & R
(St. Cloud)
612/251-4550

D. Southwestern I & R
(Marshall)
507/537-6106 or Zenith 6106

(Benson)
612/843-4280 or Zenith 4280

(Montevideo)
612/269-6553 or Zenith 6553

(Windom)
507/831-5633 or Zenith 5633

(Worthington)
507/372-2078 or Zenith 2078

E. Brown County I & R
(New Ulm)
507/354-8515 (12-3 p.m./M-F)

F. I & R of Blue Earth County
(Mankato)
507/387-6002

G. Carver County I & R
(Chaska)
612/448-3661

H. CIRS
(Minneapolis)
612/340-7431

I. Crisis Intervention Center
(Minneapolis)
612/347-2222

J. Hennepin County Library
(Minneapolis)
612/830-4944

K. Hennepin County Welfare
(Minneapolis)
612/348-8125

L. Minneapolis Public Library
(Minneapolis)
612/871-8555

M. Community Action Council
(Burnsville)
612/894-2424

N. Information and Referral Service
(St. Paul)
612/291-8393

O. Pilot City Regional Center
(Minneapolis)
612/348-4700

P. Alcohol and Drugs I & R
(Minneapolis)
612/348-8013

Q. Youth Emergency Services
(Minneapolis)
612/339-7033

R. Freeborn Community Resource Council
(Albert Lea)
507/373-1507
507/373-9358

S. Community Action Center
(Northfield)
507/645-9167

T. Community Information Service
(Austin)
507/433-2391

U. Information and VAC of Olmsted County
(Rochester)
507/289-4090

V. Goodhue County Information VAC
(Red Wing)
612/388-2809

W. Anoka County H.R.O.
(Anoka)
612/421-4760

X. I & R of St. Louis County
(Duluth)
800/232-1300
218/727-8538

Y. Itasca County I & R
(Grand Rapids)
218/326-1034 day
218/326-8565 night

Produced by the Minnesota Office of Information and Referral Services
tel.612-296-2870

	AGENCY NAME	TELEPHONE NUMBER	ADDRESS	COUNTIES COVERED
A.	Northwest Regional Information and Referral Service	218/281-4444	Information and Referral University of Minnesota Crookston, MN 56716	Kittson, Marshall, Norman, Pennington, Polk, Red Lake, Roseau
B.	Volunteers for Community Service – I & R Service	701/293-3222	641 First Avenue N Box 732 Fargo, N.D. 58102	Clay
C.	Information and Referral	612/251-4550	P.O. Box 1205 St. Cloud, MN 56301	Stearns, Benton, Sherburne
D.	I & R Service of Southwestern Minnesota, Inc.	507/537-6106 or Zenith 6106	Office of Community Develop. Administration Bldg. 308 Southwest State University Marshall, MN 56258	Lincoln, Lyon, Murray, Kandiyohi, McLeod, Meeker, Renville and counties of its satellite offices
	Satellites at:	612/843-4280 or Zenith 4280	Benson	Big Stone, Swift
		612/269-6553 or Zenith 6553	Montevideo	Chippewa, Yellow Medicine, Lac Qui Parle
		507/831-5633 or Zenith 5633	Windom	Cottonwood, Redwood, Jackson
		507/372-2078 or Zenith 2078	Worthington	Nobles, Rock, Pipestone
E.	Brown County Referral and Information Service	507/354-8515 (12:00 – 3:00/M-F)	125 1/2 S. Broadway New Ulm, MN 56073	Brown
F.	Information and Referral Service of Blue Earth County	507/387-6002	P.O. Box 3206 Mankato, MN 56001	Can answer questions for Blue Earth, Brown, Faribault, LeSueur, Martin, Nicollet, Sibley, Waseca, Watonwan
G.	Carver County Information and Referral	612/448-3661	Carver County Courthouse Chaska, MN 56258	Carver
H.	Community Information and Referral Service	612/340-7431	404 S. Eighth Street Minneapolis, MN 55404	Mpls. Metro Area
I.	Crisis Intervention Center	612/347-2222	Hennepin Co. Medical Center 701 Park Avenue Minneapolis, MN 55415	Metro Area
J.	Hennepin County Library	612/830-4944	7009 York Avenue S Edina, MN 55435	Mpls. Metro Area
K.	Hennepin County Welfare	612/348-8125	Government Center Minneapolis, MN 55487	Hennepin
L.	Minneapolis Public Library (Franklin Branch)	612/871-8555	1314 E. Franklin Avenue Minneapolis, MN 55404	Mpls. Metro Area
M.	Community Action Council of Northwest Dakota County	612/894-2424	13710 Nicollet Avenue Burnsville, MN 55337	NW Dakota
N.	Information and Referral Center	612/291-8393	333 Sibley St. Paul, MN 55101	Ramsey, Dakota, Washington
O.	Pilot City Regional Center	612/348-4700	1315 Penn Avenue N Minneapolis, MN 55411	North Minneapolis
P.	Alcohol and Drugs I & R Service (AID)	612/348-8013	1800 Chicago Avenue Minneapolis, MN 55404	Mpls. Metro Area
Q.	Youth Emergency Services (YES)	612/339-7033	608 – 20th Avenue S Minneapolis, MN 55454	Metro Area
R.	Freeborn Community Resource Council	507/373-1507 or 507/373-9358	408 Fountain Street Albert Lea, MN 56007	Freeborn
S.	Community Action Center	507/645-9167	301 Washington Northfield, MN 55057	Northfield Area
T.	Community Information Service	507/433-2391	201 Second Avenue NW Austin, MN 55912	Mower
U.	Information and Volunteer Center of Olmsted County	507/289-4090	913 SE Third Avenue Rochester, MN 55901	Olmsted
V.	Goodhue County Information and Voluntary Action Center	612/388-2809	P.O. Box 282 Red Wing, MN 55066	Goodhue
W.	Anoka County Human Resource Office	612/421-4760	Anoka County Courthouse Anoka, MN 55303	Anoka
X.	Information and Referral Service of St. Louis County	800/232-1300 or 218/727-8538	8 East Fourth Street Duluth, MN 55805	Carlton, Cook, Lake, St. Louis
Y.	Itasca County I & R Service	218/326-1034 (day) 218/326-8565 (nighttime Crisis Intervention)	126 SE First Avenue Grand Rapids, MN 55744	Itasca

Section III

NARRATIVE REVIEW OF
CURRENT MENTAL HEALTH SYSTEM AND NEEDS

1. General Overview of Mental Health System:

The broad goal of Minnesota's mental health program is to address the problems of human dysfunctioning nad maladaptive behavior; to encourage, insure, or provide opportunities for every person in Minnesota to grow in his/her ability to get along better with others in ways that are satisfying to him/her and acceptable to those around him/her. The problems are shared with other programs in the fields of welfare, health, education and criminal justice and, as a common goal, does provide the basis for joint planning with those in other fields.

This reduction of the incidence and prevalence of human dysfunctioning and maladaptive behavior will be done within a framework which:

1. Will not violate the civil and human rights of individuals, making use of the least restrictive alternative possible in each instance, and is

2. Within the statutory authority of the Commissioner of Public Welfare:

    a. To operate state mental health institutions and facilities;
    b. To supervise county welfare boards;
    c. To assist the local community mental health boards to develop, implement and evaluate a comprehensive mental health program for the area.

The Minnesota system is a mixture of public and privately operated services. These programs range from delivery of a single service to delivery of an array of services which are coordinated to provide a comprehensive program.

The Commissioner of Welfare is designated as the mental health authority for the State of Minnesota. The state hospitals are administered by the Commissioner, and state funds appropriated for both state hospitals and community mental health centers are under the control of the Commissioner. The regulating, licensing, and standard setting for mental health services and programs are also under the jurisdiction of the Commissioner.

2. Continuum of Care:

A comprehensive mental health program provides a continuum of preventive, emergency, and diagnostic treatment, and rehabilitative services which offer varying amounts of support, treatment and care, depending upon the individual patient's needs, and indirect services, such as consultation and education. This range of services is from minimum treatment and support to maximum level of treatment and support available on a 24-hour basis. The continuum, as developed in Minnesota, is not a direct line of progression, but rather demonstrates the varying amount of support and care. The conceptual framework of the continuum is applicable to the special target groups.

MENTAL HEALTH PROGRAM CONTINUUM

Degree of Service

High	Medium	Low	Level of MI Functioning
		Counselling Day Activity Own home/Ind. Living	1. Symptoms observed or reported but not impaired in carrying out daily activities or in meeting role requirements.
OTHER AVAILABLE PROGRAMS Crisis Intervention Vocational Rehabilitation Recreation Programs Community Resources (Theatres, etc.) Medication Clinics Public Health Nursing & Local Physicians Clergyman, Schools, Law Enforcement Courts Mental Health Associations	On-going MH Services Counselling from MH Center County Social Service or Private Counselling Agency or Private Practitioner Lives in own home/independent living (Could come from Residential Facility)		2. Substantial effort reported to be required to maintain unimpaired level of functioning.
	Community Day Treatment/Activity Client may live at home or short term residential		3. Observed loss of efficiency in meeting daily activity and role requirements, e.g. activity done, but slowly.
	Supportive Env - Day Activity/Treatment MH Residential Program		4. Observed loss of effectiveness in meeting daily activities and role requirements, e.g. activities done, but poorly.
Community Treatment Center Primary Residential Program			5. Functional failures in one or two important roles such as work, school, housework spouse community, e.g. some activities not performed at all.
			6. Impairment such as to that client fails to meet most roles and performance requirements.
Community MH Nursing Home Hospitalization (State and Private)			7. Impairment such as to require substantial supervision, care and treatment.
			8. Impairments so incapacitating as to require constant supervision and care by others.

Individual Program Plan

County Welfare Dept. has individual follow through responsibility. (253A.15-12)

Area Board overall program planning & provision of MH Service Responsibility (245.61)

3. Institutionalization - Deinstitutionalization:

Institutionalization is 1) the degree to which a person does not have access to, and choices about, the resources and protections of society as a whole, and 2) the effects on the personality of the individual of the interaction of prolonged reduced choice of and access to these resources and protections.

One aspect of "institutionalization" has to do with the quality of the environment, and the other aspect involves the changes in the individual as a result of his/her interaction with the environment.

The hazard in large institutions is that individual may be lost sight of, and the routines and resources of the facility may be devoted to the survival and/or convenience of the institution rather than the personal development of the individual.

Institutionalization. For purposes of this plan and Minnesota's approach to deinstitutionalization, the definition of institutionalization contains four elements:

1. Reduced accessibility to society's resources;
2. Reduced opportunity for choice;
3. Reduced protection of individual rights;
4. Changes in the person himself/herself.

Stated below are some of the most common dimensions of institutionalization. At one extreme would be a condition of total institutionalization and at the other would be a condition of total freedom and capability to make wise, responsible choices.

1. Reduced accessibility to society's resources.

    a. Meaningful employment.

        1) Free access to all employment opportunities--assignment to a work situation.
        2) Assistance in finding preferred employment--assignment to a work situation.
        3) Pay based on job responsibility and skills required--no pay or arbitrary pay.
        4) etc.

    b. Housing.

        1) Choice of living situation--arbitrary assignment to a living situation.
        2) Opportunity for privacy at person's choice--privacy limited, nonexistent, or programmed for person.
        3) Choice of time schedule for activities (rising, retiring, toileting, etc.)--schedule largely set by other.
        4) etc.

c. Social/medical/rehab/etc. services.
   1) Free choice of vendor--no choice of vendor.
   2) Free choice in seeking help--help provided when others think it appropriate.
   3) Contractual financial relationship between person and vendor (person employs vendor)--no contractual financial relationship between person and vendor (vendor paid by someone else).
   4) etc.
d. Financial.
   1) Financial independence--need for public financial assistance:
      a) food, clothing, shelter
      b) medical
      c) nonessentials
   2) etc.
e. Education.
f. Legal.
g. Political.
h. Recreation.
i. Transportation.
j. Spiritual/Religion.
k. etc.

2. Freedom to choose among a range of alternatives.

   a. Service vendors.
   b. Advocates.
   c. Practice of religion.
   d. Clothing.
   e. etc.

3. Reduced protection of individual rights.

   a. Due process.
   b. Informed consent.
   c. Privacy.
   d. etc.

Deinstitutionalization is reduction in the degree of institutionalization. Moving a patient/resident from a state hospital to a "community alternative" might increase or decrease institutionalization, or keep it at the same level. Simply moving people out of large state institutions is not the same as deinstitutionalization. State hospitals are not "good" or "bad" in themselves, but rather in the degree to which they promote or work against free choice and taking personal responsibility for one's actions.

Unfortunately, to many people, the term is synonymous with "depopulation", particularly of state hospitals. Minnesota was a pioneer in depopulating its state hospitals over approximately the last 15 years. Experience over that time strongly indicates that depopulation alone does not solve problems, either human or administrative, it simply transfers them.

The State of Minnesota has taken a number of steps to decrease the population of state hospitals over the last 15 years; provide matching funds for community-based programs, including mental health centers; assignment of a patient/resident advocate in each state hospital; creation of an outside review board for each state hospital; and inclusion of the right to treatment in the Minnesota Hospitalization and Commitment Act.

A more desirable state of affairs, while being much more difficult to achieve, is one of reintegration of people into the community to the maximum extent possible.

To that end, Minnesota has funded, with state appropriations:

A day treatment program for adults in Washington County;
A diversion program in Dakota County to keep troubled and troublesome adolescents in the community and out of institutions whenever possible;
A social rehabilitation center for ex-mental patients in Ramsey County;
Partially, six Fairweather Lodges in Hennepin County for former patients of Anoka State Hospital;
A pilot project in adult basic education in Ramsey County for ex-patients;
Partially, support for Women's Advocates, Inc., which provides a shelter in St. Paul for women in mental or physical distress--including battered women;
A pilot project in providing ex-mental patients in Ramsey County with planned experience as volunteers in serving other people;
Funding, matched by a grant from the St. Paul Foundation, to enable The Hope Transition Center, St. Paul, to remodel its building to meet the standards of the Minnesota Department of Health.

Out of a separate state appropriation, the Legislature authorized support for Sharing Life in the Community, Inc. (SLIC). SLIC is a nonprofit corporation modeled after the highly successful, NIMH-funded PACT Project of the Mendota Institute, Madison, Wisconsin. It is a nonresidential program of 24-hour, seven-days-a-week support and retraining of persons who have had three or more prior hospitalizations for mental illness problems. It is located in South St. Paul and serves residents of Ramsey, Dakota, and Washington Counties. Dakota County Mental Health Center is the fiscal intermediary for state funds first appropriated in April, 1976. SLIC accepted its first clients in August, 1976, and anticipates serving 36-48 clients per year. In accordance with a legislative directive, the Department of Public Welfare is evaluating the SLIC program, using a control group for comparative purposes.

All of the above efforts are in addition to the regular ongoing programs of the statewide network of community mental health centers which, for Fiscal Year 1978, will receive over $7 million in state matching funds, exclusive of state appropriations for mental retardation and chemical dependency services and of federal, local, and other income. Not included, above, are the legally mandated aftercare case management and/or the voluntary pre-admission screenings provided in some counties.

In addition, the Department has used part of its allocation of federal discretionary mental health money for Fiscal Year 1977 to enable:

The Range Mental Health Center, Virginia, to start a day program for elderly persons;
The Minnesota Valley Mental Health Center, Mankato, to start a day treatment center in close conjunction with the St. Peter State Hospital; and
The Hennepin County MH-MR-CD Department to contract with the Multi-Resource Center, Inc. to open a supervised apartment living project-halfway house for mentally ill persons.
See the 314(d) report on pages 14-16.

While the state has not yet achieved perfection, it is apparent that it is making a beginning in providing for the reintegration of mentally ill persons into the life of various communities.

Furthermore, based on legislative approval of the Department's proposal for additional money for deinstitutionalization, the Department expects to use the money to:

Fund a number of crisis homes, on a pilot demonstration basis as developed by Southwest Denver Mental Health Services, Inc. as alternatives to psychiatric hospitalization;
Fund a number of residential facilities across the state for persons with mental illness problems who would live in the homes while getting treatment services from community mental health centers and other outpatient providers.

The Department has responded positively to an inquiry from NIMH about its proposed Community Support Program (CSP) to provide funds for demonstration projects to develop comprehensive support systems for adults who have had mental illness problems.

If these funds become available, the Department intends to submit a proposal to develop such a system, or systems, probably in the metropolitan Twin City area. A thorough study of this issue was done by the Health and Welfare Council of Hennepin County (Minneapolis area) in 1976. This study covered Hennepin and Anoka Counties, identified problems, and suggested an array of integrated services necessary to provide a comprehensive support system.

While alternatives to hospitalization, particularly residential facilities, and the necessary supportive services are not available in either sufficient quantity or quality to assist all those persons who need help in reintegrating themselves in community living, it is apparent that the state is making a significant beginning toward deinstitutionalization and reintegration by means of the activities listed above.

The major drawback to developing adequate community residential facilities is the lack of a stable funding base. To date, this problem has not been

adequately dealt with, either in this state or at the federal level. Until it is, such facilities will be limited both as to numbers and capability.

4. Goals and Objectives - Proposed:

As previously stated, the broad goal of Minnesota's Mental Health Program is to address the problems of human dysfunctioning and maladaptive and disvalued behavior; to encourage, insure, or provide opportunities for every person in Minnesota to grow in his/her ability to get along better with others in ways that are satisfying to him/her and acceptable to those around him/her. The problems are shared with other programs in the fields of welfare, health, education and criminal justice and, as a common goal, provides the basis for joint planning with those in other fields.

As the state's responsibility for continuation of mental health programs supported by state, federal and local funds, the following Goals and Objectives are set forth to identify the major operational directions of the Department of Public Welfare. These goals are those of the Department of Public Welfare. Most, but not all of them, are the result of input from the general public, consumers, and providers. They provide a mechanism for monitoring the progress of the Minnesota Mental Health System.

GOAL I:

Mentally ill adults who need residential treatment shall have access to such treatment without regard to their ability or inability to pay for it by the end of the 1979-80 biennium, in either hospital or nonhospital settings, whichever is the least restrictive for the individual and most appropriate to the treatment needs of the individual.

Subgoal I: The Department of Public Welfare shall continue to support its proposals to the 1977 session of the Legislature that community-based nonhospital residential treatment be made available by providing reliable funding for it, establishing admission criteria, and providing certified training for facility staff.

OBJECTIVES:

1-A. The Department shall continue its efforts, begun with the 1977 Legislature, to provide nonhospital residential treatment, both as an alternative to psychiatric hospitalization and as a transitional step in treatment and reintegration, through expansion of group health insurance coverage to reimbursement of such costs in facilities licensed under DPW Rule 36. (April, 1978)

1-B. The Department shall commit $50,000 of the state funds appropriated for the deinstitutionalization of mentally ill persons to support the operation of crisis homes (similar to those developed by Southwest Denver Mental Health Services, Inc.). (October, 1977)

1-C. The Department shall commit $175,000 of the state funds appropriated for the deinstitutionalization of mentally ill persons to provide at least partial support, to the extent not available from other sources, for the operation of community-based nonhospital residential facilities qualifying for licensure under DPW Rule 36. (October, 1977)

1-D. The Department shall provide, through its anticipated grant from the Paraprofessional Branch of NIMH, certified training to paraprofessional staff of state hospitals and community residential facilities, licensed under DPW Rule 36. The purposes of this program are: 1) the enhancement of competence through attainment of demonstrated competence; 2) demonstration, in measurable terms, of more effective reintegration (deinstitutionalization); 3) improved career mobility for paraprofessionals. Training will begin by October, 1977, or whenever funds are released for this project.

1-E. The Department shall negotiate an agreement with the Minnesota Department of Health to use its ongoing care review of nursing home residents as a basis for relocating mentally ill nursing home residents not needing nursing care into facilities licensed under DPW Rule 36. (June, 1978)

1-F. The Department shall assure, through funding, policy, procedural direction, and licensing, that all such nursing home residents identified under 1-E are relocated in Rule 36 facilities. (June, 1983)

Subgoal II: The Department shall make the following changes in the state hospital system to reduce its size, improve its performance, and assure that its performance meets contemporary standards of cure and treatment:

2-A. As directed by the 1977 session of the Legislature, the Department shall cease operation of the Hastings State Hospital by May 1, 1978.

2-B. The Department shall, in carrying out this mandate, see to it that every patient of the Hastings State Hospital at the time admissions are closed has his/her situation thoroughly reviewed before a decision is made to discharge or to transfer the individual to another state hospital. This decision shall include consulting with each patient regarding his/her preference in this matter. (November, 1977)

2-C. The Department shall offer each employee of the Hastings State Hospital, who will not continue to be employed there in his/her position in subsequent use of the facility for other purposes, a comparable position at another facility or agency of state government. (November, 1977)

2-D The Department shall allocate its legislative authorized state hospital staff compliment to the remaining state hospitals so that a staff-patient ratio of at least 1:1 overall is provided in each institution. (January, 1978)

2-E. The Department shall, for each state hospital serving mentally ill people, apply for licensure under DPW Rule 36, if not already so licensed. (October, 1977)

2-F. The Department shall take whatever steps are available to it, except as by state legislative appropriations, to correct conditions in any state mental illness hospital that prevent that facility from qualifying for licensure under DPW Rule 36. (December, 1977)

2-G. The Department shall complete the work necessary to implement its system of review of patient care required under P.L. 92-603 to meet the requirements of Professional Standards Review Organizations (PSROs) by July 1, 1978.

GOAL II:

The Department shall make the following changes in its relationship with community mental health centers to increase the likelihood of quality performance, availability of services, and equity of funding through the following steps:

1-A. The Department shall complete the revision of DPW Rule 28, governing its relationships with community mental health centers and affiliated clinics. (January, 1978)

1-B. The Department shall assist the centers and clinics to be in substantial compliance with revised DPW Rule 28, as a condition of continued state funding. (June, 1978)

1-C. The Department shall certify to the Commissioner of Insurance which centers and clinics meet the requirements of DPW Rule 28, as a condition of qualifying for eligibility for group health insurance reimbursement under M.S.A. 62A.152. (July, 1978)

1-D. The Department shall take the steps necessary to distribute state matching funds to community mental health centers on a formula basis to assure equity of state funding. (July, 1977)

5. State Hospitals:

Historically, state hospitals initially constituted the total public mental health system and committed patients constituted a large share of the population. The function of state hospitals today is different than it was as recently as 15 years ago. Today, in addition to the traditional residential services, the state hospitals are being used for respite care services, diagnostic services, and an array of other services which are generally compatible with those provided in nonhospital settings.

Minnesota currently operates 10 state hospitals, eight of which are multiservice, offering mentally ill, mentally retarded, and chemically dependent programs. Two serve mentally ill and chemically dependent people and to serve mentally retarded people exclusively.

Each of the state hospitals is assigned a geographic area as a receiving district, with the exception of the Minnesota Security Hospital, which provides servcies on a statewide basis. There have been changes in the re-

ceiving districts of the state institutions over the years. Some of the factors that have influenced changes in receiving districts are: program changes within the state hospitals, new services for specific disability groups, attempts to reduce the overcrowding that existed in some of the institutions and attempts to better distribute the population among the institutions. The question has been raised as to the need for 10 state hospitals in Minnesota. The Department recommended the closing of the Hastings State Hospital and the 1977 session of the Legislature acted favorably on the recommendation by directing that it be closed by May, 1978. In recent years, Hastings has served mentally ill and chemically dependent people.

Considerable attention and effort have been given to providing various forms of treatment within the community as less restrictive alternatives to institutional care. By making greater efforts to prevent hospitalization and to develop effective aftercare plans, for example, along with other factors, it has been possible to effect reductions in the patient population and in the average length of stay.

While the average daily census has declined from over 15,000 (including all disability groups) in 1960 to about 5,300 in 1977, the mental illness figures indicate that larger numbers of people are using the state hospitals for shorter periods for acute care. Thus, while the average daily census of people with mental illness problems is now less than 1600, there were approximately 3500 admissions for this purpose during Fiscal Year 1976-77.

A study of what happens to people when they leave state hospitals has just been completed by the Department's Office of Evaluation. It is based on data on people who had been hospitalized at Hastings and Moose Lake for problems of either mental illness or chemical dependency. Significant findings of the 1976 Community Follow-Up of Mentally Ill and Chemically Dependent State Hospital Patients* include:

The average MI patient was 40 years old and equally likely to be male or female, while the typical CD patient was a 35 year old male. Both were likely to be white, unmarried, have not completed high school, and usually work in a service occupation--although many were unemployed prior to admission. Slightly more than half of the MI's were admitted voluntarily, while over 85% of the CD's were not. Most MI's received schizophrenic diagnoses, and the CD's were alcoholics.

In general, the information about patients' pre- and post-hospitalization experiences obtained from review of hospital records perhaps revealed more about the information-gathering and recordkeeping practices at the hospitals than it did about the patients. Standardization of these procedures would do much to reduce this uncertainty.

* Available on request from Dr. Roland Peek, Office of Evaluation, Department of Public Welfare.

Comparison of the hospital record review demographic data for interviewed and noninterviewed patients revealed few differences. Thus, those who were interviewed were probably not substantially different from those who were not in any aspect that would materially affect conclusions drawn from interview data.

Patient opinions of hospital living conditions were generally neutral to somewhat positive. They rated hospital staff as being highly helpful. Most patients thought that the various treatments they received were helpful, except that only half of the MI's who received drugs thought that they were helpful. Most patients said that they were not involved in planning their treatment program, but that they did participate in deciding where they would live after discharge. Most were unaware that they had been referred to any community service agencies. Nevertheless, most had some involvement with a social service agency, usually a county welfare department.

These people were quite mobile after discharge. One-half to two-thirds had lived in more than one place since discharge. At the time of interview, most lived independently, usually in single-family dwellings or apartments in medium to high density areas although, for Hastings ex-patients, about a third of the MI's lived in group residences and about a quarter of the CD's lived in halfway houses. Significant portions of both disability groups had returned to, or in the case of Moose Lake, not left the institution by the time of the interview.

Interviewers generally rated the community residences neutrally, and so did the patients. Those living in group facilities typically did not rate them differently from the hospitals on such things as meals and privacy. Most patients preferred living in the community to living in the hospital, chiefly because they had more opportunity for self-direction. Most who expressed some dissatisfaction with their community residence said it was because of interpersonal issues, rather than physical living conditions.

Most ex-patients seemed fairly able to take care of their activities of daily living, such as self-care and transportation. There was no significant change in their employment status after release, and most were receiving some type of financial assistance.

Most MI's were taking some type of antipsychotic drug that had been initially prescribed while in the hospital and, although many were uncertain why they were taking the medicine, they generally felt that they were helpful to them.

The interviewers generally rated MI's behavior as "normal" to "mildly abnormal" and saw their emotional adjustment and coping ability as somewhat poor. CD ex-patients were more often rated as normal, well adjusted, and able to cope with their life situation.

The state hospital system is to be utilized when and where appropriate to serve individuals having a problem or condition diagnosed as mental illness, chemical dependency, or mental retardation. In light of the role that state hospitals carry in the delivery of mental health services, it follows that before an individual is hospitalized, during hospitalization, as well as

after hospitalization, the county welfare board and the area mental health boards are to be actively involved in the delivery of mental health services to individuals placed at the state hospitals and to their families. To this end, laws of our state, and policies of the Department of Public Welfare, are written in such a manner as to direct such mutual involvement. In this respect also, before a state hospital embarks on establishing a new program within the broad definition of mental health, the Department of Public Welfare requires that area boards and county welfare boards, included in the state hospital service area, must sign off and endorse that there is a need for the program before authorization is given to the state hospital to proceed with the implementation of the new service or program.

Because the issue of freedom of choice is a critical component of institutionalization/deinstitutionalization in Minnesota, and because there is a greater danger of reducing that freedom unnecessarily in total care residential facilities, the state has put a relatively high priority on procedures for assuring rights of patients within state hospitals.

The 1977 Legislative Conference Bill, Section 17, states in part:

> "On May 1, 1978, the Hastings State Hospital shall be closed . . . . . The Commissioner of Public Welfare shall provide for the transfer of patients and patient records to other hospitals operated by the Department of Public Welfare or provide for alternate care. The Commissioner shall, to the extent possible, provide at least 30 days notice of the transfer and allow patients and their parents, spouse or guardian input regarding the institution to which the patient is to be transferred."

The Department has convened a task force of its own personnel and staff from the three community mental health centers and social service agencies in the couunties affected to develop and carry out a plan to carry out this mandate. As stated in Subgoal II, 2-B, pages 22 and 23, each patient's situation will be reviewed individually in consultation with the patient to the extent feasible, before a decision will be made about the patient's future. Relatives will also be involved, as required by the Legislature.

Each placement will be made on the basis of the individual assessment, his/her treatment needs, and available alternatives.

Mechanisms for Review of Treatment Procedures in State Mental Institutions:

There are at least nine (9) different mechanisms for review of various components of treatment procedures in Minnesota's state hospitals. Some of these surveillance efforts focus primarily on individual treatment plans, while others are directed at both individual treatment plans and the hospital's treatment programs.

Apart from the general screening that may go on by county welfare boards and the area mental health boards before an individual is admitted to a state hospital, and apart from the general screening and assurances that are given

to individuals (their families and interested others when appropriate) when the individual enters the state hospital, the following additional safeguards are in place to assure that patient/resident rights are protected:

a. State licensure of mental health programs: Minnesota law requires special licensure to operate programs for mental illness (Rule 36), mental retardation (Rule 34), and chemical dependency (Rule 35).
   Under state law, the Minnesota Department of Health is responsible for assuring general health and safety factors at each facility, while the Department of Public Welfare inspects for adequacy of programming, individual treatment plan, follow-up care, staffing patterns, etc. Licenses for each disability program at each institution must be reviewed annually.
b. Joint Commission on Accreditation of Hospitals: The Minnesota Department of Public Welfare has, for many years, actively sought accreditation of its institutional services by the JCAH. The current status of these accreditation efforts is summarized on page 31. Hospital treatment procedures are reviewed as a part of the JCAH site visit.
c. State Hospital Review Boards: Each state hospital is required by Minnesota law to have a review board comprised of at least three outside persons who are granted broad powers to review programs and interview patients who wish to talk with them privately. These boards meet regularly at the institutions and their findings are communicated directly to the Assistant Commissioner for Residential Services for response and action. Most are dealt with within 10 days. Those that cannot be resolved with the Residential Services Bureau are referred to the Commissioner.
d. Medical Policy Directional Committee on Mental Health: The seven mental health experts on this statutory committee are advisory to the Commissioner on a wider range of programs and treatment issues. In addition to review of specific programs and individual cases (e.g., aversive conditioning, sex offenders) the Committee has been making site visits to all of the state hospitals for purposes of general program review.
e. County Welfare Department: Under Minnesota policy, the local county welfare department maintains a share in the responsibility for case management for all patients admitted to state hospitals. The local county welfare department is also responsible for carrying out, as case managers, the individual discharge plans jointly established by the hospital and the county. Quarterly review of individual treatment plans by the hospital staff and the county welfare worker is mandatory while an individual is in a state hospital.
f. Multidisciplinary Team Meetings: Several years prior to JCAH, and federal and state regulations requiring multidisciplinary team meetings, this form of treatment monitoring was already being carried out in Minnesota's state hospitals. It continues to the present.

g. Patient Advocates and Humane Practices Committees: Each state hospital has a patient advocate who is available to patients, families, friends or other interested parties on all matters affecting patient welfare, including the appropriateness or adequacy of treatment programs. The advocates have been extremely effective agents for instigating treatment review and reform. There is no longer a statewide Humane Practices Committee but a number of the state hospitals have continued them for internal advocacy and case monitoring.

h. Utilization Review: Quality of care studies, as required by Titles XVIII and XIX, are done at all hospitals in accordance with federal laws. Compliance is enforced through visits by Minnesota Department of Health surveyors.

i. Program Offices: The Residential Services Bureau of the Department of Public Welfare is directly responsible for administrative management, budgets, staffing and other day-to-day operations affecting the state hospitals. The Community Services Bureau, through its program offices for mental health, mental retardation, and chemical dependency, is responsible for statewide planning and monitoring for each disability, including the state hospital programs. Staff from the program offices visit state hospitals and review programs and assist with new projects in the same manner as they participate in program development at other Minnesota facilities.

j. The Foundation for Health Care Evaluation in Minneapolis has been designated as the Professional Standards Review Organization (PSRO) for the metropolitan Twin City and, recently, for the northern part of the state. The PSRO for 37 counties in the southern part of the state is the Professional Services Quality Council of Minnesota located in Rochester.

The Foundation for Health Care Evaluation has received a grant to establish criteria and procedures for long-term care, in which category state hospitals are included. The Department and the Foundation have begun work on development of criteria and procedures, based on levels of care, for state hospitals. It is planned that they will also be able to fulfill Utilization Review requirements under Title XVIII and XIX. Final development and approval of delegated responsibility to the state hospitals is from one to two years away.

At this time, it is not clear how or when the Professional Services Quality Council will address the question of long-term care/state hospitals or whether its criteria and procedures will approximate those of the Foundation. The Department will continue to work with both PSROs to assure the highest possible degree of consistency in this area.

This year, the state hospitals inaugurated a uniform all-bed review system for determining appropriateness of admission and need for continued stay. The criteria and procedures were developed during the past two years by a multidisciplinary task force of

DPW Central Office and state hospital staff, Minnesota Department of Health personnel, and outside consultants, and are applied routinely to every admission and continued stay. There are separate criteria for each disability group served by the state hospitals--mentally ill, mentally retarded, chemically dependent.

The new system emphasizes "level of care" rather than traditional diagnostic categories as the primary justification for admission and/or continued stay. In addition to meeting and exceeding federal requirements for utilization review, it provides uniform criteria for monitoring the usage of state hospitals. The initial criteria sets developed by the task force are currently under review for necessary changes and adjustments after several months of field trial.

A staff person has been designated at each state hospital to coordinate the review process and assure that the procedures are correctly applied. For example, every admission is reviewed against criteria within three days and on regular scheduled intervals thereafter to determine whether the patient/resident is appropriately placed in the hospital. The levels of care for each disability group reflect the patient/resident's need for intensive treatment, medical supervision, security, training, etc.

It is not anticipated that this review system will eliminate all inappropriate usage of state hospital facilities. Rather, it is seen as another important step in the development of a rational, integrated mental health treatment program in Minnesota.

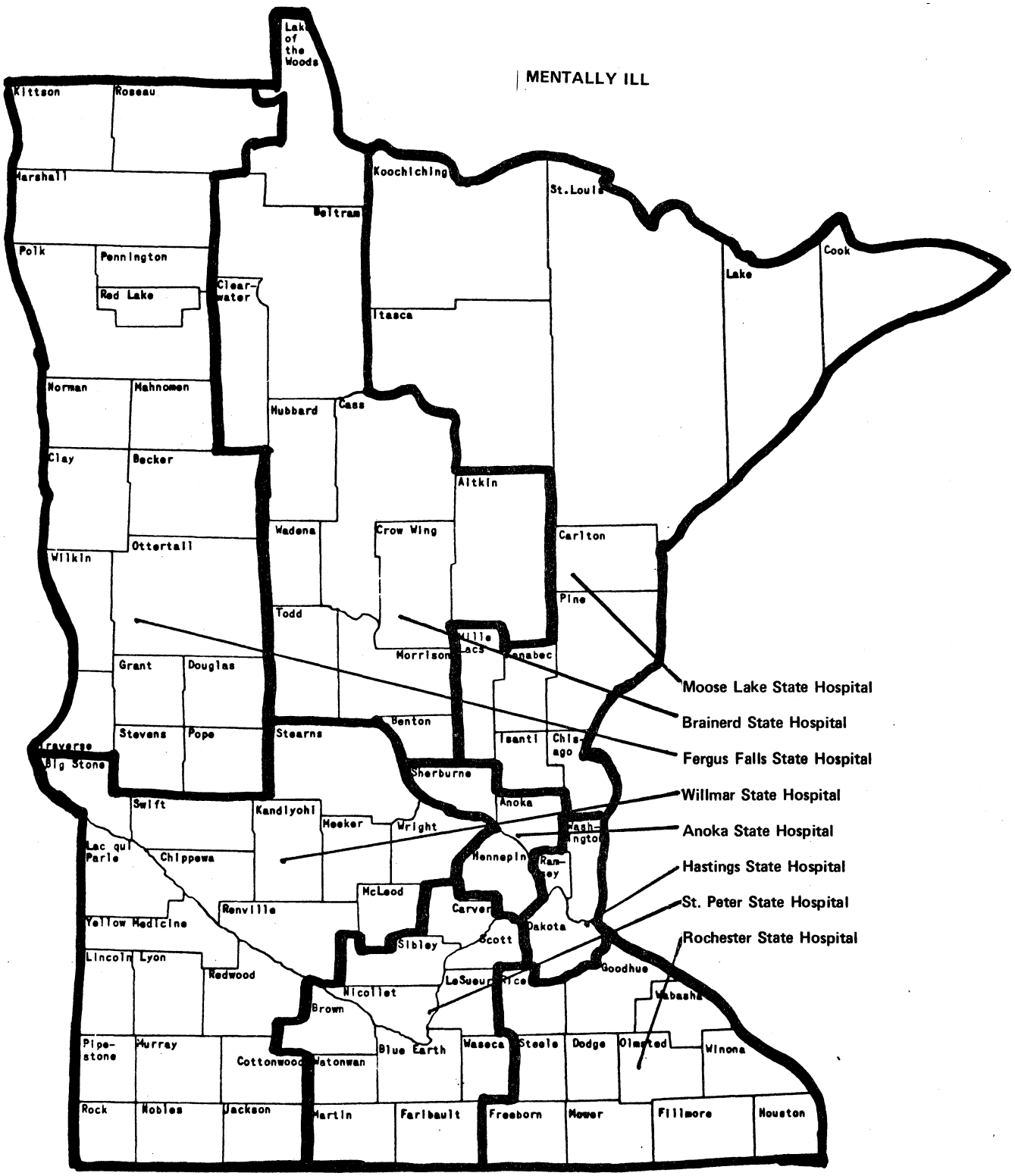
k. Pre-Petition Screening: The three most populous counties, and a number of rural counties in Minnesota, have established pre-petition screening units as part of their civil commitment procedures. County social service agency staff provide the screening, sometimes using community mental health centers and staff to provide alternatives. Their purpose is to avoid unnecessary and inappropriate commitments to mental hospitals by providing pre-petition counseling, case investigation, and exploration of less restrictive alternatives.

During the past two legislative sessions, the Department of Public Welfare has supported bills that would make pre-petition screening mandatory in every Minnesota county. These measures failed by narrow margins. Most of the opposition has come from the county (formerly probate) courts. Considerable work remains to be done with them before a bill can be drafted that can pass through the Legislature.

Accreditation Status of State Hospitals, as of June 1, 1977:

DISABILITY FACILITIES	FACILITY	ACCREDITATION STATUS	DATE OF ACCREDITATION
State Psychiatric Facilities	1. Anoka State Hospital	not accredited	--
	2. Fergus Falls State Hospital	2 years	8-75
	3. Hastings State Hospital	not accredited	--
	4. Moose Lake State Hospital	1 year	6-76
	5. Rochester State Hospital	2 years	1975-resurvey in process
	6. St. Peter State Hospital	1 year	(SPSH) survey in process
	7. Willmar State Hospital	2 years	10-75
	8. Brainerd State Hospital	1 year	7-76
Alcoholism Programs	1. Anoka State Hospital	not accredited	--
	2. Fergus Falls State Hospital	2 years	8-75
	3. Hastings State Hospital	not accredited	--
	4. Moose Lake State Hospital	1 year	4-76
	5. Rochester State Hospital	1 year	in process
	6. St. Peter State Hospital	1 year	in process
	7. Willmar State Hospital	2 years	10-75
	8. Brainerd State Hospital	1 year	6-76
Facilities for the Mentally Retarded	1. Fergus Falls State Hospital	2 years	10-75
	2. Moose Lake State Hospital	not accredited	--
	3. Rochester Social Adaptation Center	1 year	5-77
	4. Minnesota Valley Social Adaptation Center	not accredited	survey requested
	5. Glacial Ridge Training Center (Willmar S.H.)	2 years	10-75
	6. Brainerd State Hospital	not accredited	--
	7. Cambridge State Hospital	not accredited	--
	8. Faribault State Hospital	not accredited	--

HOSPITAL RECEIVING DISTRICTS



Because of the closing of the Hastings State Hospital on May 1, 1978, as directed by the 1977 session of the Legislature, it will be necessary, when the hospital closes, to make other assignments of the state hospital receiving districts for mentally ill and chemically dependent residents of Ramsey, Dakota, and Washington Counties. The Department has convened a meeting of the mental health center and social service agency directors to initiate discussion and local planning to prepare for these changes.

Protection of Employees' Rights:

The deinstitutionalization emphasis of P.L. 94-63 may reduce the need for institutional personnel in the state, although that is quite unlikely in the foreseeable future. In fact, the 1977 session of the Legislature has authorized the Department to transfer the staff compliment of the Hastings State Hospital to the remaining hospitals when Hastings is closed. In addition, the Legislature authorized an additional 100 employees for the state hospital system. The State Mental Health Plan provides a description of what equitable arrangements will protect the interest of employees of such institutions. Such arrangements should include, but are not necessarily limited to, preservation of employees' rights and benefits, training and retraining for other types of employment and, to the extent possible, guarantees of comparable employment.

At the present time, the 10 state hospitals in Minnesota have a population of approximately 5,250 patients/residents. The projected average daily population for Fiscal Year 1977-78 is estimated to be 5,300 patients/residents. The Department of Public Welfare continues to develop alternatives to state hospital treatment, care and services. Accordingly, it seems reasonable to project that population at the state hospitals will continue to decline. Given the cost of developing alternatives to state hospital care and service, however, we do not anticipate a gross change in the next three (3) - four (4) years. Accordingly, it appears reasonable that in Minnesota we anticipate an average daily population of approximately 4,950 by July 1, 1979. With such a projection in mind, and recognizing the state hospital system must stand ready and able to respond to community needs if crises arise, we project that the hospital system should maintain approximately 5,500 licensed beds (we are projecting an average of 90% utilization at each of the state hospitals - the other 10% is for crisis and/or unforeseen circumstances which might occur/arise).

The following projection, through 1981, reflects remodeling that is currently planned to upgrade facilities to meet all regulatory codes and licensing regulations:

Minnesota Department of Public Welfare
Residential Services Bureau May 26, 1977*

	Population (Average for April, 1977)	Maximum Potential after all Remodeling is completed to conform to existing codes (1980-1981)
Anoka	340	352 + 25 Functional Hospital Beds
Brainerd	649	825 + 17 Functional Hospital Beds
Cambridge	594	590 + 20 Functional Hospital Beds
Faribault	886	850 + 35 Functional Hospital Beds
Fergus Falls	533	646 + 10 Functional Hospital Beds
Hastings	115	-----
Moose Lake	434	627 + 13 Functional Hospital Beds (Includes converting the dormitory into 40 CD beds.)
Rochester	488	410 + 4 Functional Hospital Beds + 184 Beds for Security (Security includes actual and planned remodeling.)
Willmar	587	633 + 30 Functional Hospital Beds
	5204	5474 + 258 + 184 Security

* Represents present planning

In light of the estimated population-licensed bed projection reflected above, we do not foresee any sizeable reduction in the work force now employed at the state hospitals. For the biennium 1977-79, we have an authorized legislative complement of 5,454 positions. With the ever-increasing demands placed upon staff at our state hospitals (more rigid regulatory requirements), and with the state hospital system being called on to serve the more difficult patient/resident, we anticipate that the reduction in staff at the state hospitals from the existing authorized complement will be minimal, if at all.

In the future, state hospital employees, because of their background, training, skill and expertise, may be called on to serve in a greater degree to bolster community programs. Personnel policies of our state are such that such use of state hospital employees can be encouraged, while at the same time protecting the employee's rights and benefits. In this respect, also, the Department of Public Welfare is authorized to retain employees over the authorized complement if a unit or units of a state hospital closes. Such authorization is specifically directed toward protecting the rights of the individual employee.

Even though reduction in staff at state-operated facilities is not contemplated in the immediate future, efforts have and are being made to effect statewide personnel policies, and practices which provides for flexibility and continuity of employment for individual employees to provide a continuum of care. Their efforts include, but are not limited to, the following:

-Work of the Department sponsored Classification Committee: A Committee established in August, 1973, to study job classifications utilized within the public and private sector. The Committee participants included representatives from the state hospital system, private sector providers of service, State Personnel Department, statewide associations and union representatives. The study effort was to focus on recommending and helping effect uniform and comparable job definitions. One tangible result of the Committee's work effort was the consolidation of a number of specific classifications into a definable career ladder construct. Although the career ladder construct has not, as yet, been effected for all classifications within the system, the principles have been recognized by the State Personnel system with adherence to such principles now reflected in existing union contracts.

-Legislative presentations have been made by the State Personnel Department, the Department of Public Welfare, and union officials, outlining various options that could be adopted by the state to further effect flexible personnel practices and to protect the rights of individual employees. Presentations have included such options as early retirements with retirement benefits providing for retention of employee fringe benefits as an employee might move from and to employment with municipal, city, county and state government.

-Ongoing meetings with union officials occur directed toward developing agreements and understandings in regard to protecting the rights of employees.

-An interim legislative committee was appointed and has held numerous meetings in the summer of 1976 in the broad subject of deinstitutionalization--its meaning, problems associated with it, quality of service being provided within the state, effect on patients/residents, effect on employees and numerous other associated issues. A Committee report was presented to the 1977 Legislature.

Efforts such as those described above have resulted in specific legislative action, as well as personnel policies directed toward flexible personnel practices which protect the employee's rights and benefits. Examples of actions taken to protect employees are reflected in the recent legislative actions:

> "Notwithstanding any law to the contrary, when institutions of the department of public welfare or the department of corrections are consolidated, the commissioner of personnel and the commissioner of administra tion shall direct the department incorporating the consolidation and all other departments of the state of Minnesota to employ the affected employees at no loss in salary."
>
> "The commissioner of personnel is hereby directed to temporarily suspend any rules, regulations, or laws to accommodate these provisions. Any department which employs any of the affected employees is authorized to temporarily exceed its approved complement. The commissioner of administration shall develop procedures to insure that the moving expenses are reimbursed for those employees who relocate pursuant to the consolidation."

The 1977 Legislature Conference Bill, Section 17, provides, in part as it pertains to the closing of the Hastings State Hospital, the following:

> "All affected employees of the Hastings State Hospital shall continue employment in the department of public welfare or they may voluntarily accept employment in another state department, with no reduction in salary or other benefits. The commissioner of personnel shall reimburse employees who relocate for all legitimate expenses incurred in relocation.
>
> "Notwithstanding any other law an employee who waives his right to transfer to a hospital other than Hastings State Hospital or other state employment shall be entitled to severance pay in the amount equal to five percent of the employee's base salary or wage, not to exceed $500, multiplied by the number of years in state service, but in no case shall the total amount exceed $3,000."

6. County Welfare - Social Service Departments:

In Minnesota, the county welfare departments have been assigned certain statutory responsibilities for mentally ill persons over a period of years, dating back to 1953:

1. The county welfare departments have been responsible to see that persons with mental illness problems who are eligible for benefits under the Social Security Act get those benefits;

2. The Minnesota Hospitalization and Commitment Act requires the county welfare department to submit a social history on each committed person;

3. The Minnesota Hospitalization Act, 253.15, Subdivision 12, requires participation of the county welfare boards and community mental health centers in the predischarge planning and required them to assist the individual in his/her adjustment within the community and to see to it that needed resources are made available to enhance the probability of a successful adjustment.

The Department of Public Welfare regards this responsibility as one of case management. That is, the county welfare department is responsible for seeing to it that a plan is developed, with the hospital, and to the extent possible, with the patient, which combines the best possible array of resources available for him/her. This may be accomplished by individual counseling, participation in an integrated aftercare program provided by team members from other agencies, the provision of a place to live, assistance in finding employment, etc.

The responsibilities assigned to the county welfare department by statute focus on those individuals with existing statutorily defined problems. The county also has the continuing responsibility for the overall plan for each individual. The county welfare department is important in the aftercare program, as it focuses on the adjustment and well-being of the previously hospitalized patient and the linking of the patient of the various resources.

For county welfare departments to perform their responsibilities, they must maintain regular communication with community mental health centers, state hospitals and support services such as: public health nursing, vocational rehabilitation, education, employment offices, etc.

The Department supports, through use of part of its allotment of federal mental health (Section 314(d)) funds, the activities of two Staff Development persons who work with the counties. Their emphasis is on developing, in county staff, the skills necessary to carry out these responsibilities. Also, in 1977, the Department published a practice handbook for county staff who have mental health responsibilities.

When the Minnesota Hospitalization and Commitment Act was passed in 1967, an original requirement in the bill of mandatory pre-petition screening was modified to require only that the county welfare department submit a social history on persons subject to a commitment petition. Several attempts since that time to get the original intent included in the law have not been successful.

The three major urban counties and a number of the smaller counties have voluntarily initiated pre-petition screening. The Department has encouraged this development, pending the building of consensus of support for mandatory legislation.

7. Community Mental Health Center Programs:

Minnesota's enabling legislation for the establishment of community mental health programs was passed in 1957. By 1969, the last three counties in the state had made arrangements to participate in community mental health programs, making a total of 26 community mental health programs in the State of Minnesota. These programs are locally administered and they have a contractual agreement with the Commissioner for each fiscal year. They are assigned responsibilities for mental health, mental retardation and chemical dependency. The programs are funded by means of a grant-in-aid mechanism, and receive up to 50% of state funds appropriated by the state Legislature for the specific purpose of their operation. (See Appendix for development and location of community mental health programs.)

The Community Mental Health Act assigns these programs responsibility for the following activities:

1. Development of an area plan for mentally ill (MI), mentally retarded (MR), and chemically dependent (CD) populations.
2. Collaborative and cooperative services with public health and other groups for programs of prevention of MI, MR and CD.
3. Information and educational services to the general public, lay and professional groups.
4. Consultative services to schools, courts, health and welfare agencies, both public and private.
5. Outpatient and diagnostic services.
6. Outpatient treatment services.
7. Rehabilitative services for MI, MR, and CD disorders, particularly those who have received treatment in an inpatient facility.
8. Detoxification services and treatment services for (alcohol and drug) CD population.
9. Evaluation of program.
10. In-service training for personnel.

The Minnesota Hospitalization and Commitment Act includes community mental health centers in its definition of hospitals. This definition provides that individuals may be committed to a community mental health center.

Som distinguishing characteristics of the state community mental health programs are:

1. The community mental health program has multidisciplinary professional staff with mental health expertise, as do the state hospitals. Standards for community mental health centers are found in DPW Rule 28. (See Appendix.)

2. Community mental health center boards are required to address the problems of mental illness on two levels. One is the level of programs addressed to populations, reducing the prevalence and incidence of mental illness. The other is services focused on individuals and groups (including families), which are designed to carry out the mental illness programs and which are not otherwise available. (See Minnesota Statutes 245.61.)

These responsibilities include:

a. Development of the plan for the area.
b. Provision of collaborative and cooperative services with other groups for programs of prevention.
c. Provision of information and educational services to general public, and lay and professional groups.
d. Provision of consultative services to the public and private health and welfare agencies, schools and courts.
e. These programs also are assigned outpatient diagnostic and outpatient treatment responsibilities.
f. They are assigned planning and coordination responsibilities for target populations that include publicly-defined mental illness, as well as the portion of the mentally ill target population needing direct services which are not available elsewhere.
g. They are assigned primary and secondary prevention activities, in addition to the tertiary prevention activities.

3. Another distinguishing factor of the community mental health programs is the requirement of a minimum population base for service delivery. The Minnesota law requires a minimum population base of 50,000; federal standards call for a base of 75,000.

The requirements of a minimum population base provides a practical approach to establish and maintain a comprehensive mental health program which provides a continuum of preventive, diagnostic, treatment and rehabilitative services to be provided in nonresidential, partial residential and residential services which offer varying amounts of care and support, depending upon the individual's needs.

A spectrum of rehabilitative and supportive services helps to improve functioning and promote recovery. Services must be specific to individual needs. They must also be responsive to the varying types and degrees of stress and dependency. Since the needs of troubled individuals do vary from time to time, services should be available that respond to these changing requirements.

4. Six (6) of the state funded community mental health programs are also federal-style comprehensive community mental health centers and are receiving, or have received, Federal Community Mental Health Center Staffing/Operations Funds and meet Federal Alcohol, Drug and Mental Health Administration (ADAMHA) requirements. Two (2) programs have federally funded staffing grants for children's mental health services. These programs are identified on page 39.

The State of Minnesota has never adopted a policy that every area or region should be served by a comprehensive center, based on the premise that this decision should be made locally. The Department assists local areas in qualifying for federal funds when there is interest in doing so.

Monitoring is currently done for the comprehensive centers through a combination of site visits by state and Regional Office staff, annual reports and budgets, plus those mechanisms required of all local boards receiving state matching funds; i.e., annual grant-in-aid proposals and quarterly reports. Once a revised version of Rule 28 has been adopted, the Department intends to do on-site monitoring of all local mental health programs, using Rule 28 as the standard of performance.

In the section on Human Service Integration, it is noted that three (3) counties have withdrawn from their original participation in human service boards. Arrangements are being made for them to qualify for state matching funds and to purchase mental health services from neighborhing area/human service boards. The affected counties are Waseca, LeSueur, and Sibley.

FEDERAL MODEL COMPREHENSIVE COMMUNITY MENTAL HEALTH PROGRAMS
AND RESIDENTIAL AFFILIATES

COMMUNITY MENTAL HEALTH PROGRAMS	LOCATION	RESIDENTIAL AFFILIATE	CAPACITY
Central Minnesota	St. Cloud	St. Cloud Hosp./2W	30
Hennepin County MH/MR	Minneapolis	Henn. Co. Gen. Hosp.	20
		Metropolitan CMHC	109
Northeast Area MH/MR/I (children's program)	Duluth	St. Louis County Crisis Shelter (children & youth)	20
		Bethany Home	44
		Northwood (children)	36
		Woodland Hills (children)	45
		St. Luke Hospital	50
		Miller Dwan Hospital	20
		Comm. Memorial Hosp.* Cloquet	
		Lakeview Memorial Hosp.* Two Harbors	
		Cook Co. Community Hosp.* Grand Marais	
Northland Area MH/MR/CD Program	Grand Rapids	Itasca Memorial Hospital Grand Rapids**	10
Northwestern MHC	Crookston	Northwestern Hospital Thief River Falls	10
Range Area Human Resources	Virginia	Hibbing General Hosp. Virginia General*	15
West Central Community Service Center	Willmar	Hutchinson Comm. Hosp. Hutchinson	12
		Rice Memorial Hosp. Willmar	19
Washburn Child Guidance	Minneapolis	University Hospital* Henn. Co. Medical Center Minneapolis	
Zumbro Valley MHC	Rochester	Rochester State Hospital	

*These hospitals have agreements to accept patients. However, the agreements do not designate a number of beds.

**Opening November, 1977.

Service Needs of Special MI Target Populations

In addressing service needs, special attention must be paid to target population subgroups whose needs are specific to their age and particular problems, These groups include children and the elderly as well as the general MI population.

The following description of service needs directs itself to subgroups within the MI population: children and youth, aging, and MI offenders.

1. Services for Children and Youth: There is a rising social consciousness about the strange, tragic and severely handicapping mental illnesses of early childhood. There are still pitifully few services and still fewer appropriate services available.

   Mental health problems do not occur overnight. The manifestations of these problems appear as a result of what one may call unsuccessful attempts at coping with one's environment. Many mentally ill or emotionally disturbed or even poorly adjusted adults were, at one point in their lives, emotionally disturbed children. The situations and problems which these children encounter during their growing up years contributed to the problems which these persons face now as adults.

   Particular Service Needs for Children and Youth: Minnesota has achieved success in the development of its community mental health programs; however, there is need for considerable more expansion and development to make the continuum of care for children and the elderly a reality in each area.

   The community mental health programs have good potential for the delivery of mental health services for children, along with other public and private agencies. There is need, at the state and area level, for planning development, implementation and coordination with appropriate departments, agencies, organizations and resources to bring about a full continuum of care and treatment and linkage with appropriate supportive services for children.

   An emotionally disturbed child is defined in the 1970 Report of the Joint Commission on Mental Health of Children as:

   > "one whose progressive personality development is interfered with or arrested by variety of factors so that he shows impairment in the capacity expected for him for his age and endowment in: 1) reasonable accurate perception of the work around him; 2) for impulse control; 3) for satisfying and satisfactory relations with others; 4) for learning; 5) any combination of these."[3]

[3] Report of the Joint Commission of Mental Health of Children, Harper and Row, 1970, p. 253-254.

The Commission estimated the incidence of mental and emotional disorders among children as: .6% of the nation's children are psychotic; 2-3% are severely disturbed; and an additional 8-10% have emotional problems such as neurosis serious enough to require treatment. The Commission estimated that only 5-7% of those needing psychiatric help are receiving it.

Data is not available on the incidence of mental illness among children in Minnesota. Information regarding the mental health services for children has been presented in regard to residential or hospitalization resources. While the community mental health centers serve children and their families, the amount and kinds of service vary. Two of the programs have NIMH staffing grants for children. There are a few specialized children's mental health clinics in the state.

There is need to develop a plan and continuum for children's mental health programs. The continuum should contain the following specific services for children:

Inpatient and/or residential treatment services;
Intensive partial hospitalization or residential programs, including services such as day treatment, specialized classes for disturbed children, evening care, etc.,
Emergency services;
Diagnostic and assessment service providing initial evaluation, follow-up and aftercare;
Consultation and educational services;
Transitional care programs such as group homes;, halfway houses, foster homes and social rehabilitation programs.

Some of the essential supportive services are:

Head Start programs
Day care programs
School, including, but not limited to, special education
County social service departments
Public health nursing agencies
Recreational groups
Neighborhood houses
Correctional facilities
Probation and juvenile officers

Children's Hospital in Minneapolis has a unique approach which involves particular attention to emotional needs of the child while he/she is hospitalized for various physical reasons. This program fosters involvement of parents during the child's hospitalization.

There are 16 residential treatment centers for emotionally disturbed children. These centers are located throughout the state, with the exception of the southwestern portion of the state.

Residential treatment centers may be considered a primary resource for residential treatment for children in the state. They care for approximately 600 children. Some private hospitals also provide specialized mental health programs for children and youth. Willmar State Hospital and Rochester State Hospital also operate an adolescent unit.

The specialized chidlren's mental health programs providing services to nonhospitalized are limited. These include Washburn Child Guidance Clinic in Minneapolis and (Wilder Clinic) Disenmenger School in St. Paul. The St. Paul School District #625 also has a specialized program for preschool children.

2. Services for the Aging: Older persons, growing as a population group, are increasingly becoming aware of and vocal about their economic, health, and social needs. They are developing and maintaining interest groups and senior coalitions, and are raising the consciousness of professionals and the total population to the special problems and needs of the aging. One of these special problems is meeting their mental health needs.

Mental health services for this population group have been available in the various private and public delivery systems in Minnesota. Data is not readily available as to the extent of the needs of the aging and it is not known how adequately the current system works in supplying their needs. This data should be located and collected. Attention should be focused on coordination and cooperation between the various service providers in planning, developing and implementing mental health services for the aging.

State mental hospitals have been and are providing for mental health care of older persons, and older patients are being moved out into community mental health programs. There is a group of patients who, because of chronic illness and behavioral problems, are difficult to place in the community. Therefore, the phase-out of state hospitals should proceed on a coordinated schedule with a phasing-in of appropriate alternative community resources.

The efforts to decrease the elderly census in a state mental hospital should continue in the context of a fully developed community supportive services package.

Many of the older residents of state mental hospitals needing long-term care are placed in nursing homes: Intermediate Care or Skilled Nursing Facilities. These nursing homes meet the required standards for those classifications in order to be certified by the Health Department for those purposes. Many of the standards are based upon federal regulations so the providers of service will be eligible vendors of services to receive federal funds.

The aging need to be part of their community as long as they can be maintained in their own homes. The 1976 Minnesota Legislature passed legislation authorizing the use of Title XIX (Medicaid) funds

for public health nursing services for this purpose. It is equally important for the community to have interaction with its aging population. For those persons who do not require nursing home care, a full range of services to assist them in remaining in their homes and in the community are vital. Older persons, finding themselves depleted in self-concept, health, finances, and capabilities of all kinds (and facing negative societal attitudes toward aging) often are isolated, lonely and hopeless.

Community mental health centers are in an excellent position to provide comprehensive services to the elderly. In addition, many are consultants to nursing homes and other community support services in developing training programs which will result in increased treatment skills. One goal can be to achieve positive staff attitudes in treating the aged.

FACILITIES LICENSED UNDER DPW RULE 36 (ADULT MENTALLY ILL)

APARTMENT LIVING PROGRAM
MULTI-RESOURCE CENTERS
727 Fifth Avenue South
Minneapolis, MN 55415
Hennepin County-Region 11 W
16 Residents, 18 years & over
Director: Russ Stricker
612/871-2402

BIRCHWOOD CARE HOME, INC.
715 West 31st Street
Minneapolis, MN 55408
Hennepin County-Region 11W
55 MI Residents, 5 MR Residents,
18 years & over
Director: Dave Dakken
612/823-7286

HEWITT HOUSE
1593 Hewitt Avenue
St. Paul, MN 55104
Ramsey County-Region 11E
22 Residents, 18-35 years
Director: Rev. Donald Bump
612/645-9424

HOPE TRANSITION CENTER, INC.
1471 Como Avenue
St. Paul, MN 55108
Ramsey County-Region 11E
40 Residents, 18 years & over
Director: Harriet Grinstead
612/644-7961

HORIZON HOME
306 Byron
Mankato, MN 56001
Blue Earth County-Region 9
11 Residents, 18 years & over
Director: Evelyn Dawley
507/388-4468

HUTCHINSON COMMUNITY HOSPITAL
Mental Health Unit
Hutchinson, MN 55350
McLeod County-Region 6
12 Residents, 16 years & over
Director: Thomas Olson
612/896-1665

LEE'S BOARDING HOME
2623 West Fourth Street
Duluth, MN 55806
St. Louis County-Region 3
12 Residents, 30-60 years
Director: Lawrence E. Lee
218/722-9887

MERRITT HOUSE
P.O. Box 470
Biwabik, MN 55708
St. Louis County-Region 3
23 Residents, 18-55 years
Director: David Salsman
218/865-6743

MIKETIN'S PINE BOARDING & LODGING HOME
102 West Gary Street
Duluth, MN 55808
St. Louis County-Region 3
40 Residents, 20 years & over
Director: Frank Miketin
218/626-1459

LOTTIE PAYNE GROUP HOME
Box 291
Deer Creek, MN 56527
Otter Tail County-Region 4
6 adult males
Director: Lottie Payne
218/462-2280

PINE VIEW ENTERPRISES, INC.
P.O. Box 236
Soudan, MN 55782
St. Louis County-Region 3
42 Residents, 35 years & over
Director: Kenneth Pointfield
218/753-5876

RICE MEMORIAL HOSPITAL
Mental Health Unit
402 West Third Street
Willmar, MN 56201
Kandiyohi County-Region 6
19 Residents, 14 years & over
Director: Ralph Johnson
612/235-4543

RIVERVIEW HOMES, INC.
Star Route
Brookston, MN 55711
St. Louis County-Region 3
30 Residents, 30-60 years
Director: Patricia Maki
218/453-4163

ST. FRANCIS HALFWAY HOUSE
Box 75
Atwater, MN 56209
Kandiyohi County-Region 6
13 females, 18 years & over
Director: Robert McLaughlin
612/774-8850

WILLMAR STATE HOSPITAL MI UNIT
Box 1128
Willmar, MN 56201
Kandiyohi County-Region 6
304 Residents, 18 years & over
Director: Ted W. Olson
612/235-3322

CONSTANCE BULTMAN WILSON CENTER
14th Street at Shumway
Faribault, MN 55021
Rice County-Region 10
30 Residents, 14-25 years
Director: William Korff
507/334-5561

Preadmission Screening

P.L. 94-63 requires that community mental health centers provide assistance to courts and other public agencies in screening residents of the catchment area who are being considered for referral to state mental health facilities in order to determine the appropriateness of such referral. Screening is also designed to identify persons for whom treatment through the center is an appropriate alternative to inpatient care in a public mental institution.

This federal requirement is not counter to Minnesota Statutes. Currently, screening is not required by Minnesota Statutes.

The Minnesota Hospitalization and Commitment Act (253A.01-253A.21), Sec. 7, relating to Judicial Commitment, requires that a petition for commitment shall be accompanied by a statement from a licensed physician that he/she has examined the proposed patient and is of the opinion that the proposed patient is mentally ill, mentally deficient or inebriate and should be hospitalized; or with a written statement that, after reasonable effort, the petitioner has been unable to obtain an examination by a licensed physician; or that an examination could not be performed. This section also requires that a copy of the petition be sent to the county welfare department.

Subdivision 2, Section 7, further requires that the court appoint two examiners, at least one of which shall be a licensed physician. If the proposed patient is alleged to be mentally deficient, then one of the examiners shall be skilled is ascertainment of mental deficiency. If the proposed patient is alleged to be drug dependent, then it is required that one of the examiners be qualified in the field of alcohol and drug abuse. The statute is silent on this matter for the mentally ill.

Subdivision 7, Section 7, requires that the court direct the county welfare department to make an investigation into the financial circumstances, family relationships, residence, social history and background of the proposed patient and to submit the information, in writing, to the court for use and guidance of the state hospital.

Bills have been introduced the past two legislative sessions which would include mandatory screening for the mentally ill prior to commitment. Department staff will be conferring with members of the County Judges Association in the Fall of 1977 to begin discussion on a bill that would have the support of both the mental health providers and the courts.

8. Residential Facilities:

Rule 36 Facilities -

A long-standing problem nationwide is the lack of stable funding for community residential facilities for people with mental illness problems. In most states, including Minnesota, reliable funding is available for state mental hospitals and, for eligible individuals, for nursing home care.

Yet, many people who have had mental illness problems (including an estimated 40% of the 6100 diagnosed mentally ill residents in nursing homes, for instance), and are not yet ready to live independently, have little recourse.

To begin remedying this situation, the Department established its Rule 36 which provides program licensure of residential facilities serving adults who have had mental illness problems. This program licensure is complemented by facility licensure by the Health Department under its Supervised Living Facility (SLF) rule. These requirements, along with inspection by the fire marshal, assure that both the facility and its program have met minimum standards. Most states have minimum health and safety standards, but few also have additional program standards.

The Department has identified approximately 150 facilities as being potentially eligible for Rule 36 licensure. To date, 15 facilities have been licensed and 14 more applications are being reviewed.

As yet unresolved is the basic issue of ongoing state/federal funding.

Board and care facilities, most of which are located in the three (3) largest counties of Hennepin, Ramsey, and St. Louis, are supported by some combination of SSI, Minnesota Supplementary Assistance (MSA), or general relief funds. There is no provision from these sources to pay for program staff.

Two (2) Rule 36 facilities have received both maintenance reimbursement (not to exceed six months) and program reimbursement under Title XX (federal financial participation in approved social services). Because of limitations and some cutbacks in these funds, these two facilities may receive only programmatic reimbursement from this source in the future. If this happens, they will have to rely on the same sources as the board and care homes for maintenance costs.

Federal funding under Title XIX (Medicaid) is limited to facilities qualifying as Intermediate Care Facilities (ICFs). Title XIX regulations identify facilities serving more than 51% mentally ill persons as "institutions for nervous and mental diseases" and exclude them from Medicaid reimbursement. The existing federal regulations are also inappropriate for people not in need of nursing care and institutional living. Further, most adults between the ages of 21-65 are not eligible for Medicaid unless they are welfare clients, very poor, or eligible for SSI as permanently and totally disabled. Hopefully, President Carter's Commission on Mental Illness will address this national problem.

The Department has made the 1977 Legislature aware of this problem through a request for $1,900,000 for the deinstitutionalization of mentally ill people. Since an appropriation of $1,786,000 has been awarded, the Department will allocate $400,000 of it for partial subsidies to residential facilities licensed under DPW Rule 36 or otherwise eligible for such licensure if programmatic costs could be reimbursed. It is estimated, based on current costs of licensed facilities, that such care can be provided in the range of $20-$30 per person per day. Facilities with minimal daytime staffing where the residents' programs call for them to be gone during the day should be able to operate on less.

Until this problem, and the related one of adequate support services, are addressed by the Congress, state legislatures, and county boards, the successful reintegration and rehabilitation of mentally ill people will continue to be a disgrace. The Department regards these two problems as the most significant ones yet to be resolved for mentally ill people.

Nursing Homes:

The 1975 Quality Assurance and Review Program, performed by the Minnesota Department of Health, included individual patient assessments on each of the 28,000 Medicaid patients, out of a population of about 40,000, in 582 long-term care facilities.

The mental health related findings are summarized as follows:

1. The demographic characteristics of patients, when placed in subgroups and compared with Skilled Nursing Facilities (SNF) patients showed:

    a. Significantly more persons were admitted to Intermediate Care Facilities (ICF) -I and -II from homes or mental hospitals and less from acute hospitals.
    b. The length of stay was moderately longer.
    c. Fewer patients had relatives living within 20 miles.
    d. ICF-II patients were younger than ICF-I and SNF patients, within nearly three (3) times as many under age 65 and only about half as many over age 80.
    e. 21% of ICF-II patients (298) were admitted from a psychiatric hospital and 62% (737) had a diagnosis of mental disorder, 12% were mentally retarded and 23% had schizophrenia.

2. Data from the MI Addendum indicated:

    a. 87% of the MI subgroup had a history of mental illness prior to admission, 79% had been in a mental hospital and 92% of those previously hospitalized were in a state hospital.
    b. The mental illness was rated as severe in only 10% of patients, but 44% showed special behavior problems.
    c. A psychiatric evaluation had been recorded for 51% of the mentally ill patients, but the average length of time since the most recent evaluation was 54 months.

It is readily apparent that there is a marked need for stronger programs for mental health services in nursing homes where over 6,000 of the residents have a diagnosis of mental illness.

The profile of the ICF-I patient suggests that 15-20% of this group are quite like the ICF-II group. They have little competency in activities of daily living, need little or no nursing care, and have a high incidence of mental illness.

To relate the problems of mentally ill people in Intermediate Care Facilities with the total Medicaid population, data from SNF, ICF/MR and state institutions was analyzed. Fifth-four percent (54%) of all Medicaid patients in the

data sample had a diagnosis of mental illness. The following estimates were made to show the distribution of all Medicaid patients with mental illness:

Classified as SNF	23%
Classified as ICF-I	31%
Classified as ICF-II	7%
Classified as ICF/MR	14%
State ICF/MR	22%
State Mental Hospital	2%

It is apparent that the one of the serious problems in long-term care is the need for professional leadership to develop guidelines and methods for optimum placement and continued mental health services for the several kinds of mental illness. Some nursing home residents need institutional nursing services but others may not, particularly if program activities were available for them.

Many aspects of this situation are outside of the control of DPW; e.g., placements by individual physicians, lack of alternatives, lack of stable funding for alternative living arrangements, etc.

At the same time, the Department has taken the following steps:

1. Encouragement of county social service departments to use part of their allotments of Title XX Social Service funds to provide support services (chore, homemaker, transportation, etc.) to keep people out of nursing homes and living independently whenever possible.

2. Similar encouragement to the counties to use some of their allotments to purchase available residential treatment and halfway house services for people with mental illness problems when nursing care is not needed.

3. Continued encouragement of community mental health centers to provide consultation to nursing homes (DPW policy allows for payment of such services through Title XIX when reimbursement rates are established).

4. The Department intends to use the funds appropriated for Deinstitutionalization of the Mentally Ill to fund alternative residential facilities. The funds will be used to support crisis homes based on the experience of Southwest Denver Mental Health Services (described on page 37) and residential facilities eligible for licensure under DPW Rule 36. This will be a significant beginning in providing supervised living facilities for people who cannot live independently, but who do not need nursing care.

Halfway Houses:

Much of the material on Rule 36 facilities is also applicable here. Problems of financing short-term halfway house facilities are very similar to those of intermediate term residential facilities. The result is that there are no halfway houses exclusively for mentally ill people. Of the 60 halfway

houses for chemically dependent persons, most also admit mentally ill people, serving about 10% of them at any given time. They have a total capacity of 10 beds.

Department staff are consulting with the people planning to open Summer House, a 4-plex in Minneapolis, in January, 1978. They have been advised of the procedures for applying for 314(d) and state deinstitutionalization funds for Fiscal Year 1978. They are also negotiating with the Hennepin County Welfare Department for social service reimbursement. Summer House has the endorsement of the Hennepin County MH-MR-CD Department. The Health and Welfare Council of Hennepin County also endorses this proposal as another step in carrying out its impressive 1976 study of aftercare.

In the event that Minnesota qualifies for a NIMH grant for a Community Support Program (CSP), residential living facilities including halfway houses could very likely be a priority item. (See the section on Deinstitutionalization, pp. 26-30.)

Crisis Home:

Several Minnesotans, including two (2) Department staff, have visited the Southwest Denver Mental Health Services, Inc. and were positively impressed with the crisis homes operated there for the past 4 1/2 years.

The center contracts with individuals or married couples who are well established in their neighborhoods to take into their homes one or two people at a time who are experiencing serious mental illness crises. The couples are recruited, trained, and given 24-hour-a-day, 7-day-a-week, backup by center staff.

In Colorado, unlike Minnesota, community mental health centers serve a gatekeeper function for admissions to state hospitals. By using the crisis home effectively, the center generally does not exceed its contract with the state hospital for 120 bed days per year. With a catchment area of 105,000 people, and no inpatient psychiatric unit in the area, this means that the center meets its inpatient hospital needs with approximately one-third of a bed per day.

Because of widespread interest in this program, the Department invited two people directly involved in it to speak at an open meeting in St. Paul on April 29, 1977. Highlights of that meeting are as follows:

The emphasis of the entire program is on prompt and effective crisis intervention. A minimum of counseling is done in center offices, for instance. Staff are encouraged to meet with clients and the significant other people in their lives in homes, places of work, etc., where the problems are occurring.

This approach of interviewing in the least disruptive way possible carries over into residential care and treatment for those people who do need it. Instead of routinely hospitalizing such people, the center places them in the sponsor's home for an average time of about 10 days.

Tranquilizing medications, prescribed by center psychiatrists, and monitored by center psychiatric nurses, are often used heavily the first few days a person is in one of the homes.

Center staff are convinced that most people needing acute psychiatric care do not have something inherently wrong with them but rather fail to cope effectively with social or personal crisis when they occur.

The efforts of the center staff, volunteers, and home sponsors are directed to teaching people how to cope better with crises or separations. Usually, this means dealing with the other significant people in the client's social system so that he or she can promptly reenter that system on a different basis.

Evidence gathered so far indicates the homes are most effective in a first crisis, moderately effective in a second one, and about as effective as a hospital for a person going through the third (or more) crisis.

The 75 or 80 attending the meeting were generally positively impressed. Some wondered how to make the approach work in a less densely populated rural area.

The presenters stressed that the center and its state hospital, Fort Logan, have moved beyond earlier competitiveness. Both now recognize that they need each other and that each can make a unique contribution to the care of mentally ill people.

9. Human Services Integration:

The 1973 Minnesota Human Services Act, as amended in 1975, which permits one (1) or more contiguous counties having more than 50,000 population to form human service boards, resulted in the creation of four (4) local boards, all in South-Central Minnesota.

Scott County has the most completely integrated human services agency, providing under its own auspices, mental health, mental retardation, social service, public health, and corrections functions. It contracts for subacute detoxification services from a neighboring facility.

The Faribault-Martin-Watonwan Human Service Board provides mental health services for residents of Faribault and Martin Counties, and purchases them for residents of Watonwan County from the Sioux Trails Mental Health Center in New Ulm.

Sibley County withdrew from its human service board agreement with Brown and Nicollet Counties. The director of the Brown-Nicollet Human Service Board is also the director of the Sioux Trails Mental Health Center, which serves all three (3) of these counties.

Waseca and LeSueur Counties have withdrawn from their human service board agreement with Blue Earth County, which has reconstituted its own human service board. The Blue Earth Human Service Board is the area board and appli-

cant for state matching funds for the Minnesota Valley Mental Health Center, Mankato, which will continue serving LeSueur County under contract. Because state law requires area mental health board boundaries to conform to those of the state's economic regions, Waseca County, which is in Region X, will continue to contract with the Luther Youngdahl Human Relations Center, which is in Region IX.

Otter Tail County, in Northwestern Minnesota, has obtained legislative authorization to establish its onw single-county human service board.

The County has drafted a proposal for the approval of the State Departments of Welfare, Corrections, and Health. Once approved, the Otter Tail County Human Service Board will contract with the Lakeland Mental Health Center, Fergus Falls, for mental health, mental retardation, and chemical dependency services. Currently, Otter Tail receives these services from Lakeland as a participating county. Creation of the new human service board will affect the flow of state matching funds, but not the provision of services. Otter Tail County's Human Services Board will begin operation on July 1, 1977.

The State Office of Human Services has studied the issue of integration at the state level and has recommended the creation of two state agencies, one concerned with human service systems, including mental health, and the other concerned with financial assistance, which would include the Department of Public Welfare Income Maintenance Bureau, Vocational Rehabilitation, and Unemployment Compensation.

As a result, two (2) bills carrying out these recommendations were introduced into the 1977 Legislature. The bill relating to financial/vocational assistance passed on a modified scale. It draws together, effective July 1, 1977, the Division of Vocational Rehabilitation, the Department of Employment Services, and the Governor's Manpower Office. The Department of Public Welfare's Income Maintenance Bureau (which includes the management of Medicaid funds) will not be included in the new department at this time.

The proposal to combine human service agencies will be carried forward to the 1978 session for further study.

10. Coordination of Planning:

The Department is engaged in a variety of planning activities, due to its manifold responsibilities and to its necessary relationships with other organizations. Described herein are those coordination efforts most pertinent to mental health.

a. Health Planning. Late in 1976, the Governor appointed the members of the Statewide Health Coordinating Council (SHCC), as required by P.L. 93-641. The Council is currently developing its work plan and becoming familiar with its responsibilities.

   Staff support for the SHCC is provided by the Health Planning Section of the State Planning Agency. Mr. Steven Mosow, Assistant Director of that office, is a member of the State Mental Health

Advisory Council and provides coordination between his office and the Mental Health Program Division. Mrs. Harriet Mhoon, Chief Social Worker at the Anoka State Hospital is also a member of both the State Mental Health Advisory Council and of the SHCC.

While the SHCC does not yet have review and approval over health-related plans, such as this one, the Department will submit it to the SHCC for review and comment prior to formal submission to the federal government. This review was held at the June 15, 1977 meeting of the SHCC.

During Fiscal Year 1978, the Department and the State Planning Agency will negotiate an agreement regarding mutual responsibilities in carrying out P.L. 93-641 and P.L. 94-63.

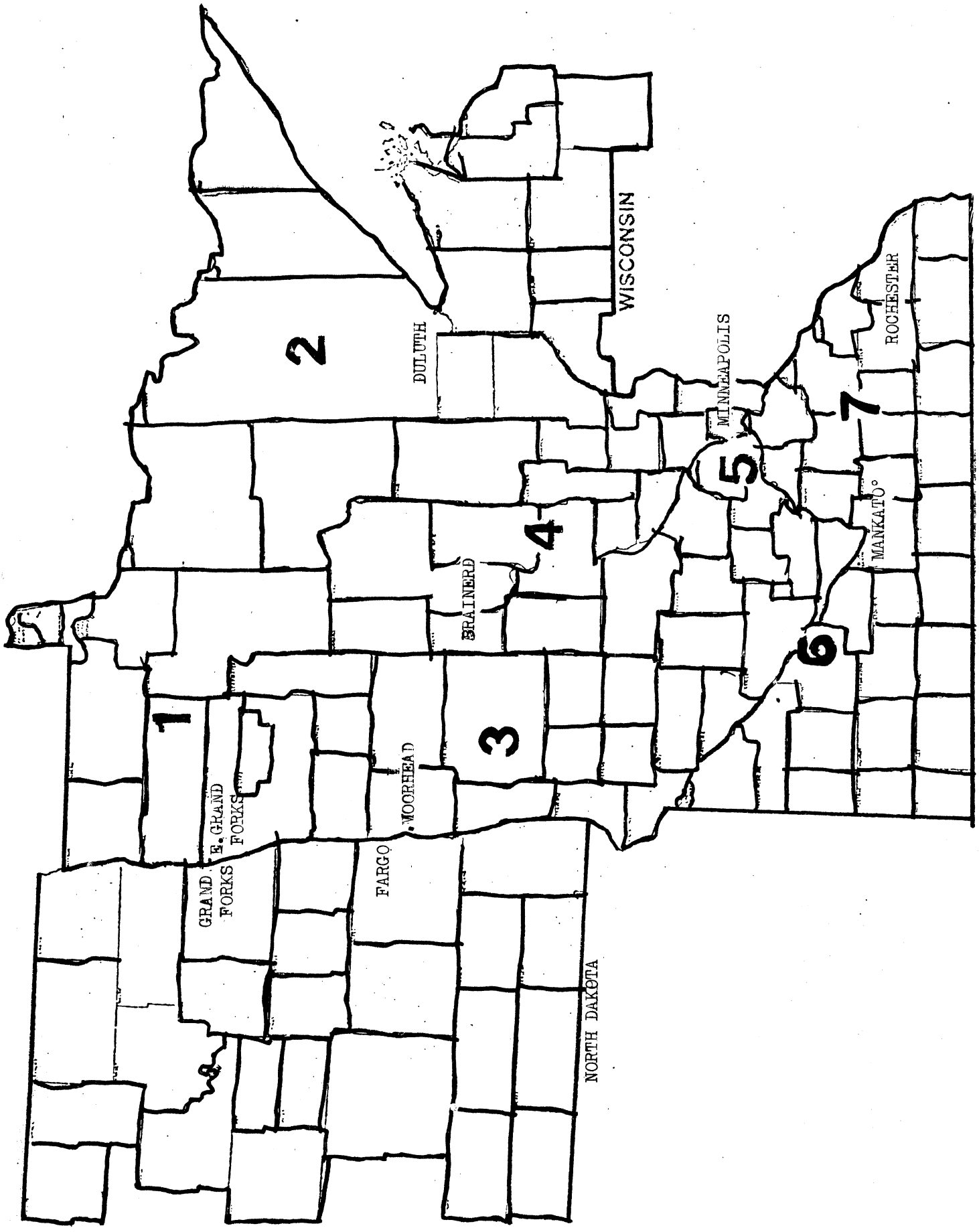
b. Alcohol and Drugs. In Minnesota, these two (2) state level responsibilities have been combined for several years into the Chemical Dependency Program Division. Like the Mental Health Program Division, the Chemical Dependency Program Division is part of the Community Services Bureau of the Department of Public Welfare.

As a result of their proximity to one another, and their mutual interests, the two (2) Divisions work closely together in a number of areas. Each provides review and comments on drafts of the other's State Plan. Both are currently participating in the revision of DPW 28, which governs the Department's relationships with the area boards/community mental health centers. Since both Divisions have specific responsibilities to evaluate components of their delivery systems, they are collaborating, where feasible, in designing their evaluation instruments. The directors of both Divisions meet regularly with their peers and the Assistant Commissioner of Community Services. Currently, they are formulating together Division and Bureau goals for Fiscal Year 1978.

c. Title XX. The Division of Social Services which administers the Title XX Plan governing federal financial participation in approved social services is also part of the Bureau of Community Services.

Currently, the State Title XX Plan includes mental health services with general health services. At the request of the Mental Health Program Division, Mental Health Services will have a separate designation in the Fiscal Year 1978 Plan.

HEALTH SERVICE AREAS FOR THE STATE OF MINNESOTA



GENERAL HOSPITALS IN MINNESOTA
WITH PSYCHIATRIC UNITS

REGION	NAME & LOCATION OF HOSPITAL	CAPACITY
I	Northwestern Thief River Falls*	10
II	None	
III	Miller Dwan Duluth	21
	St. Luke's Duluth	40
	St. Mary's Duluth	34
	Hibbing General Hibbing*	10
	Itasca Memorial* Grand Rapids	10
IV	St. Ansgar's Moorhead	28
V	None	
VI	Hutchinson Community Hutchinson*	12
	Rice Memorial Willmar*	18
VII	St. Cloud St. Cloud*	29
	St. Cloud Veterans Adm. St. Cloud	561
VIII	None	
IX	Immanuel-St. Joseph's Mankato	26
X	Rochester Methodist Rochester	68
	St. Mary's	50
XI	St. Mary's Minneapolis	59
	**Fairview Minneapolis	75
	**University of MN Minneapolis	65
	Metropolitan Minneapolis	115
	**Abbott Minneapolis	81
	Northwestern Minneapolis	25
	**Golden Valley Health Center Minneapolis	177
	North Memorial Minneapolis	22
	*Hennepin County Gen. Minneapolis	20
	Veterans Adm. Minneapolis	61
	**Ramsey St. Paul	64
	**Miller United St. Paul	59
	Mounds Park St. Paul	49
	St. Joseph St. Paul	44

*Affiliated with Community Mental Health Center
**These Hospitals also have special units for children. Information obtained by telephone survey and Metropolitan Council Health Board data.
***Opening about November, 1977

V - Catchment Area Mental Health Program

A. Catchment Areas:

Minnesota enabling legislation for the establishment of community mental health programs was passed in 1957. By 1969, all counties in the state had made arrangements for community mental health services. The state is currently divided into 26 community mental health programs. However, the two largest metropolitan counties, Ramsey and Hennepin, are further subdivided into five and eight planning areas respectively, which makes a total of 36 mental health catchment areas within the state.

Community mental health programs receive state funding through the grant-in-aid mechanism. The Community Mental Health Services Act provides for state funding up to 50% of eligible budget per fiscal year. State funding is not provided for inpatient services. Grants-in-aid awards are made to each community mental health board based upon the approved plans and budgets. In Hennepin and Ramsey counties, a single award is made to the respective Community Mental Health Boards; and funds are distributed for service delivery within the various planning areas. The submitted plans and budgets identify the distribution of state funding.

The grant-in-aid mechanism functions as a contractual agreement between the Commissioner of Welfare and the community mental health programs.

The responsibilities ascribed by state statute to the community Mental Health programs are identified on page 185.

There is a difference in minimum population base between state and federal stipulations. The state minimum is 50,000, and the federal minimum base is 75,000 population.

Population Exceptions:

Six of the current designated catchment areas are below the federal base of 75,000 population. These are:

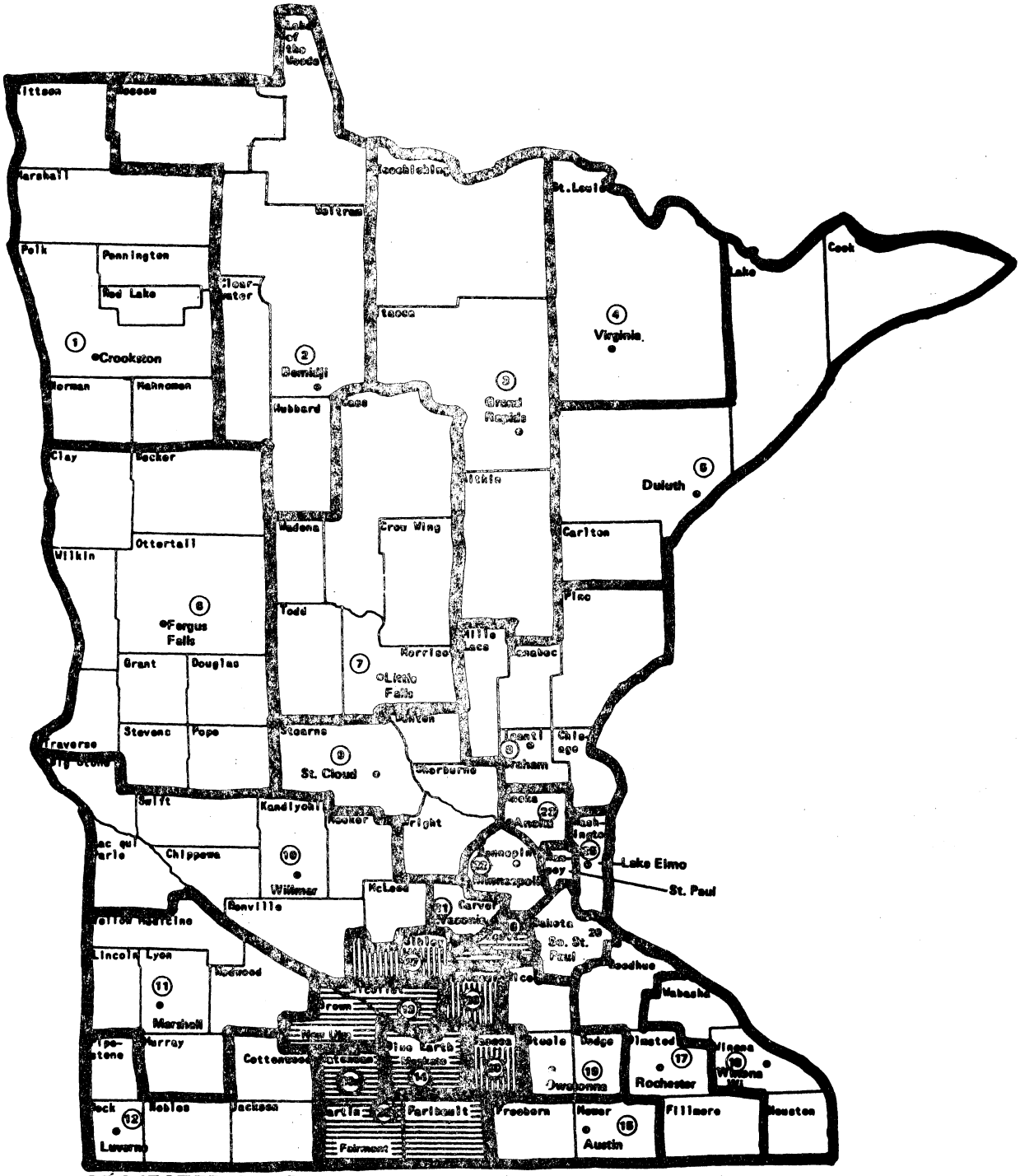
AREA	POPULATION
Scott County Human Service Area	37,800
Carver County Mental Health Center Area	33,000
Northland Mental Health Center Area	64,064
Minnesota Valley Mental Health Center Area	74,000

The rationale for these population exceptions is presented in the following.

Carver and Scott counties, prior to January, 1975, had a joint community mental health board and program. With the advent of Minnesota Human Service legislation, the two counties dissolved their mental helath board and program. Scott County was granted special permission by state legislature to develop a Human Service program with a population below the state minimum base of 50,000. Carver County subsequently requested authorization of the Commissioner of Welfare to establish a community mental health program for an area

below the minimum base population. As indicated on the state maps, Carver County is within Region XI. Hennepin County, being the only adjacent county in Region XI, was not a suitable county for joint sponsorship on a Community Mental Health program. Carver County is in a geographic position to contract across regional and area lines for specialized services with Hennepin County and with the other adjacent mental health programs.

AREA PROGRAM AND HUMAN SERVICE BOARDS



PROJECTED Area Program and Human Service Board Boundaries
EFFECTIVE July 1, 1977

DEVELOPMENT OF MINNESOTA COMMUNITY MENTAL HEALTH CENTERS

YEARS ESTABLISHED		CMHC PROGRAM	SERVING COUNTIES	MAIN OFFICE LOCATED IN
Center	Clinic			
*1959	1949	***Lakeland Mental Health Center	Becker, Clay, Douglas, Grant Otter Tail, Pope, Stevens, Traverse, Wilkin	Fergus Falls
*1960	1951	Southern MN Human Development Center	Faribault, Freeborn	Austin
*1957	1938	North Eastern MN MH/MR/I **(Human Development Center, Duluth)	Carlton, Cook, Lake, St. Louis	Duluth
1957		**Zumbro Valley Mental Health Center (staffing grant expired 9/75)	Olmsted, Goodhue, Fillmore	Rochester
1958		Mower County Consultation Center	Mower	Austin
1958		***Northwestern Mental Health Center **(Northwestern Hospital, Thief River Falls)	Kittson, Mahnomen, Marshall, Norman, Pennington, Polk, Red Lake	Crookston
1958		***West Central Community **Services Center	Big Stone, Chippewa, Kandiyohi, Lac Qui Parle, McLeod, Meeker Renville, Swift	Willmar
1959		**Central MN Mental Health Center	Benton, Sherburne, Stearns, Wright	St. Cloud
1959		***Northland Area MH/MR/I	Aitkins, Itasca, Koochiching	Grand Rapids

YEARS ESTABLISHED	CMHC PROGRAM	SERVING COUNTIES	MAIN OFFICE LOCATED IN
1959	***Southwestern Mental Health Center	Cottonwood, Jackson, Nobles Pipestone, Rock, Hennepin	Luverne
1960	**Hennepin County MH/MR/I Program ***Southeast and Central Areas	Hennepin	Minneapolis
1960	***Upper Mississippi Mental Health Center	Beltrami, Cass, Clearwater, Hubbard, Lake of the Woods, Roseau	Bemidji
1960	***Western Human Development Center	Lyon, Lincoln, Yellow Medicine, Redwood, Murray	Marshall
1960	Luther W. Youghdahl Human Relations Center	Dodge, Rice, Steele, Waseca	Owatonna
1961	Northern Pines Mental Health Center	Crow Wing, Morrison, Todd, Wadena	Little Falls
1962	**Range Mental Health Center (staffing grant expired 2/76)	Upper two-thirds of St. Louis County	Virginia
1962	St. Paul-Ramsey Mental Health Center	Ramsey	St. Paul
1964	Dakota County Mental Health Center	Dakota	South St. Paul
1964	Five County Human Development Center	Chisago, Isanti, Kanabec, Mille Lacs, Pine	Braham
1965	Hiawatha Valley	Houston, Wabasha, Winona	Winona
1965	Minnesota Valley Mental Health Center	Blue Earth, LeSueur	Mankato

YEARS ESTABLISHED	CMHC PROGRAM	SERVING COUNTIES	MAIN OFFICE LOCATED IN
1965	Sioux Trails	Brown, Martin, Nicollet, Sibley, Watonwan	New Ulm
1967	Anoka County Human Resources Office	Anoka	Anoka
1968	**Washburn Child Guidance (Part F. Children's Services)	Anyone within commuting distance	Minneapolis
1969	Carver-Scott Area Mental Health Center (separated into two separate county agencies in 1975)	Carver, Scott	Chaska
1969	Washington County MH/MR Board	Washington	Lake Elmo
1975	Carver County Mental Health Center	Carver	Waconia
1975	Scott County Human Service Agency (Providing mental health services under its own auspices)	Scott	Shakopee
1976	Faribault-Martin-Watonwan Human Service Board (Providing mental health services under its own auspices)	Faribault, Martin, Watonwan	Fairmont
1976	Freeborn-Mower Mental Health Center (formed when Southern Minn. Human Development Center was dissolved & Faribault County joined a Human Service Board)	Freeborn, Mower	Austin

YEARS ESTABLISHED	CMHC PROGRAM	SERVING COUNTIES	MAIN OFFICE LOCATED IN
1976	Blue Earth-LeSueur-Waseca Human Service Board (currently contracting for mental health services with Minn. Valley Mental Health Center, Mankato)	Blue Earth, Waseca, LeSueur	Mankato
1976	Brown-Nicollet Human Services Board (currently contracting for mental health services with Sioux Trails Mental Health Center, New Ulm)	Brown, Nicollet	St. Peter
1977	LeSueur and Waseca Counties withdrew from human service board agreement with Blue Earth County. Blue Earth County HSB takes over operation with Minn. Valley Mental Health Center and contracts for services with LeSueur County. Waseca contracts with Luther Youghdahl Human Relations Center, Owatonna.	Blue Earth, Waseca, LeSueur	Mankato
1977	Sibley County withdraws from Human Service Board agreement with Brown and Nicollet Counties, while contracting for MH services with Sioux Trails MHC, New Ulm.	Sibley, Brown, Nicollet	New Ulm
1977	Comprehensive center staffing grant shifted for its last year from NW Hospital, Thief River Falls, to NWMHC, Crookston, by mutual agreement.	Kittson, Mahnomen, Marshall Norman, Pennington, Polk, Red Lake	Crookston

*Established prior to 1957 State Community Mental Health Act
**Comprehensive Community Mental Health Centers
***Federally designated poverty areas--August 3, 1976

PRIORITY RANKING OF CATCHMENT AREAS

I. Demographic, Economic, and Social Indicators

A. Source of Data

Eight indicators were used to rank the 36 catchment areas according to demographic, economic, and social factors. These indicators were those recommended by the 1976 federal guidelines (p. 51). The data for each catchment area were obtained from the 1970 total population data (Table 5) from the MHDPS. Total population data were used, rather than that for blacks and whites separately because the proportions of blacks (and other nonwhites) in Minnesota catchment areas were quite low (see Table 1) and it was therefore concluded that racial weighting would not be used. This conclusion was reinforced by the discussion on page 53 of the guidelines and by Wisconsin's finding that their application of the recommended racial weighting system had not resulted in a significant change in C.A. ranks (see p. V-20 of the Wisconsin state plan, 1976).

Variables from sources other than the MHDPS were considered but not included because the information was not reliably or readily available.

B. Indicator Definitions

The eight indicators used were:

1. Low Occupational Status: Percent of employed males age 16 and over who are operatives, service workers, and laborers.

2. Percent of Population in Poverty: Percent of those employed who were earning less than the 1969 poverty income level.

3. Percent of Households with Husband-Wife Families: Self-explanatory.

4. Percent of Households with Heads who are Primary Individuals: Self-explanatory.

5. Youth Dependency Ratio: Persons under age 18 per 100 persons 18 to 64.

6. Aged Dependency Ratio: Persons over age 65 per 100 persons 18 to 64.

7. Overcrowded Housing: Percent of household population in housing units with 1.01 or more persons per room.

8. Recent Movers: Percent of population who moved into present residence in 1969 and 1970.

C. Ranking Method

The procedures described on pages 51 and 52 of the federal guidelines were followed except, as noted above, total population data were used and the racial weighting system was not used. For each of the eight indicators, the data were listed by catchment area and the areas were ranked, with a rank of 1 denoting the greatest need and a rank of 36 the least needs. Tied catchment area values were assigned the average rank, which was then rounded to the nearest whole even numbers for computational convenience. These data are shown in Table 2.

The summary score for each catchment area was derived by summing the ranks for seven of the eight indicators. The ranks for Low Occupational Status and Percent in Poverty were multiplied by 2 before summing, as recommended in the guidelines. Either Youth Dependency Ratio or Aged Dependency Ratio was used, depending on which one had the lowest rank. The weighted sums of the seven indicators were the ranked, with a rank of 1 assigned to the lowest sum and a rank of 36 to the highest sum. The summary scores and final sociodemographic ranks are also shown in Table 2.

II. Available Mental Health Resources

A. Source of Data

Only one of the two indicators recommended by the guidelines was used, namely the number of acute inpatient beds. The number of outpatient mental health personnel weekly hours was not used because these were not reported by several catchment areas in the most recent Area Survey of Mental Health Resources. Other measures of mental health resources were not reliably reported or readily available and hence were not included. Thus, only the number of acute beds reported in the last survey of resources was used.

B. Ranking Method

The procedure recommended by the federal guidelines was followed. That is, the number of acute beds was first converted to the rate per 100,000 general catchment area population. These rates were then ranked from low to high, so that a rank of 1 would indicate the least number of beds. Average ranks were assigned to tied values, as previously described. These data and ranks are shown in Table 3.

III. Other Social and Health Indicators

As recommended by NIMH personnel, beds were pro-rated for those catchment areas within each of the metropolitan counties, Hennepin and Ramsey. This was accomplished by obtaining the total number of beds within each county and then allocating this total to each catchment area within the county according to that area's proportion of the total county general population.

This procedure was followed because the inpatient facilities within these counties are available to persons from throughout the county, not just those from the catchment area within which the facility is located.

Other measures were not reliably or readily available in time for inclusion in the priority ranking.

IV. Final Ranking of Catchment Areas

The final ranks of the catchment areas were derived from a weighted sum of the demographic, economic, and social rank and the acute beds rank. A weighted sum was used because only one of the available mental health resources indicators (acute beds) was used, and because it was decided that this variable should have a relatively minor effect on the final ranking since it was felt that this measure was perhaps less reliably reported, would tend to be more variable over time, and because beds had been prorated to some catchment areas, as previously described.

The final summary score was calculated by multiplying the demographic rank by five and adding this product to the acute beds rank. These sums were then ranked from low to high. These data are given in Table 4.

CATCHMENT AREA NUMBERS AND NAMES

Final Rank	Code No.	Name
25	1	Anoka County Human Resources Office
26	2	Carver Area
6	3	Central Minnesota Mental Health Center
30	4	Dakota County Mental Health Center
8	5	Northeast Area Board
12	6	Five County Mental Health Center
20	7	Freeborn-Mower
5	8	Hennepin - Central
3	9	Hennepin - North
19	10	Hennepin - Northeast
10	11	Hennepin - Southeast
31	12	Hennepin - Southwest
36	13	Hennepin - South Sub.
35	14	Hennepin - West Sub.
34	15	Hennepin - Northwest Sub.
14	16	Hiawatha Valley Mental Health Center
13	17	Lakeland Mental Health Center
11	18	Minnesota Valley Mental Health Center
8	19	Northern Pines Mental Health Center
2	20	Northland Area
16	21	Northwestern Mental Health Center
18	22	Range Mental Health Center
29	23	St. Paul 1
4	24	St. Paul 2
14	25	St. Paul 3

Final Rank	Code No.	Name
33	26	Ramsey 1
32	27	Ramsey 2
9	28	Scott Area
23	29	Sioux Trails Mental Health Center
21	30	Southwestern Mental Health Center
1	31	Upper Mississippi Mental Health Center
27	32	Washington County
24	33	West Central Mental Health Center
17	34	Western Mental Health Center
22	35	Youngdahl Human Resource Center
28	36	Zumbro Valley Mental Health Center

TABLE 1

TOTAL POPULATION DESCRIPTORS

C.A.	1970 POPULATION	% BLACK	% OTHER NONWHITE
1	154,556	0.1	0.6
2	28,310	0.0	0.2
3	173,512	0.0	0.2
4	139,808	0.1	0.4
5	177,776	0.5	1.0
6	76,351	0.1	0.9
7	102,743	0.1	0.3
8	112,931	6.3	3.8
9	83,139	10.6	2.3
10	53,175	0.0	1.0
11	60,438	1.3	2.5
12	131,603	2.0	0.7
13	180,849	0.2	0.5
14	163,271	0.1	0.5
15	174,674	0.2	0.5
16	79,183	0.0	0.2
17	185,376	0.1	1.0
18	73,654	0.1	0.2
19	96,301	0.1	0.2
20	64,064	0.1	1.9
21	88,648	0.0	1.1
22	87,763	0.0	0.9
23	101,589	0.7	0.6
24	111,437	6.9	1.7
25	94,420	0.5	0.8
26	91,057	0.2	0.7
27	75,216	0.4	0.4
28	32,423	0.2	3.9
29	106,846	0.0	0.1
30	76,584	0.2	0.2
31	77,848	0.1	7.0
32	82,948	0.1	0.4
33	145,550	0.0	0.2
34	79,366	0.1	0.4
35	98,210	0.0	0.2
36	140,783	0.2	0.4

TABLE 2

TOTAL POPULATION DEMOGRAPHIC,
ECONOMIC, AND SOCIAL INDICATORS

C.A.	LOW OCCUPATIONAL STATUS		PERCENT IN POVERTY		PERCENT HUSBAND-WIFE FAMILIES		% PRIMARY INDIVIDUALS	
	RATE	RANK	RATE	RANK	RATE	RANK	RATE	RANK
1	33.9	16	3.4	30	84.7	36	9.0	36
2	35.2	12	7.1	23	80.2	29	13.3	30
3	34.8	13	11.2	12	76.3	27	16.3	27
4	27.9	26	3.5	29	82.0	31	11.7	32
5	38.6	6	7.7	22	68.6	9	22.4	8
6	34.5	14	12.1	9	74.6	26	17.9	26
7	38.6	6	9.3	16	74.4	25	18.3	25
8	44.2	3	9.6	15	35.5	1	52.8	1
9	44.3	2	11.3	10	59.1	4	24.8	6
10	41.1	5	5.7	26	64.3	7	23.4	7
11	35.9	10	6.5	24	50.9	2	39.2	2
12	24.6	32	3.6	28	63.3	6	26.4	5
13	19.7	35	1.9	36	80.8	30	13.4	29
14	22.5	34	3.3	31	78.4	28	14.7	28
15	27.7	29	2.9	34	84.0	35	9.8	34
16	35.6	11	10.0	14	71.6	15	20.4	12
17	27.7	29	14.0	5	72.5	16	19.5	18
18	32.1	19	8.6	18	70.6	11	22.4	8
19	31.8	20	17.0	2	73.0	18	19.3	20
20	44.0	4	13.3	7	73.6	20	18.8	23
21	19.0	36	15.4	3	70.7	12	20.3	15
22	37.6	9	8.1	20	71.3	14	20.4	12
23	27.7	29	3.1	33	61.3	5	28.9	4
24	44.7	1	9.2	17	52.6	3	34.0	3
25	38.2	8	6.4	25	67.7	8	21.0	11
26	22.6	33	2.4	35	82.3	32	12.3	31
27	27.8	27	3.2	32	83.8	34	9.8	34
28	31.3	22	11.1	13	69.9	10	21.9	10
29	31.5	21	11.2	12	73.7	22	19.3	20
30	29.1	23	12.5	8	74.2	23	19.4	19
31	34.2	15	19.0	1	71.0	13	20.3	15
32	32.3	18	4.0	27	83.0	33	10.6	33
33	28.3	24	13.5	6	73.6	20	19.0	22
34	25.5	31	14.6	4	73.3	19	19.5	18
35	33.2	17	8.5	19	74.3	24	18.6	24
36	28.2	25	8.0	21	72.7	17	20.3	15

TABLE 2 (continued)

C.A.	YOUTH DEPENDENCY RATIO RATE	RANK	AGE DEPENDENCY RATIO RATE	RANK	OVERCROWDED HOUSING RATE	RANK	RECENT MOVERS RATE	RANK	SUM TOTAL	RANK
1	88.7	2	5.8	36	21.2	4	21.4	11	181	25
2	80.2	7	19.4	24	15.8	17	15.5	35	188	28
3	86.7	3	19.1	26	25.1	2	20.7	14	123	7
4	83.9	5	9.4	31	17.0	12	21.1	12	202	31
5	67.9	26	20.7	20	16.3	16	20.0	18	127	8
6	77.6	8	28.1	2	18.0	10	19.9	19	129	10
7	71.4	21	22.5	18	13.8	24	16.9	31	167	21
8	34.8	36	27.1	6	10.5	31	28.2	2	77	3
9	67.4	28	25.7	11	15.4	19	25.5	4	68	1
10	53.5	33	19.8	22	11.3	30	19.4	22	150	17
11	36.1	35	19.9	21	10.1	33	38.7	1	127	8
12	52.2	34	26.2	9	6.8	36	18.4	24	200	30
13	70.8	22	8.0	32	10.2	32	19.5	20	275	36
14	68.2	25	11.7	29	9.7	34	20.9	13	258	35
15	77.4	9	6.5	34	14.7	22	21.9	10	236	33
16	71.8	18	24.8	13	15.7	18	17.7	26	134	12
17	71.7	20	25.3	12	17.1	11	20.5	16	141	14
18	65.8	30	21.0	19	14.9	21	24.2	5	138	13
19	80.4	6	28.2	1	21.2	4	17.6	27	114	6
20	74.2	13	22.8	17	22.9	3	17.0	30	111	5
21	74.8	12	27.3	3	19.6	7	17.2	29	144	16
22	68.3	24	19.4	24	18.9	9	15.2	36	153	18
23	54.1	32	27.2	4	9.2	35	20.5	16	188	28
24	59.7	31	24.6	14	16.5	15	23.9	6	77	3
25	66.2	29	18.1	28	16.6	14	20.5	16	143	15
26	70.7	23	5.8	36	14.1	23	23.7	7	252	34
27	85.4	4	8.0	32	19.4	8	17.5	28	226	32
28	18.1	28	18.1	28	16.9	13	25.8	3	134	12
29	71.7	20	24.6	14	12.7	28	15.7	34	184	26
30	73.2	14	25.9	10	13.2	26	16.0	32	172	22
31	72.4	16	26.4	8	25.4	1	22.4	8	77	3
32	91.4	1	11.0	30	20.8	6	19.4	22	185	27
33	72.1	17	27.1	6	13.6	25	16.0	32	165	20
34	76.6	10	26.7	7	15.1	20	17.9	25	159	19
35	75.1	11	23.2	16	12.7	28	19.5	20	179	24
36	72.4	16	19.8	22	12.5	29	21.9	10	179	24

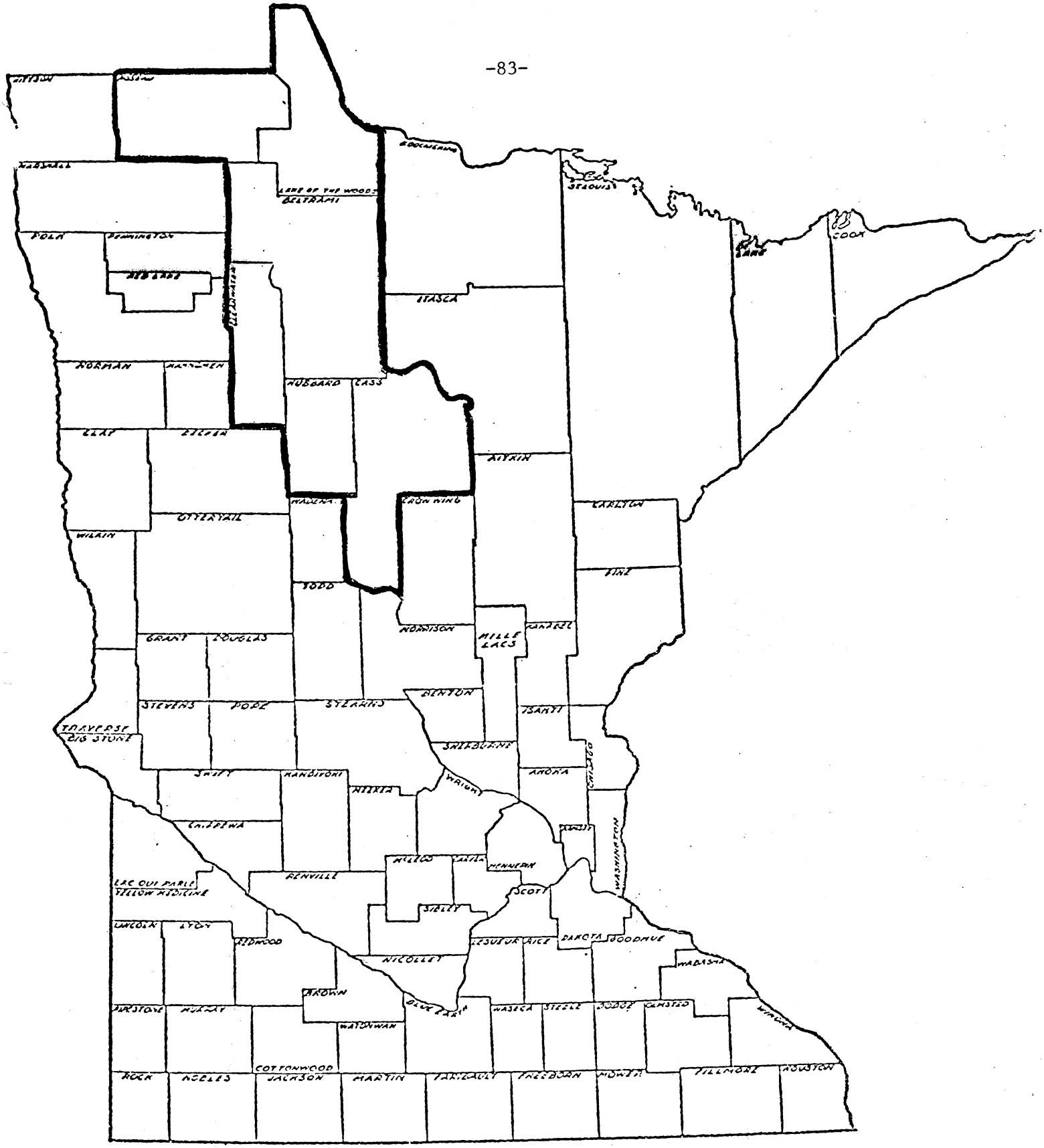
TABLE 3

ACUTE INPATIENT BEDS

C.A.	NUMBER OF BEDS	RATE/ 100,000	RANK
1	25	16.2	12
2	0	0	4
3	45	25.9	14
4	0	0	4
5	97	54.6	22
6	240	314.3	36
7	4	3.9	9
8	78	69.1	30
9	57	68.6	27
10	36	67.7	24
11	42	69.5	31
12	90	68.5	25
13	124	68.6	27
14	112	68.6	27
15	120	68.7	29
16	63	79.6	34
17	102	55.0	23
18	22	29.9	15
19	70	72.7	32
20	0	0	4
21	29	32.7	16
22	14	16.0	11
23	49	48.2	17
24	54	48.5	18
25	46	48.7	19
26	45	49.4	21
27	37	49.2	20
28	0	0	4
29	0	0	4
30	2	2.6	8
31	0	0	4
32	8	9.6	10
33	232	159.4	35
34	0	0	4
35	20	20.4	13
36	111	78.8	33

FINAL RANKINGS

C.A.	DEMOGRAPHIC, ECONOMIC AND SOCIAL RANK	ACUTE INPATIENT BEDS RANK	WEIGHTED SUM	FINAL RANK
1	25	12	137	25
2	28	4	144	26
3	7	14	49	6
4	31	4	159	30
5	8	22	62	8
6	10	36	86	12
7	21	9	114	20
8	3	30	45	5
9	1	27	32	3
10	17	24	109	19
11	8	31	71	10
12	30	25	175	31
13	36	27	207	36
14	35	27	202	35
15	33	29	194	34
16	12	34	94	14
17	14	23	93	13
18	13	15	80	11
19	6	32	62	8
20	5	4	29	2
21	16	16	96	16
22	18	11	101	18
23	28	17	157	29
24	3	18	33	4
25	15	19	94	14
26	34	21	191	33
27	32	20	180	32
28	12	4	64	9
29	26	4	134	23
30	22	8	118	21
31	3	4	19	1
32	27	10	145	27
33	20	35	135	24
34	19	4	99	17
35	24	13	133	22
36	24	33	153	28



UPPER MISSISSIPPI MENTAL HEALTH CENTER

*Main office: Bemidji, Minnesota 56601

Region 2
HSA-1
Priority Rank 1

UPPER MISSISSIPPI MENTAL HEALTH CENTER
Bemidji

This catchment area services six counties in the north central part of the state, bordering Canada on the north. It is 216 miles long, and varies from 20 to 96 miles wide. According to the 1970 Census, 77,848 persons live on 9,418 square miles averaging 8.5 persons per square mile. The largest municipality is Bemidji with 11,400 persons. There are only six other towns with populations greater than 1000 persons.

There are parts of three (3) reservations within the catchment area, resulting in a substantial Native American population. White ethnic groups include Norwegians, Swedish and German.

The major industries are lumber, farming and recreational tourism. Per capita income is low, unemployment or underemployment is high; and the area generally has a poor standard of living as compared to the rest of the state.

In recent years, there has been increasing conflict between Native American and non-Native American groups regarding use of reservation land, customs, practices, and the cost of a wide range of social services. This conflict has been diminished by legislative policy changes aimed at increasing Native American independence and providing supplemental funding for social services. Both the geographic nature of this area and the diversity of population groups create difficulties in providing mental health services in this area.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

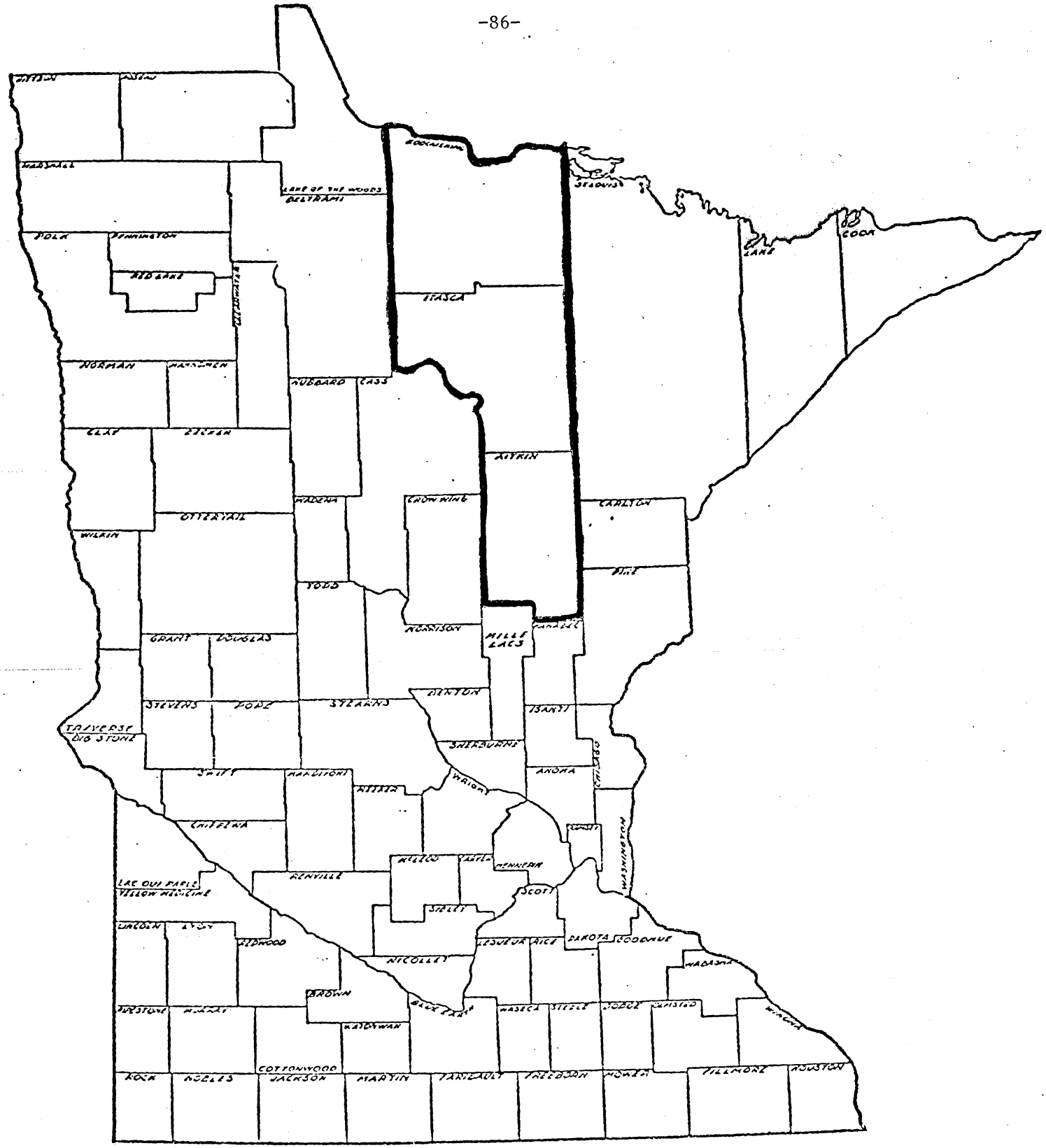
Halfway houses

*Alcohol services

*Drug treatment services

Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



NORTHLAND AREA MH-MR PROGRAM

*Main office: Grand Rapids, Minnesota

Region 3
HSA-2
Priority Rank 2

NORTHLAND AREA MENTAL HEALTH-MENTAL RETARDATION PROGRAM
Grand Rapids

This area inclludes Aitkin, Itasca and Koochiching Counties and is located in the extreme north central part of Minnesota bordering Canada on the north. It is a long, narrow catchment area covering 7,588 square miles. According to the 1970 Census, the total population was 64,064. The catchment area is sparsely populated varying from 14.5 to 5.6 persons per square mile. The largest population centers are Grand Rapids (7,247) and International Falls (8,555).

There is a substantial Native American population living on two reservations within the area. The remaining white population are of Finnish, Yugoslavian, Scandinavian or German extraction.

The major industry of the area is lumbering and wood products. Additionally, the area depends heavily on tourism and summer and winter recreation for employment and income. The per capita income is below the state average. Two of the three counties regularly receive additional state funds to relieve financial distress and provide welfare, mental health and mental retardation services.

This area is distinguished by the extremely cold winter temperatures. Transportation is difficult since there is no train service, limited air service and limited bus services. The character of the land and sparsity of the population make provision of services difficult and expensive.

Northland has submitted an application for federal community mental health center construction funds, with which it is building a new office building and an addition to the adjoining Itasca Memorial Hospital for the inpatient and partial hospitalization units. The inpatient unit will have 10 beds. The Department has requested a waiver of the catchment area minimum population size in conjunction with Northland's construction application. Construction should be completed about November, 1977.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization (upon completion of construction about November, 1977)

*Partial hospitalization (day/night) (upon completion of construction about November, 1977)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

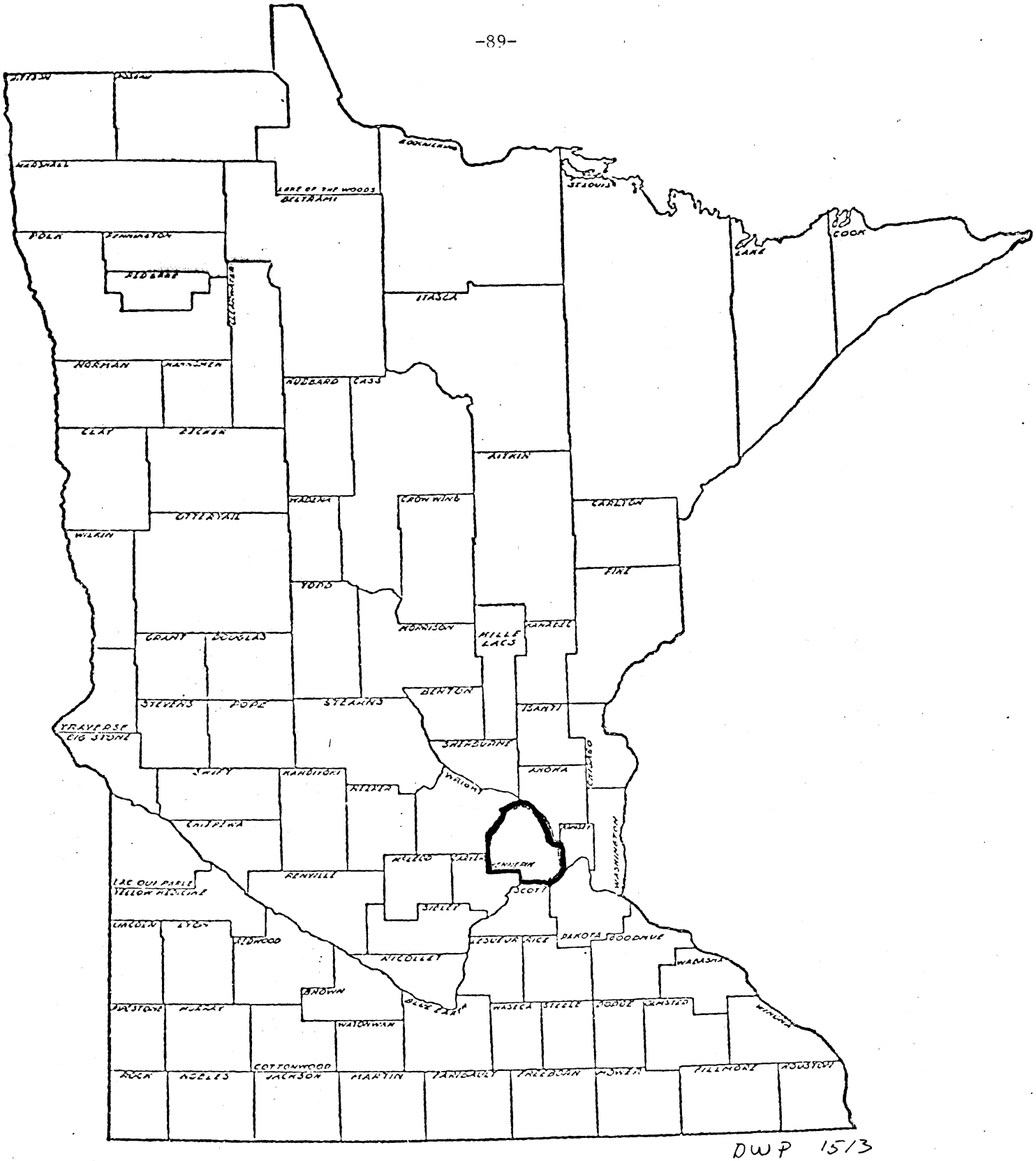
Halfway houses

*Alcohol services

*Drug treatment services

Special services for elderly people

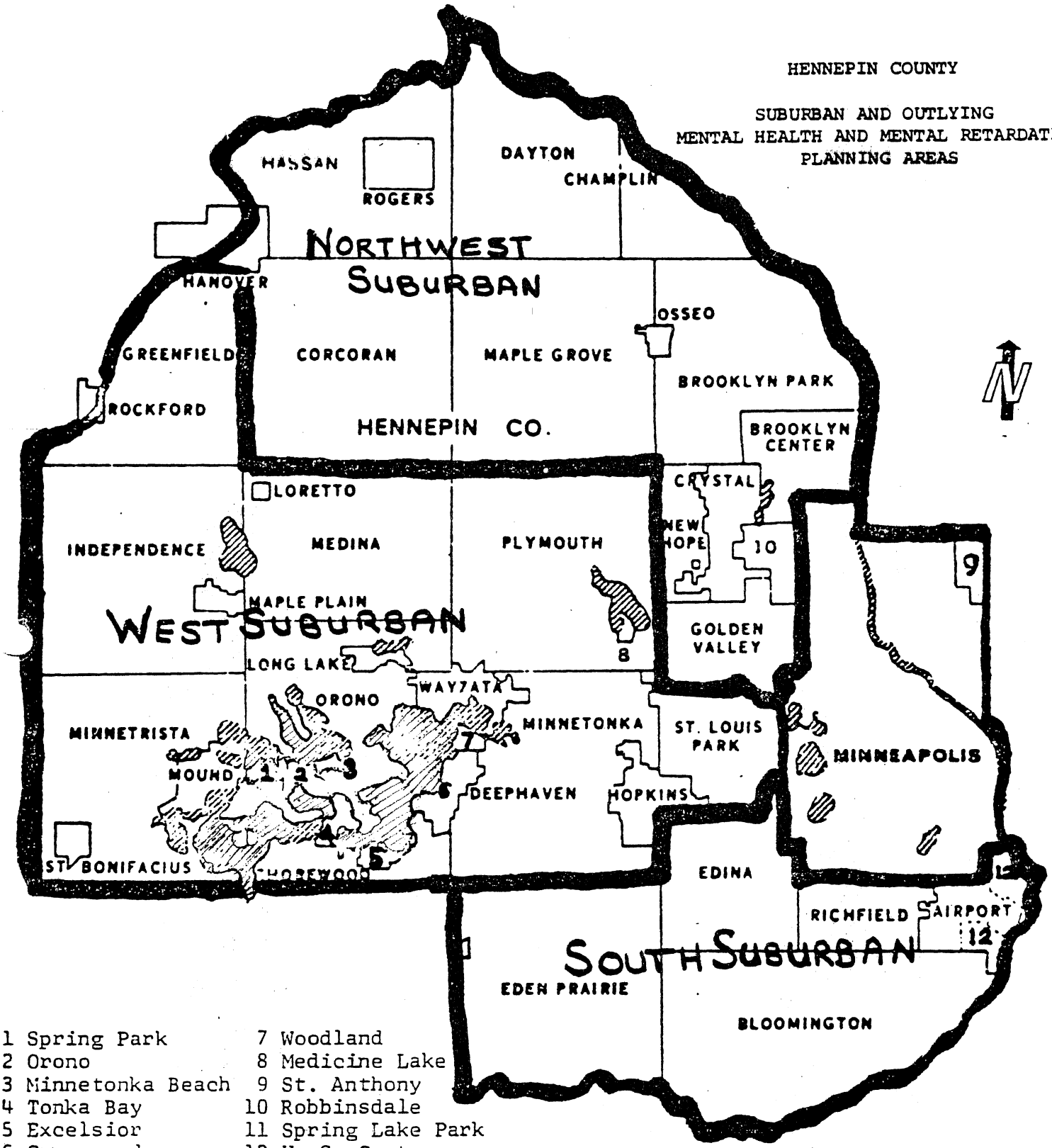
*Community program planning and coordination for MH/MR/CD services



DWP 1513

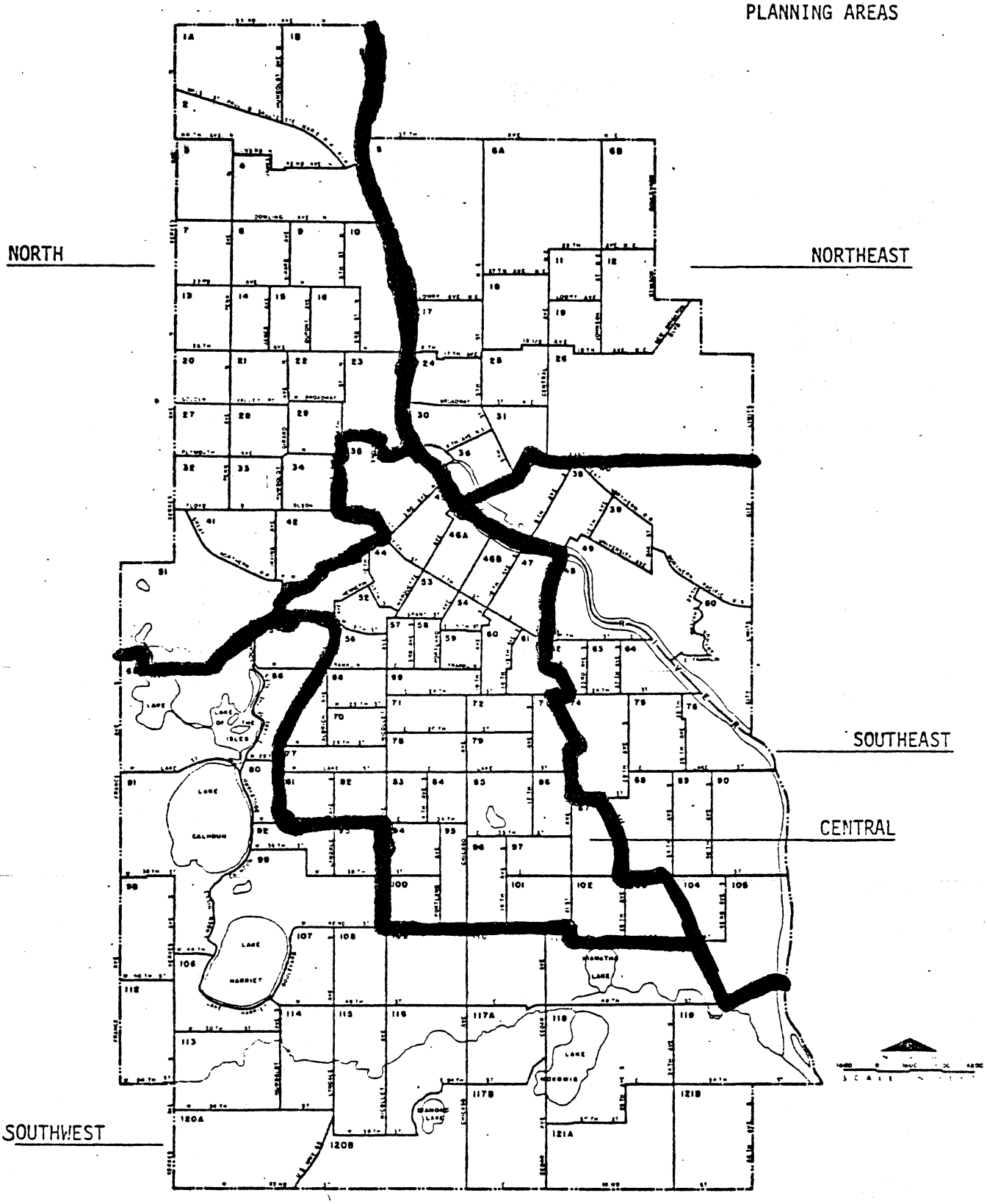
HENNEPIN COUNTY MH-MR-CD DEPARTMENT

*Main office: Minneapolis, Minnesota



1 Spring Park
2 Orono
3 Minnetonka Beach
4 Tonka Bay
5 Excelsior
6 Greenwood
7 Woodland
8 Medicine Lake
9 St. Anthony
10 Robbinsdale
11 Spring Lake Park
12 U. S. Govt.

HENNEPIN COUNTY
CITY OF MINNEAPOLIS
MENTAL HEALTH AND MENTAL RETARDATION
PLANNING AREAS



Region 11
HSA-5

HENNEPIN COUNTY DEPARTMENT OF MENTAL HEALTH-MENTAL RETARDATION-CHEMICAL DEPENDENCY
Minneapolis

Hennepin County has the second largest area of the seven metropolitan counties, with 567 square miles. It has the largest population of any county in the state, estimated in 1974 at 924,800 persons (960,072 in 1970). Hennepin County ranks second to Ramsey County in population density, with 1,631 persons per square mile. The majority of the county is urban; however, there are some rural areas in the extreme west and northwest parts of the county.

Contained within Hennepin County is the City of Minneapolis, the state's largest. It is the financial center for much of the Upper Midwest. Diversified commercial and industrial activity is centered in Minneapolis and the surrounding suburbs. The main campus of the University of Minnesota, including the University Hospitals, is located in Minneapolis.

The largest population groups are Scandinavian and German, with sizeable representation from most other European nationalities. Most of the city's black population reside in the south central and near north areas. An increasing Indian population is concentrated mainly along East Franklin Avenue.

The county currently maintains a Department of Mental Health-Mental Retardation-Chemical Dependency which carries out area board planning and coordinating functions, under the direction of the Board of County Commissioners.

Present plans are to combine this department with the social services component of the county welfare department, the mental health center, and Circle F into a Department of Community Services.

Hennepin County is divided into eight mental health planning areas. The geographic boundaries for these areas have changed since the 1970 Census. Due to time limitations and restrictions, the demographic statistics are not available for the current boundary designations. The statistics that have been used for the catchment area rankings are estimates drawn from the 1970 statistical information. For four of the planning areas, the 1970 statistics have been averaged to achieve the best estimate of the demographic characteristics of the areas as they are now defined.

The area program is administering the last year of a Staffing Grant which was originally awarded to the Metropolitan Mental Health Center and transferred to the area program several years ago. Currently, Hennepin County has applied for a Planning Grant which has been approved but not funded.

A brief description of each of the eight planning areas will follow.

Services available in this county through the mental health department, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

*Rape prevention and treatment (treatment only)

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

*Halfway houses

*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services

The list of services available in Hennepin County and in Minneapolis, as given above, will not be repeated for each of the catchment areas within the County. Mental health centers and services are not perfectly evenly distributed but are, in fact, available, particularly to people in the lower income levels.

Region 11
HSA-5
Priority Rank 3

HENNEPIN COUNTY

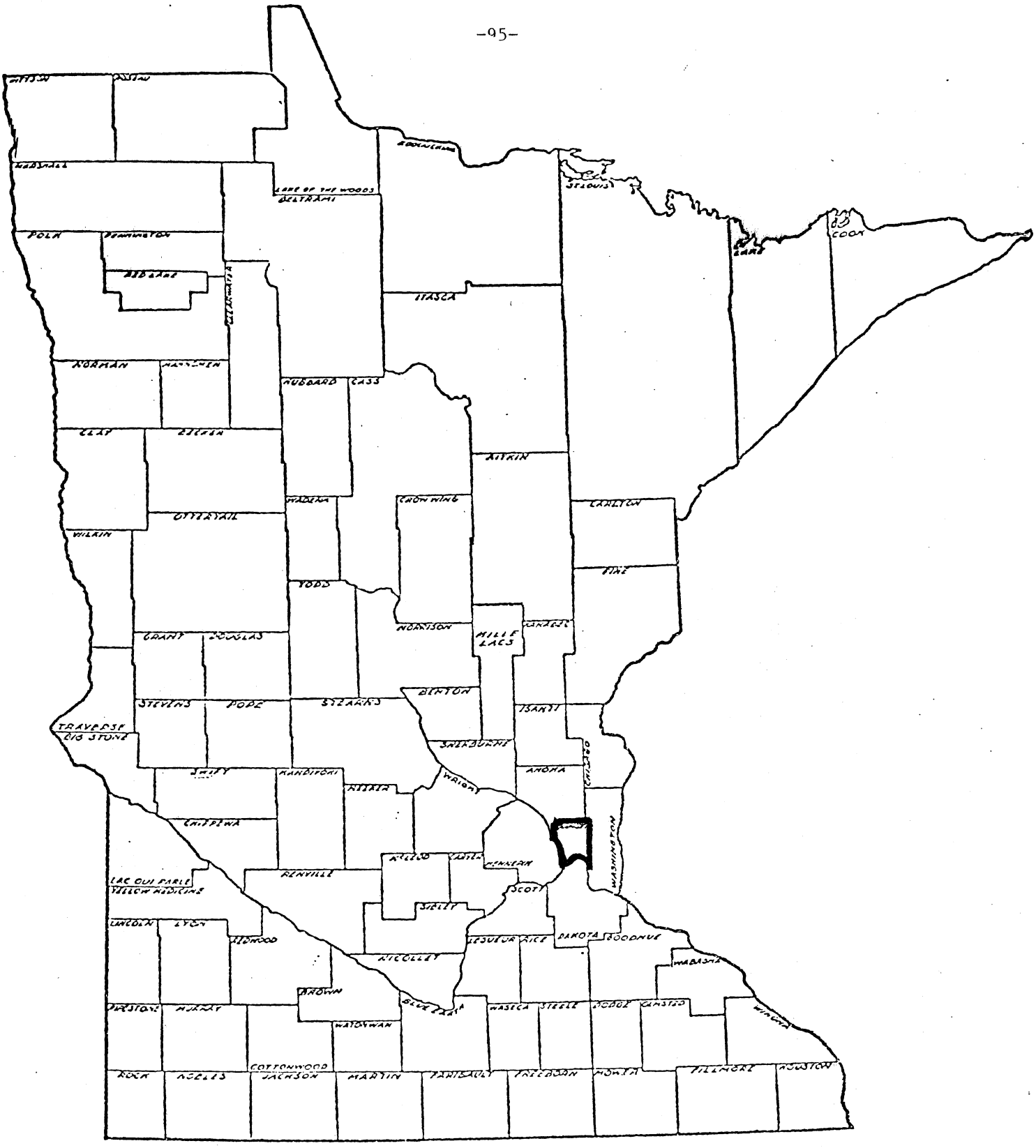
NORTH AREA

The North area includes the two Minneapolis neighborhoods, Near North and Camden. Camden, with a mean family income of $10,700, is considerably more affluent than Near North which has a mean income of $8,974. The Near North Side contains a sizeable black population. As a whole, Area #1 ranks as one of the two most economically depressed planning areas in the county. The North area has the youngest population of any planning area in Minneapolis. It had a population of 83,139 in 1970.

Income: The North area has a mean family income of $9,500--second lowest among all county planning areas. In addition, it has the highest percentage of individuals and families with incomes below the poverty level.

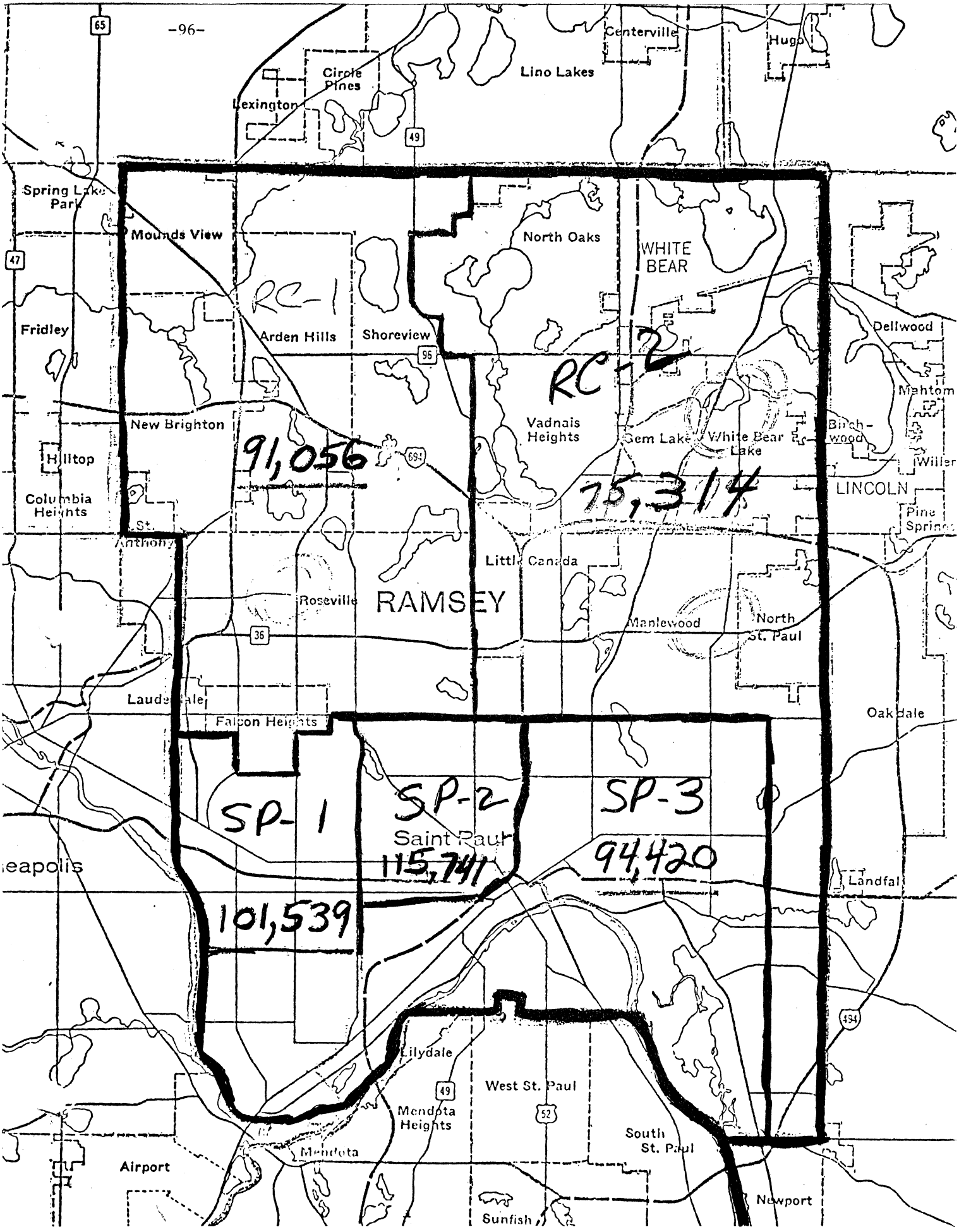
Unemployment: In 1970, the North area had the second highest rate of unemployment among planning areas.

Age and Family Characteristics: The North area ranks first among areas within Minneapolis in percent of families having one or more children under age 18 and in percent of population under age 18. It ranks third in percent of population 65 or older. The North area has the second highest percent of persons age 14-54 who are widowed or divorced.



RAMSEY COUNTY MENTAL HEALTH DEPARTMENT

*Main office: St. Paul, Minnesota


RC-1
RC-2
91,056
75,314
SP-1
SP-2
SP-3
115,741
94,420
101,539
RAMSEY
WHITE BEAR
LINCOLN
Saint Paul
Centerville
Hugo
Lino Lakes
Circle Pines
Lexington
Spring Lake Park
Mounds View
North Oaks
Fridley
Arden Hills
Shoreview
Dellwood
Mahtomedi
New Brighton
Vadnais Heights
Gem Lake
White Bear Lake
Birch-wood
Willer
Hilltop
Columbia Heights
St. Anthony
Little Canada
Roseville
Manlewood
North St. Paul
Lauderdale
Falcon Heights
Oakdale
Landfall
Lilydale
West St. Paul
Mendota Heights
Mendota
South St. Paul
Airport
Sunfish
Newport
65
49
47
96
694
36
52
494

Region 11
HSA-5

RAMSEY COUNTY MENTAL HEALTH DEPARTMENT
St. Paul

Ramsey County has the smallest area within the metropolitan counties, with 155 square miles. It has a population (1975 estimate) of 495,500 people. Of this figure, a substantial majority reside in urban areas (83%). Ramsey County ranks first in population density (1975 estimate) with 3,197 persons per square mile.

The State Capitol is located in St. Paul. There are also four private colleges in the city, plus a seminary. Another college and two seminaries are located in the suburbs. Employment is diversified among industry, commerce, and government.

The predominant population groups in St. Paul are German and Irish, with significant representation from the other European nationalities. The black community is located west of downtown and a grouping of Mexican-American neighborhoods is centered on the West Side of St. Paul.

Ramsey County is divided into five mental health catchment areas. The City of St. Paul comprises three of these catchment areas, and accounts for one-third of the total area. The remainder of the catchment areas are found north of the city and are described as the North Suburban area. Sixteen incorporated areas comprise the North Suburban catchment areas.

Services available in this county through the mental health department, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning andcoordination

*Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

*Halfway houses

*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services

Priority Rank 4

ST. PAUL-2

The St. Paul-2 catchment area is primarily the central area of St. Paul. The area houses practically all of the Spanish-American, Native-American, and Black minority persons in the community. This area has the poorest housing in Ramsey County, and a great deal of absentee landlord rental property. All of the designated poverty areas are located in the area. Many of the direct service agencies function in this area. Even though much substandard housing has been replaced with Interstate Highway 94 and Industrial Park development, the population density is high.

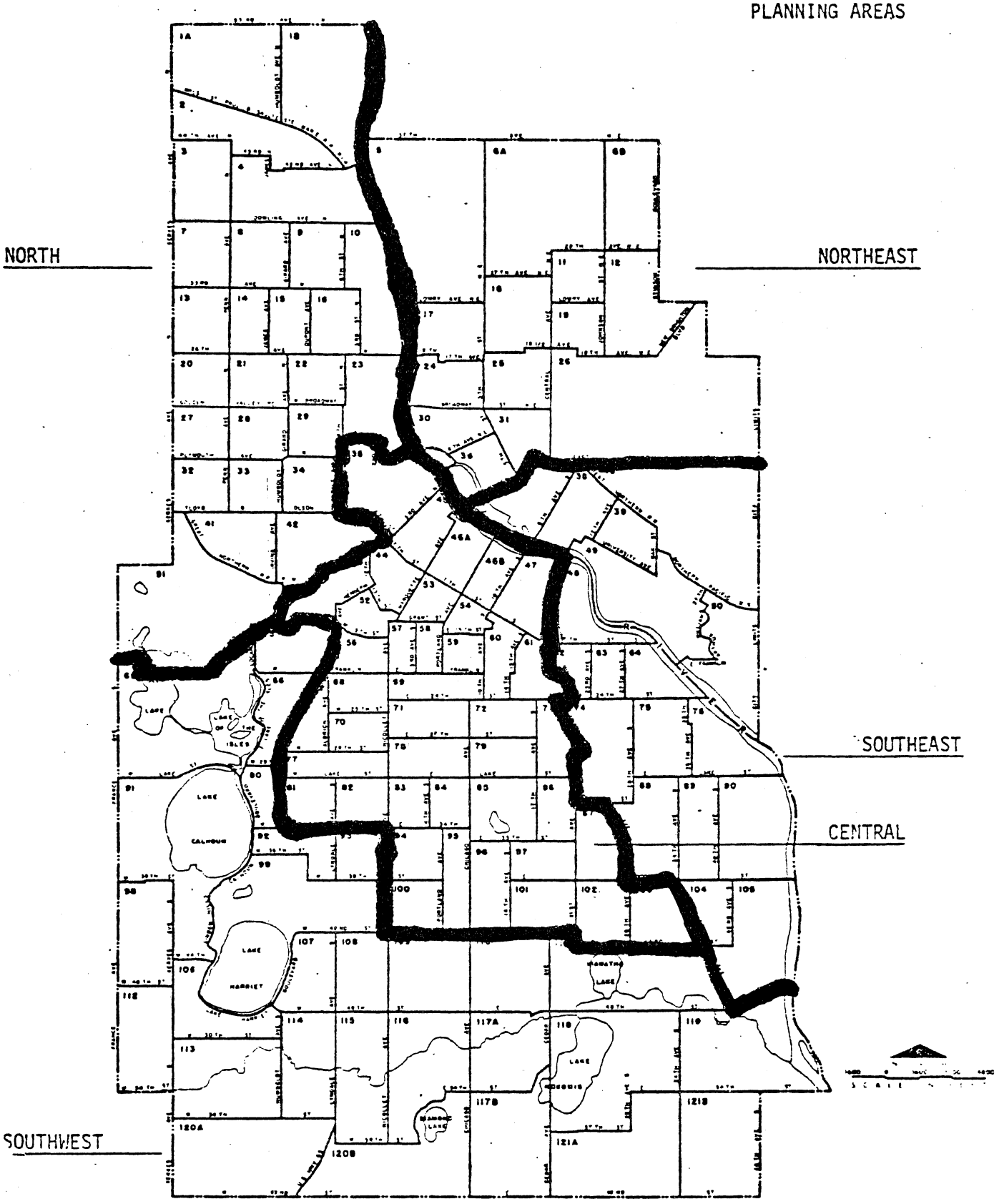
Population: St. Paul-2 ranks first in population, with a total of 113,971 people. In 1970, 111,437 people lived here.

Income: The mean family income is $7,225. This is the lowest total of all five catchment areas. Approximately 13% of the population has income that falls below the poverty level. This constitutes the highest percentage of all areas.

Education: St. Paul-2 ranks last in proportion of persons under 25 and over who are high school graduates.

Age and Family Characteristics: St. Paul-2 has the second lowest percentage total of persons under 18 and families with children under 18. It has the second highest percentage of people over 65, and contains the highest percentage divorce rate. This area contains the highest percentage of non-whites (approximately 10%).

HENNEPIN COUNTY
CITY OF MINNEAPOLIS
MENTAL HEALTH AND MENTAL RETARDATION
PLANNING AREAS



Priority Rank 5

HENNEPIN COUNTY
Central Area-Minneapolis

CENTRAL AREA

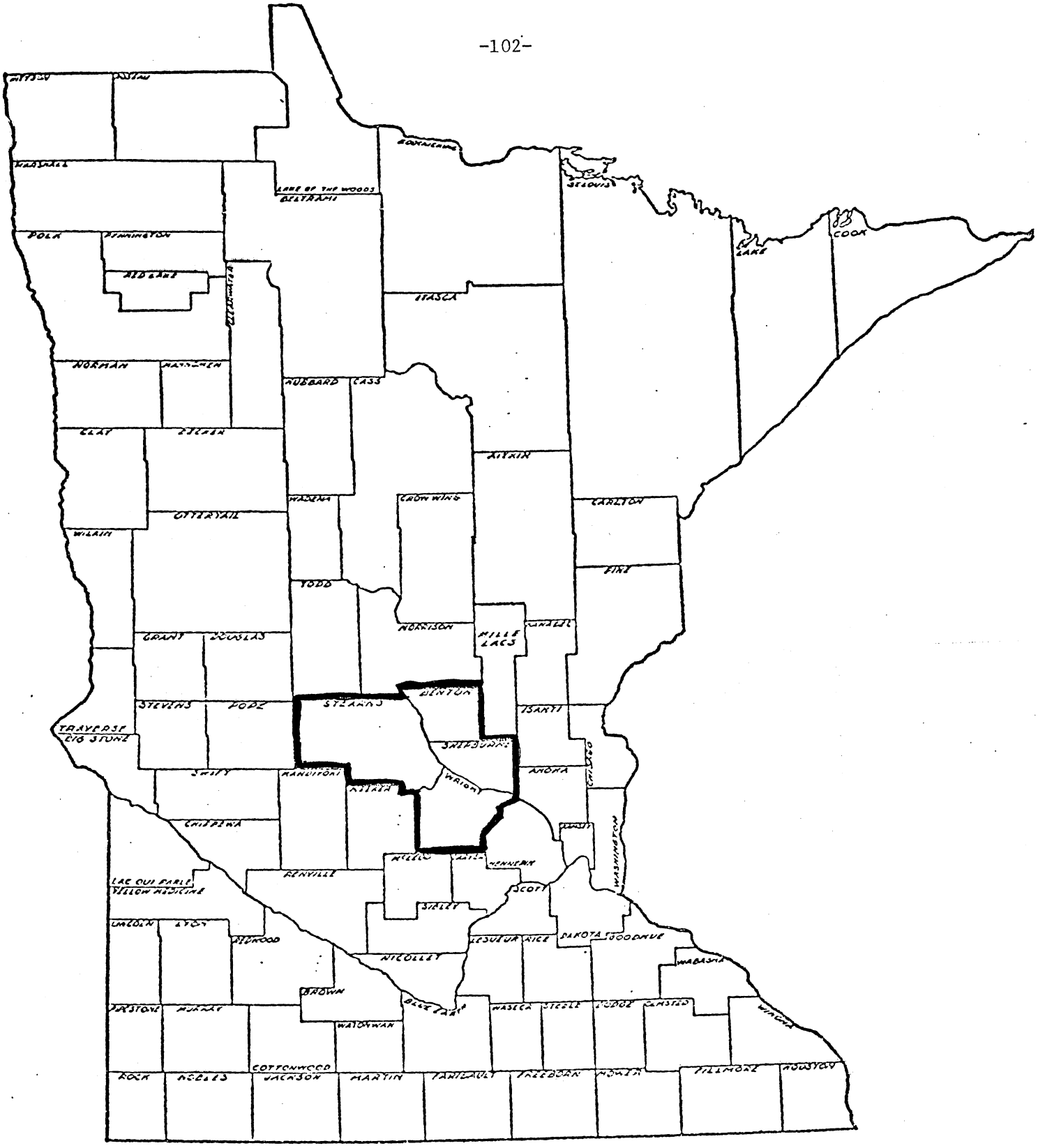
The Central area is comprised of the Minneapolis Powderhorn and Central neighborhoods. Minneapolis' Central neighborhood contains the central business district, and nearly all residences in the neighborhood are multiple dwellings. Powderhorn is largely a residential neighborhood, and about 70% of the residences are multiple dwellings. Mean family income is low in both neighborhoods ($7,750 in Central and $8,850 in Powderhorn). In 1970, 112,931 people lived here.

Income: The Central area ranks lowest among all county planning areas with a mean income of $8,200. Only the North area has a greater proportion of residents below the poverty level than the Central area. About 7.2% of all individuals and 9.6% of all families in the Central area are below this level.

Unemployment: The Central area has the highest rate of 1970 unemployment.

Educational Attainment: The Central area has the third largest proportion of population age 25 and older with less than 12 years of education.

Age and Family Characteristics: The Central area has the second lowest percent of families with children under age 18 among county planning areas. The proportion of residents under age 18 is the second smallest among planning areas. The Central area has the largest percent of residents age 65 and older. It also has the highest percent of persons age 14-54 who are widowed or divorced.



CENTRAL MINNESOTA MENTAL HEALTH BOARD

*Main office: St. Cloud, Minnesota

Region 7W
HSA-4
Priority Rank 6

CENTRAL MINNESOTA MENTAL HEALTH CENTER
St. Cloud

Central Minnesota has a population of 195,000, an area of 2,849, and a population density of 64.6 persons per square mile. In 1970, the population was 173,518. This four-county area is generally rural, although there is one clearly dominant urban area, located in the south central portion of the area. Stearns County, and its central city, St. Cloud, are significantly larger and more densely settled. A great deal of light industry is located here along with a granite industry. The balance of the area is best characterized as rural and semi-rural. Major institutions located in the area include a large Veterans Administration Hospital (MH), a state university, a private university, a private college and a large medical complex near St. Cloud. The central location of this area and the high quality agricultural land have facilitated the development of this area.

There are no significant racial or ethnic minorities in this area. The state university has some racial minority students and instructors, although the numbers are small. Generally, this area reflects a mixture of Central European backgrounds and some Scandinavian influence. There is a strong tradition which preserves ethnic heritage, especially in and around the portion of the area where institutions (churches - schools) have remained strong.

Health and social services are readily available, although not always decentralized.

Central Minnesota has applied for Conversion and Consultation and Education Grants. Its Staffing Grant expired on 5/31/76. It has a Growth Grant which will be in effect until 1978, and a Part F Grant for Children's Mental Health Services which will continue until 1982.

Services available in this catchment area through the mental health center and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

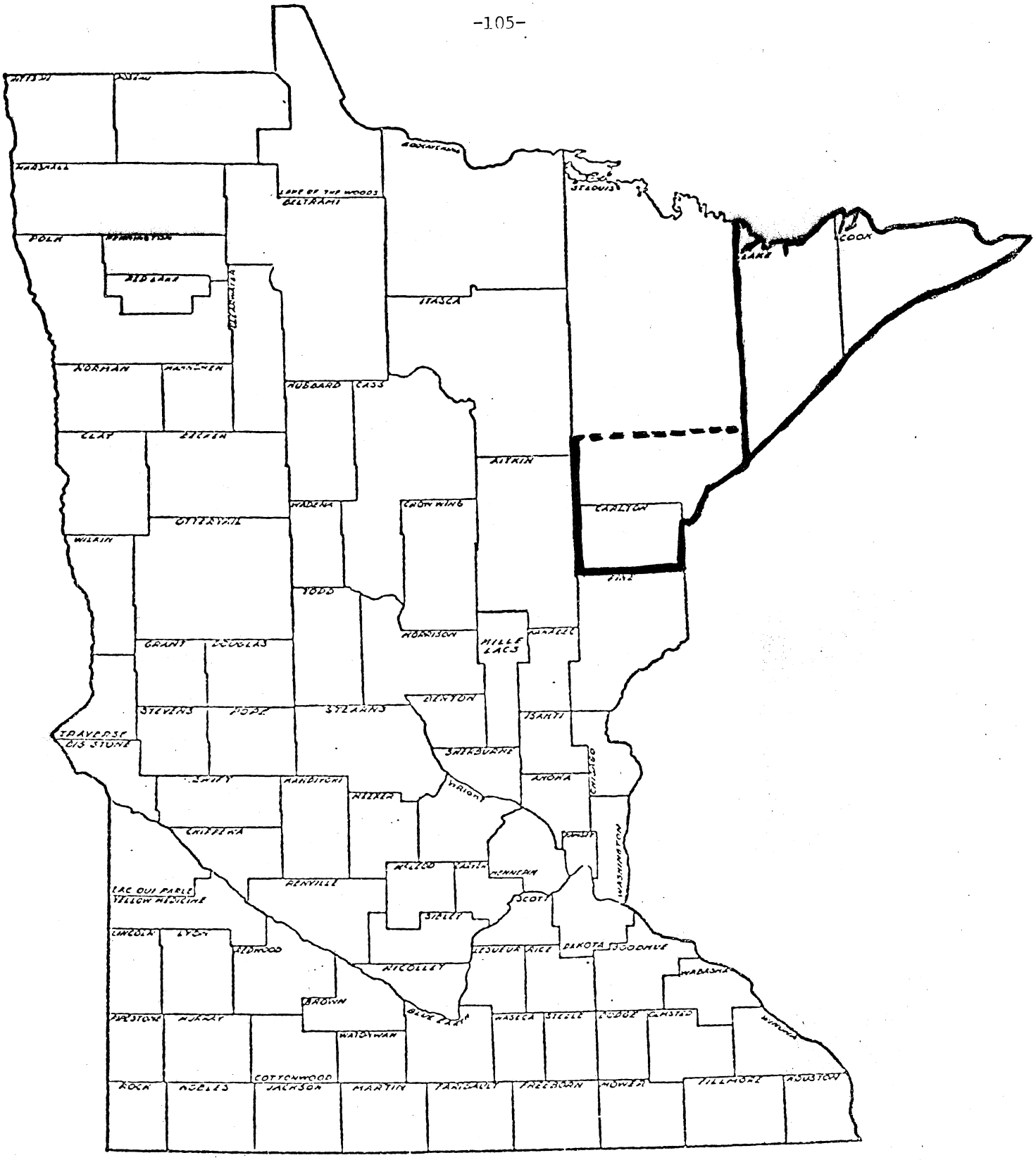
Halfway houses

*Alcohol services

*Drug treatment services

Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



AREA MH-MR-I BOARD OF NORTHEAST MINNESOTA

Main office: Duluth, Minnesota

Region 3
HSA-2
Priority Rank 8

NORTHEAST MINNESOTA AREA MENTAL HEALTH-MENTAL RETARDATION BOARD
Duluth

This catchment area, located in the northeastern-most part of the state, serves Lake, Cook, Carlton and the lower one-third of St. Louis County. It has an area of 6,491 miles and a population of 177,776 persons (1970 census). Duluth, the county seat of St. Louis County, has a population of 100,500 and is the only population center of any size in the catchment area. With the exception of Duluth, this catchment area is essentially rural.

The ethnic composition of the catchment area is largely Scandinavian, Finnish and Slavic. There are two small Indian reservations within the area and a concentration of Native Americans in Duluth. There is a very small percentage of Black people within the area.

The Port of Duluth, which is the end of the St. Lawrence Seaway, is one of the major industries of the area. Other major industries are lumbering, iron ore processing and recreational tourism.

With what appears to be the final resolution of the Reserve Mining Company lawsuits by the Minnesota Supreme Court, efforts are underway to develop on-land dumping facilities for the taconite waste products which Reserve currently dumps into Lake Superior. The resolution of this long-standing litigation provides, among other things, for reasonable assurance of continued employment for people working in the taconite industry and in related support services. Continuing demand for iron ore adds to the likelihood that the taconite industry will continue to prosper.

The Human Development Center in Duluth has a Part F Grant for Children's Mental Health Services which will continue until 1980. No additional applications for federal funds are pending at this time.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

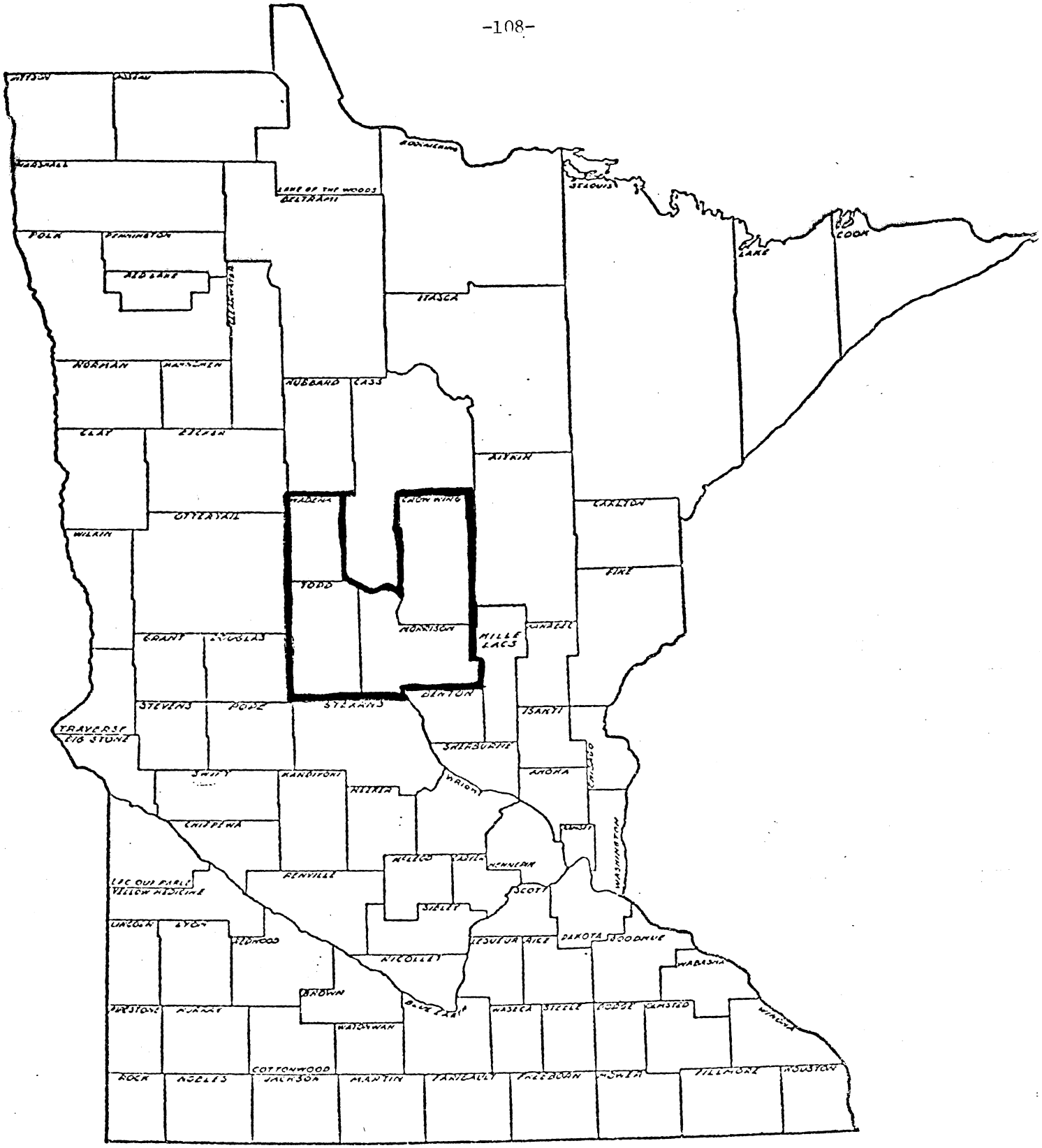
*Halfway houses

*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



NORTHERN PINES MENTAL HEALTH CENTER, INC.

*Main office: Little Falls, Minnesota

Region 5
HSA-4
Priority Rank 8

NORTHERN PINES MENTAL HEALTH CENTER
Little Falls

The Northern Pines catchment area, serving the counties of Todd, Morrison, Crow Wing and Wadena, lies in the north central part of the state. The catchment area has a total population of 103,300 persons (up from 96,301 in 1970), an area of 3,600 square miles and a population density of 28.5 persons per square mile.

The area is primarily rural. Brainerd, in Crow Wing County, is the largest town in the area with a population of 11,667 persons. There is a small state college located in Brainerd. The predominant economic activity in this area is agricultural, particularly small family farms. There is some light industry in the area which includes paper products, clothing and dry goods manufacturing and furniture manufacturing. Crow Wing County is dominated by its tourism and recreational industries.

Although there are no significant ethnic populations in the area, there are areas with heavy concentrations of particular nationalities. These include Finnish, Polish and German people. These ethnic communities are characterized by isolationism and a heavy emphasis on the "work ethic". These attitudes negatively affect the acceptability and delivery of mental health services.

Although distances between population centers are expansive, efforts have been made to coordinate services through the schools and county family service agencies. Little Falls was the site of the first day treatment center for the elderly and has since become a model for programs for the elderly.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

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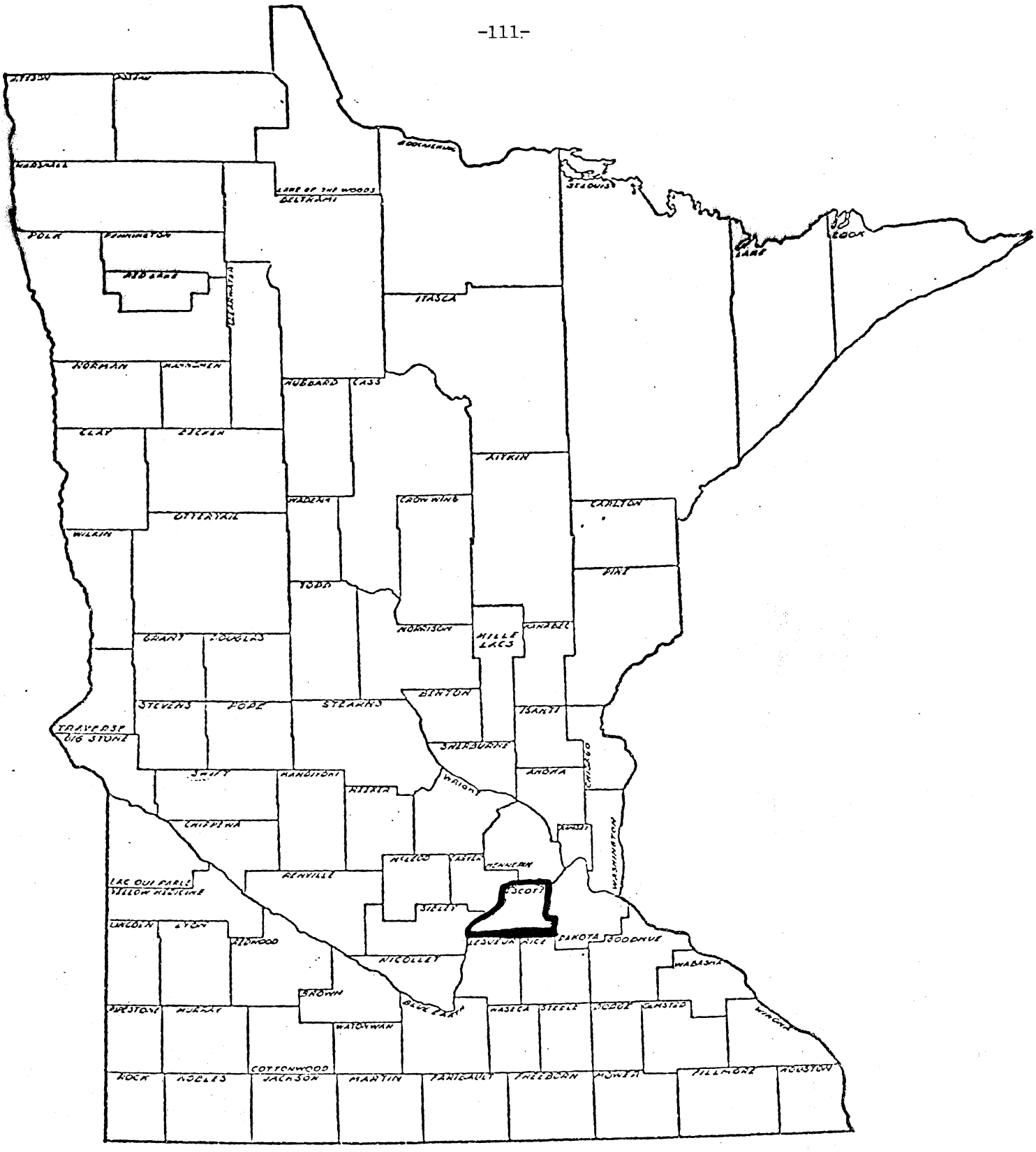
*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



SCOTT COUNTY HUMAN SERVICES BOARD

*Main office: Shakopee, Minnesota

Region 11
HSA-5
Priority Rank 9

SCOTT COUNTY HUMAN SERVICES BOARD
Shakopee

Scott County is one of the still partially rural, outlying counties of the officially designated seven-county Metropolitan Region. As expected, the area is experiencing a rapid population growth, with a 1974 estimated population of 37,800, as compared to a 1970 Census figure of 32,423. The county comprises only 353 square miles with a population density of 107.1 persons per square mile, which ranks it as the seventh highest in the state. Ethnically, the population is quite heterogeneous and well integrated, including the small Native American group that is a branch of the Lower Sioux Tribe Headquarters at Redwood County.

Until 1974, Scott and Carver Counties jointly sponsored a community mental health center program. Each now have separate, one county, operations. Scott is the first county of the state to adopt and fully implement Human Service Board legislation. This organizational structure combines welfare (includes MH-MR-CD), public health and corrections under a single board and management authority. Since Scott is the first implemented human service board, it is placed in a position of "piloting" the concept for the state. At this point in time, the program is not fully developed, although it is stated that efforts are being made to progress toward the provision of a continuum of care for the MH-MR-CD disability groups. Proximity to the metropolitan area permits availability of a number of professional personnel and specialized services.

Services available in this county through the Human Service Baord, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

Partial hospitalization (day/night)

Emergency/crisis services (including nights and weekends)

Consultation and education

*Specialized services for children

*Planning and coordination

Rape prevention and treatment

Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

Halfway houses

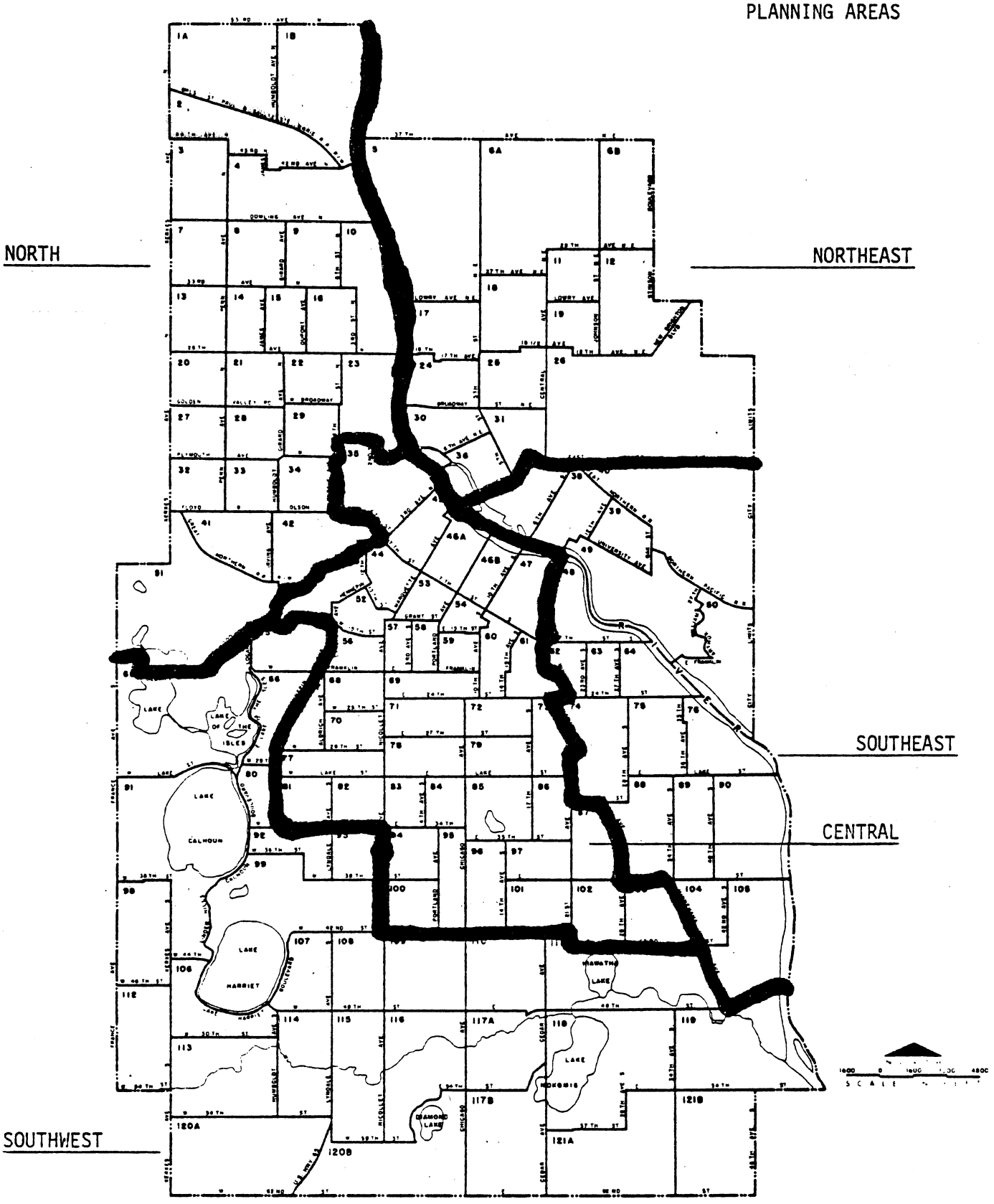
*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services

HENNEPIN COUNTY
CITY OF MINNEAPOLIS
MENTAL HEALTH AND MENTAL RETARDATION
PLANNING AREAS



Priority Rank 10

HENNEPIN COUNTY
Southeast Area - Minneapolis

SOUTHEAST AREA

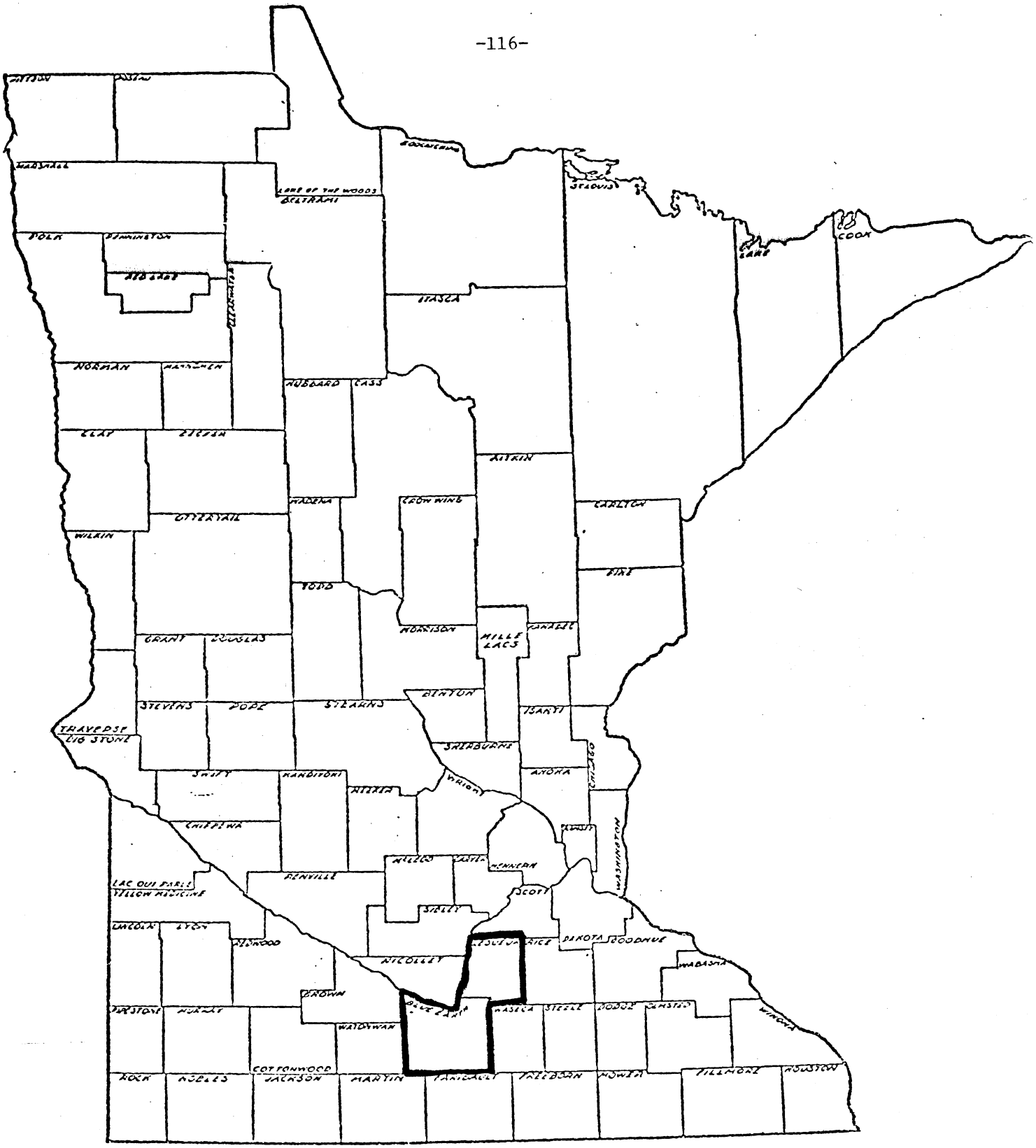
The Southeast area encompasses the University neighborhood and the Longfellow neighborhood. The Longfellow neighborhood is largely a middle class residential area with a mean income of $10,850. Highly transient students make up a significant proportion of the population in the University neighborhood, and the mean income there is $9,000. The two neighborhoods also differ significantly in educational level, as 46% of those 25 and older in Longfellow have less than 12 years of education, compared to 28% in University. 60,430 people lived here in 1970.

Income: The mean income in Southeast is $10,000. This is substantially below that in the suburban areas, but ranks in the middle among planning areas in Minneapolis. Southeast has about the same proportion of individuals and families who are in poverty as Northeast.

Unemployment: Southeast's 1970 unemployment rate is the lowest among city areas.

Educational Attainment: Among city persons, Southeast has the second lowest percent of individuals age 25 and older who have less than 12 years of education.

Age and Family Characteristics: Southeast's percent of families with children under age 18 is the smallest of all county planning areas. Southeast also has the smallest percent of people under age 18. Among city areas, Southeast has the smallest portion of persons 65 and older (12%). It also ranks last among city areas in percent age 14-54 who are divorced or widowed.



MINNESOTA VALLEY MENTAL HEALTH CENTER, INC.

*Main office: Mankato, Minnesota

Region 9
HSA-6
Priority Rank 11

MINNESOTA VALLEY MENTAL HEALTH CENTER
Mankato

The catchment area is comprised of LeSueur and Blue Earth Counties. The population in 1970 was 73,654. Approximately two-thirds of the 50,000 people who live in Blue Earth County live in the City of Mankato. There are approximately 24,000 people living in LeSueur County where there are no large towns. LeSueur County is entirely rural.

In this catchment area, it should be noted that there are no significant numbers of minority groups, except at harvest time in the fall or late summer, when there are migrant workers, many of whom are of Mexican-American extraction. Western LeSueur County, the St. Peter area, was originally a Swedish settlement. Scandinavians continue to be the predominant ethnic group.

The chief industries of this region are manufacturing in Mankato and farming in the outlying rural areas. Mankato State University, with an enrollment of about 11,000, is probably one of the largest industries in the region and certainly the student population has had its influence on Mankato. There have been Mankato students on the City Council, and one former student at Mankato was elected to the Minnesota Legislature.

In regard to the economic character of the region, it appears that it is, generally, affluent. It appears that there are no significantly large pockets of poverty, and that a large majority of the farmers, particularly in Blue Earth, are doing well financially.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

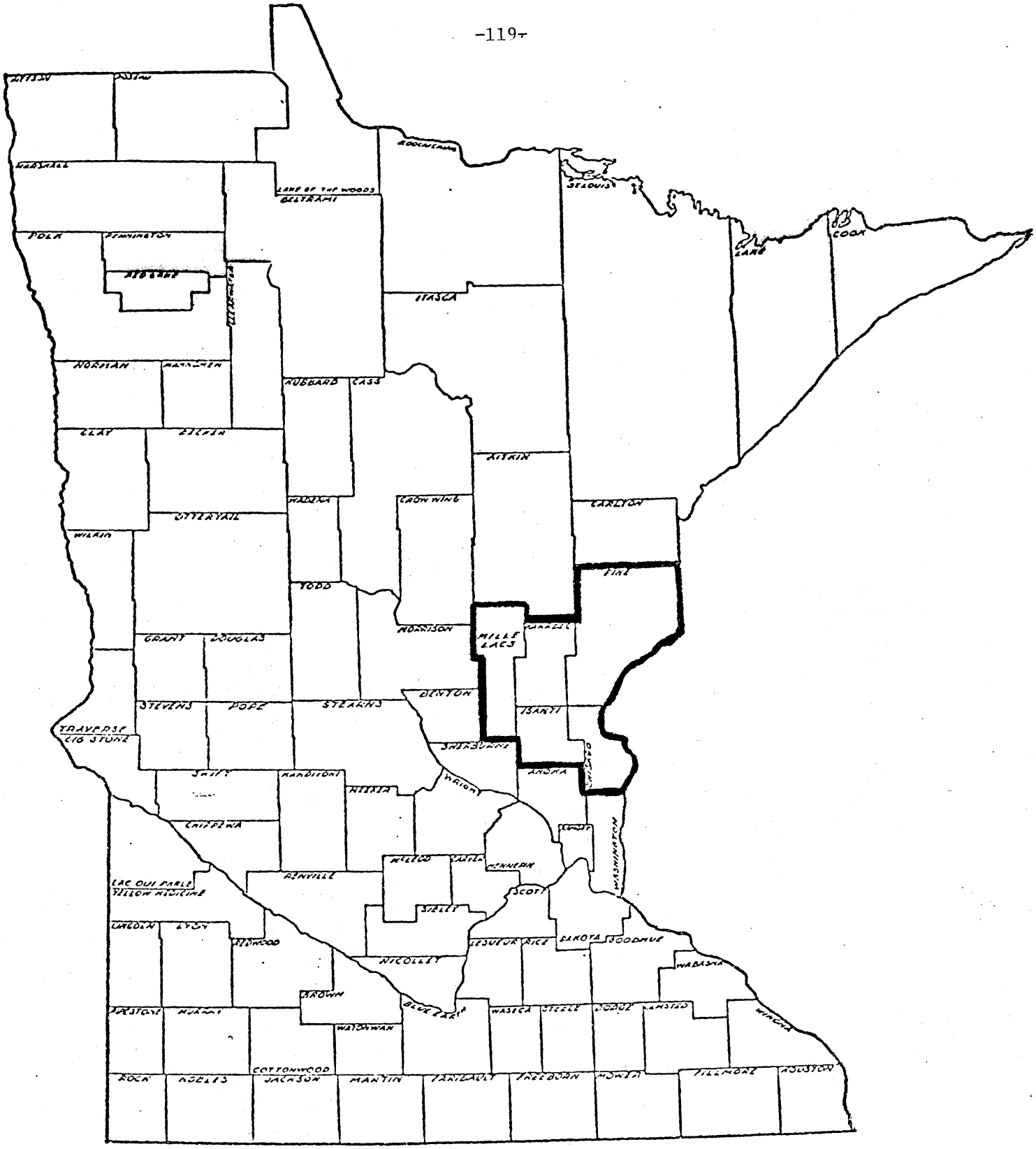
Halfway houses

*Alcohol services

*Drug treatment services

Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



FIVE COUNTY HUMAN DEVELOPMENT PROGRAM, INC.

*Main office: Braham, Minnesota

Region 7E
HSA-4
Priority Rank 12

FIVE COUNTY HUMAN DEVELOPMENT CENTER
Braham

The Five County catchment area covers an area of 3,366 square miles. This is a predominantly rural area with a population of 88,800 and a population density of 32.5 persons per square mile. In 1970, the Census reported a population of 76,351.

The cultural heritage of the area is Scandinavian. There are no significant racial minorities.

Farming and agriculture are the predominant industrial activities. There are some light industries which are farm-related and a recent influx of light manufacturing. Three of the five counties (Pine, Mille Lacs, Kanabec) reflect general economic distress and out-migration.

This area is characterized by a predominantly rural past and present, low urban development, some economic distress, a firm independent public attitude. Although health and social services are available, they are not decentralized, thus presenting some access problems.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

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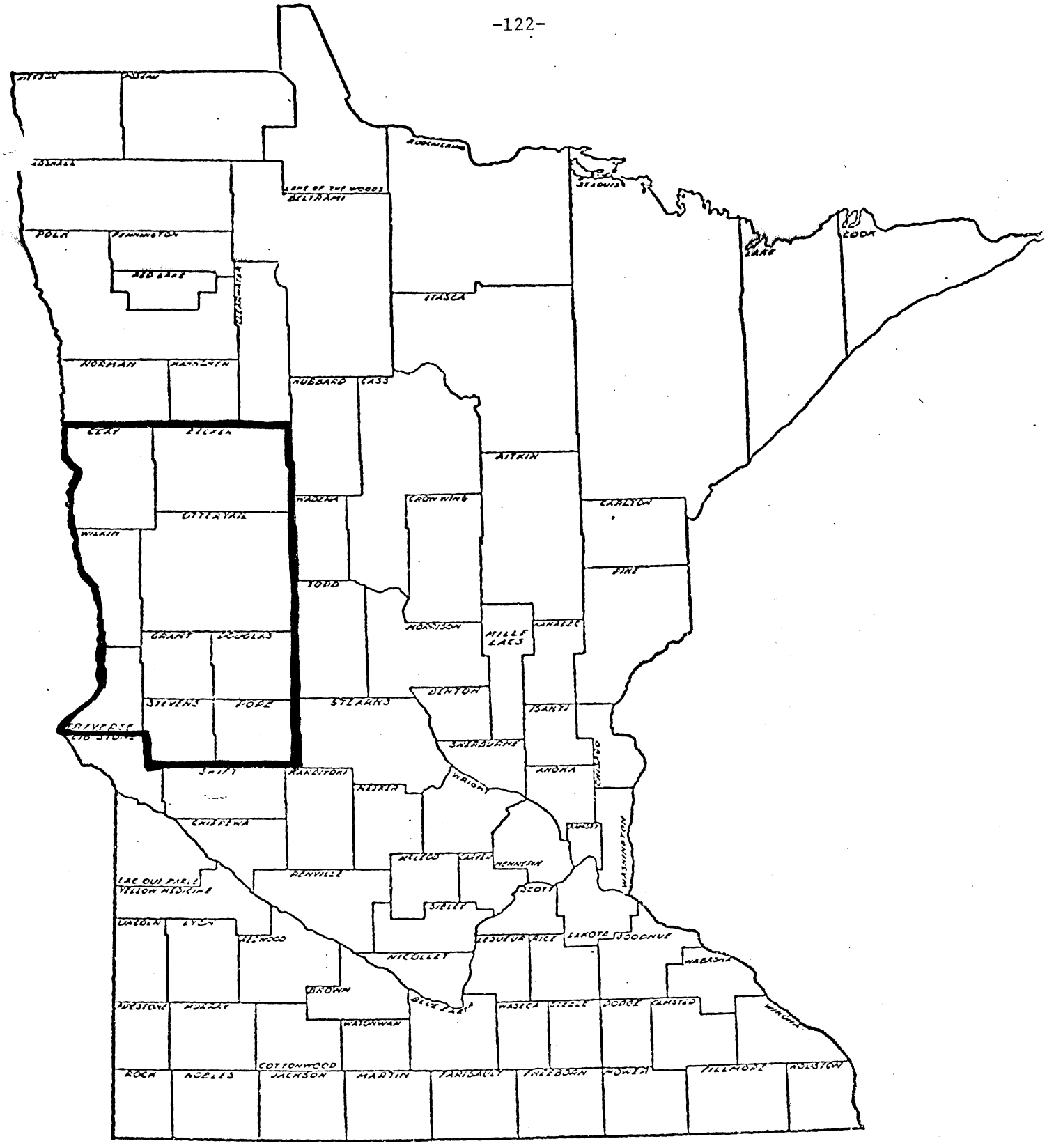
*Community program planning and coordination of MH/MR/CD services



Lakeland Mental Health Center, Inc.

*Main office: Fergus Falls, Minnesota

Region 4
HSA-3
Priority Rank 13

LAKELAND MENTAL HEALTH CENTER
Fergus Falls

This is a large rural and relatively well-populated nine county area bordered on the west by both North and South Dakota. The area comprises 8,324 square miles, with a 1974 estimated population of 192,100 (1970 Census 185,376). The area counties are Becker, Clay, Douglas, Grant, Otter Tail, Pope, Stevens, Traverse and Wilkin.

The population ethnic background is primarily Northern European, with a portion of the White Earth Indian Reservation included within the area. Also, the farming industry annually attracts a sizable migrant group to the area.

Although there are no substantial population centers, and the distance people must travel for trade and services is great, there exists a fair system of community-based services for the disability populations. The proximity of Fergus Falls State Hospital to all the area counties makes available a specialized backup resource for the community system. All the area provider groups participate in a regionwide coordination and planning council.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

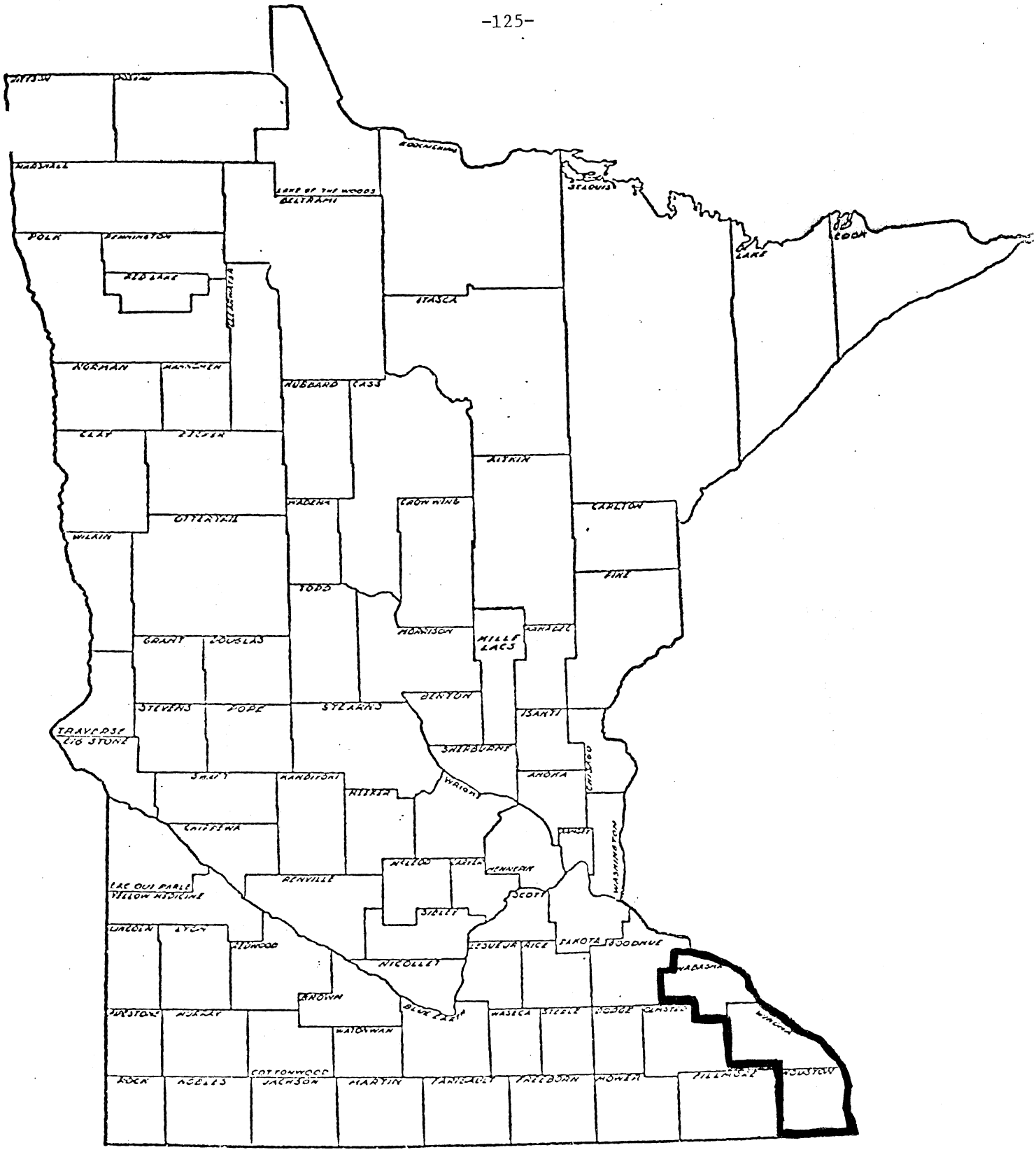
*Halfway houses

*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



HIAWATHA VALLEY MENTAL HEALTH CENTER, INC.

*Main office: Winona, Minnesota

Region 10
HSA-7
Priority Rank 14

HIAWATHA VALLEY MENTAL HEALTH CENTER
Winona

The population for this three-county area was 79,183, and the total area in square miles is 1,707. Approximately 65-70% of the County of Winona's population is contained within the City of Winona. The City of Winona has a population of 30,000. Other than Winona, there are no towns larger than 4,000-5,000 people. The primary ethnic groups are Northern European.

Winona is the industrial, cultural, marketing and educational center for this particular region of the state. There are over 90 large and small industries, two colleges, one university and one vocational-technical school. Approximately 7,000 students attend St. Mary's College, St. Teresa's College and Winona State University. Even though much of the topography is hilly, rugged country, the rural areas away from Winona tend to rely on agriculture as a major industry. It appears that no particular type of farming pervades, but rather a mixture of cash crop and livestock.

Except for the City of Winona, which has a large percentage of transient and young people associated with the colleges and the University, most of the area has a slightly older population and is very stable. Aside from some small pockets of poor in the City of Winona, there is limited poverty in the area.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

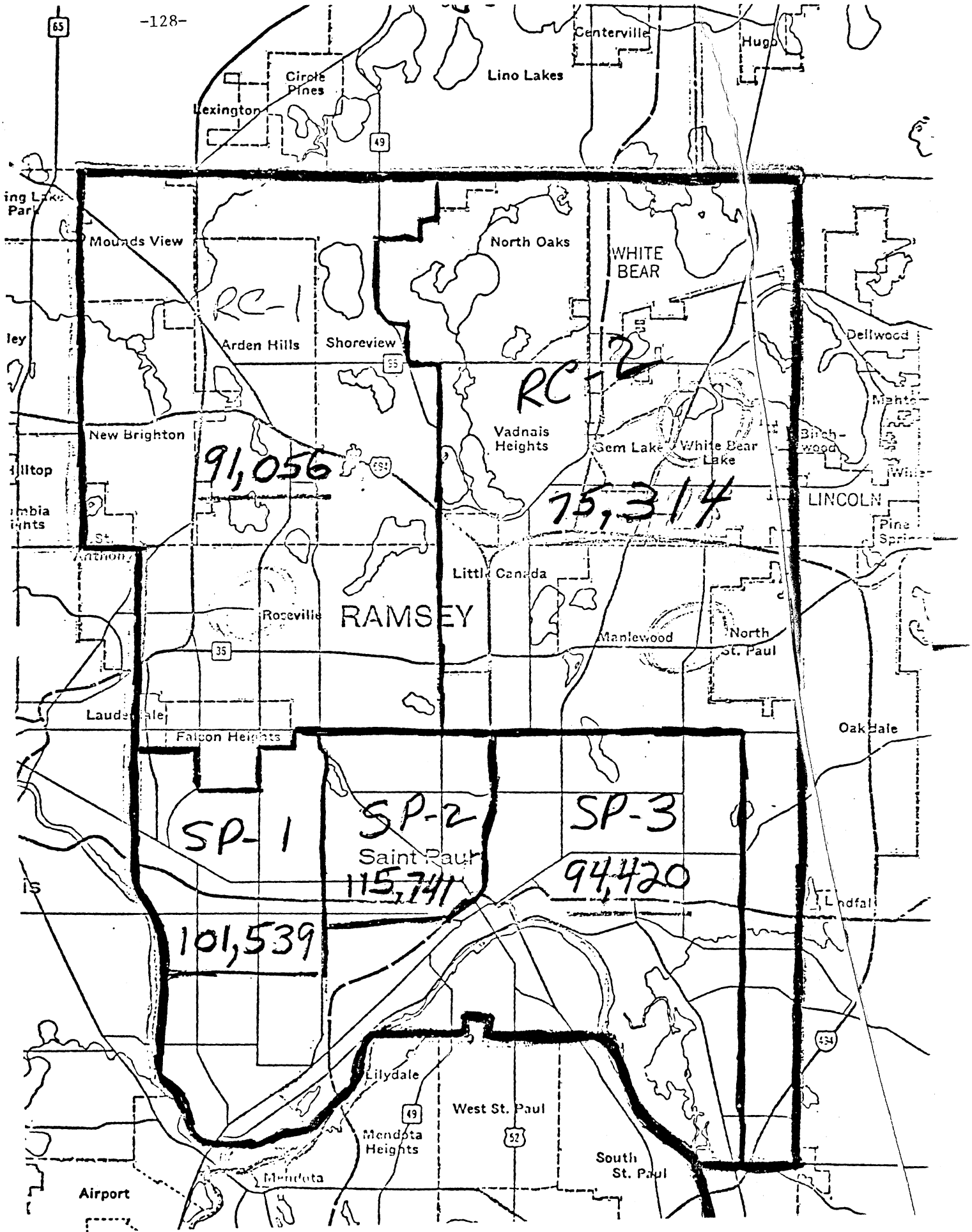
Halfway houses

*Alcohol services

*Drug treatment services

*Community program planning and coordination of MH/MR/CD services

Special services for elderly people


Centerville
Hugo
Lino Lakes
Circle Pines
Lexington
Mounds View
North Oaks
WHITE BEAR
RC-1
RC-2
Arden Hills
Shoreview
Dellwood
New Brighton
Vadnais Heights
Gem Lake
White Bear Lake
Birch-wood
91,056
75,314
LINCOLN
Little Canada
RAMSEY
Roseville
Manlewood
North St. Paul
Falcon Heights
Oakdale
SP-1
SP-2
SP-3
Saint Paul
115,741
94,420
101,539
Lilydale
West St. Paul
Mendota Heights
South St. Paul
Mendota
Airport

Region 11
HSA-5
Priority Rank 14

ST. PAUL-3

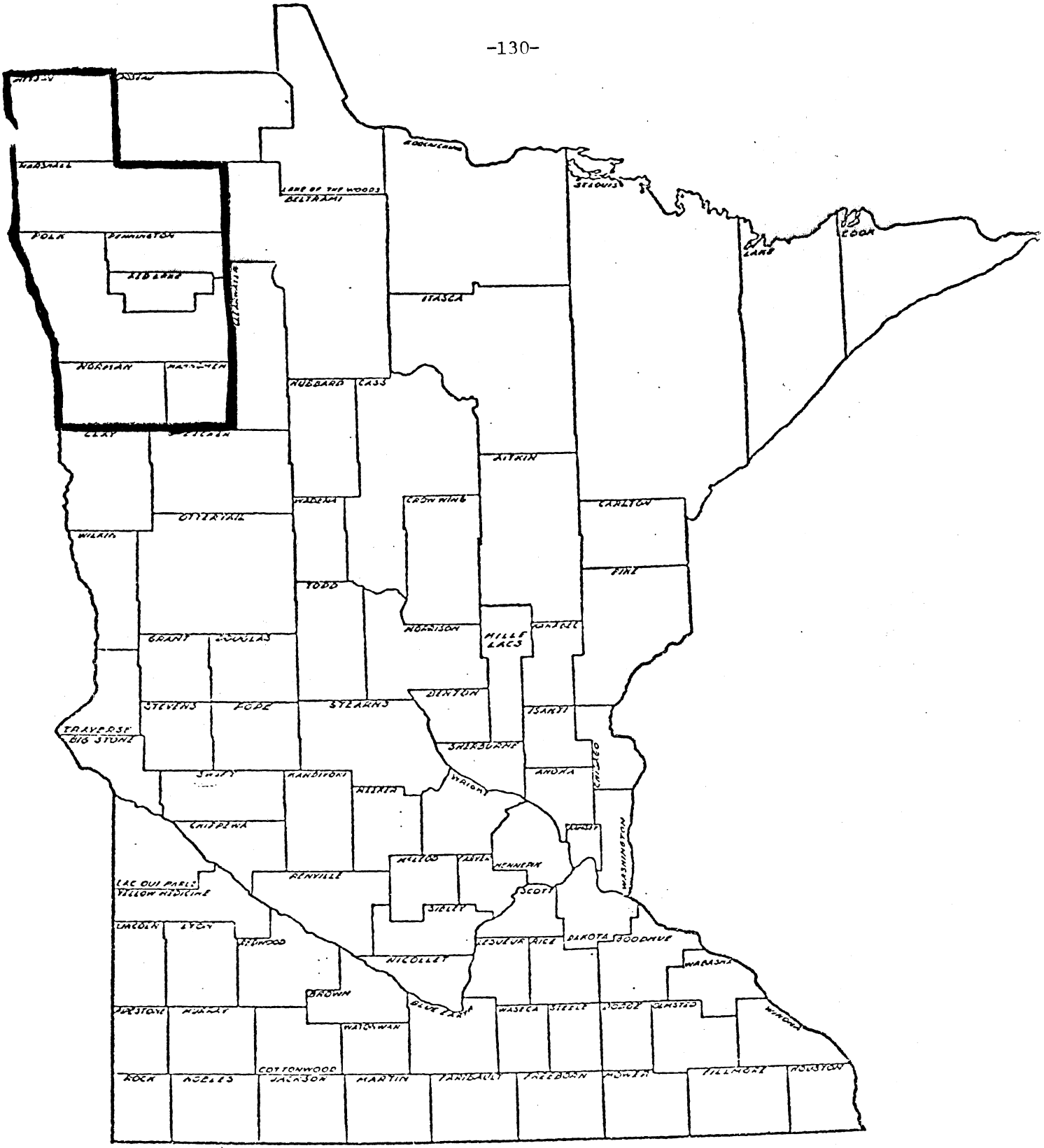
The St. Paul-3 catchment area is basically a middle class area. This area is basically Scandinavian in background, with a great number of the working people employed in skilled labor jobs. There is a large portion of "middle management" employees from business and industry living in this area. At one time, there was a large area of undeveloped land in the southern third of the area, which has been subdivided into residential plots. Housing and schools are being constructed. This area produces the fewest demands for all human services based on population density.

Population: St. Paul-3 ranks third in population, with a total of 94,420 people, according to the 1970 Census.

Income: The mean family income is $9,791, which ranks it first in St. Paul catchment areas and third within the total of five. Approximately 8% of the population has income that falls below the poverty level.

Education: St. Paul-3 ranks in the middle of the three St. Paul areas, and fourth overall in percentages of individuals who are high school graduates.

Age and Family Characteristics: St. Paul-3 has the highest St. Paul percentage total of persons under 18 and families with children under 18, and third highest total overall. It has the third highest percentage of people over 65, and contains the second highest divorce percentage.



NORTHWESTERN MENTAL HEALTH CENTER

*Main office: Crookston, Minnesota

Region 1
HSA-1
Priority Rank 16

NORTHWESTERN MENTAL HEALTH CENTER
Crookston

This is a seven-county area in the extreme northwest corner of the state, bordering on Canada and North Dakota. The area covers 6,147 square miles, and has a population of 87,465 in the 1970 Census (1973 estimated population 97,925) composed primarily of persons of Scandinavian stock. The largest minority group is Indian, most of whom are located in the White Earth Reservation. The principal industry is farming.

This is a rural area, remote in distance from population centers and from most facilities for special care of emotional difficulty. Some towns in the area are 240 miles from the regional state hospital (Fergus Falls).

Other local factors are: higher incidence of the aged; large percentage of young people emigrating to the industrial area; two minority groups in the area are Indians on White Earth Reservation, and the migrant laborers of Mexican descent. The Indian population is less than 1% of the geographic population.

Northwestern Mental Health Center has been an affiliate of Northwestern Hospital in Thief River Falls since the beginning of the Federal Mental Health Staffing Grant. Agreement has been reached that the remaining year of the federal staffing grant will be shifted from the hospital to the mental health center. No other federal mental health grant applications are pending at this time.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

Planning and coordination

Rape prevention and treatment

Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

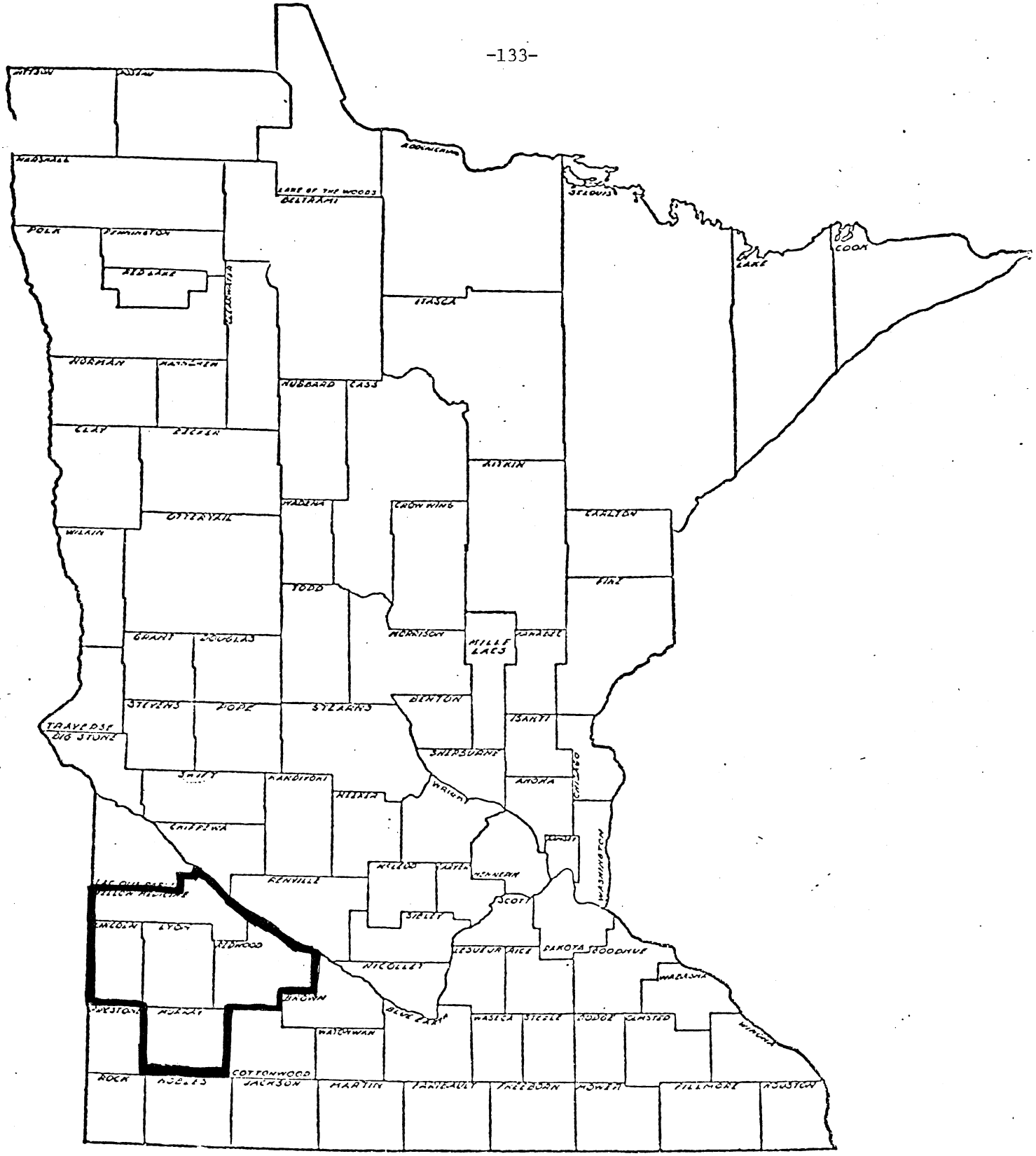
*Halfway houses

*Alcohol services

*Drug treatment services

Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



WESTERN HUMAN DEVELOPMENT CENTER, INC.

*Main office: Marshall, Minnesota

Region 8
HSA-6
Priority Rank 17

WESTERN HUMAN DEVELOPMENT CENTER
Marshall

This is a five-county area of Southwestern Minnesota, bounded on the west by South Dakota, with a total area of 3,571 square miles and a population of 79,366. The catchment area counties are Lincoln, Lyon, Murray, Redwood and Yellow Medicine.

The area's ethnic background is largely Northern European, with a relatively small Native American population located at the Upper Sioux Reservation in Redwood County.

Farming and agri-business are the major industries. The area has a state university located centrally at Marshall.

The Western Human Development Center and the Southwestern Mental Health Center, located in Luverne, are currently exploring the feasibility of jointly applying for a federal planning grant as a prelude to the establishment of a comprehensive community mental health center in the combined 10-county area. No final decision has been made on this question, as of June, 1977.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

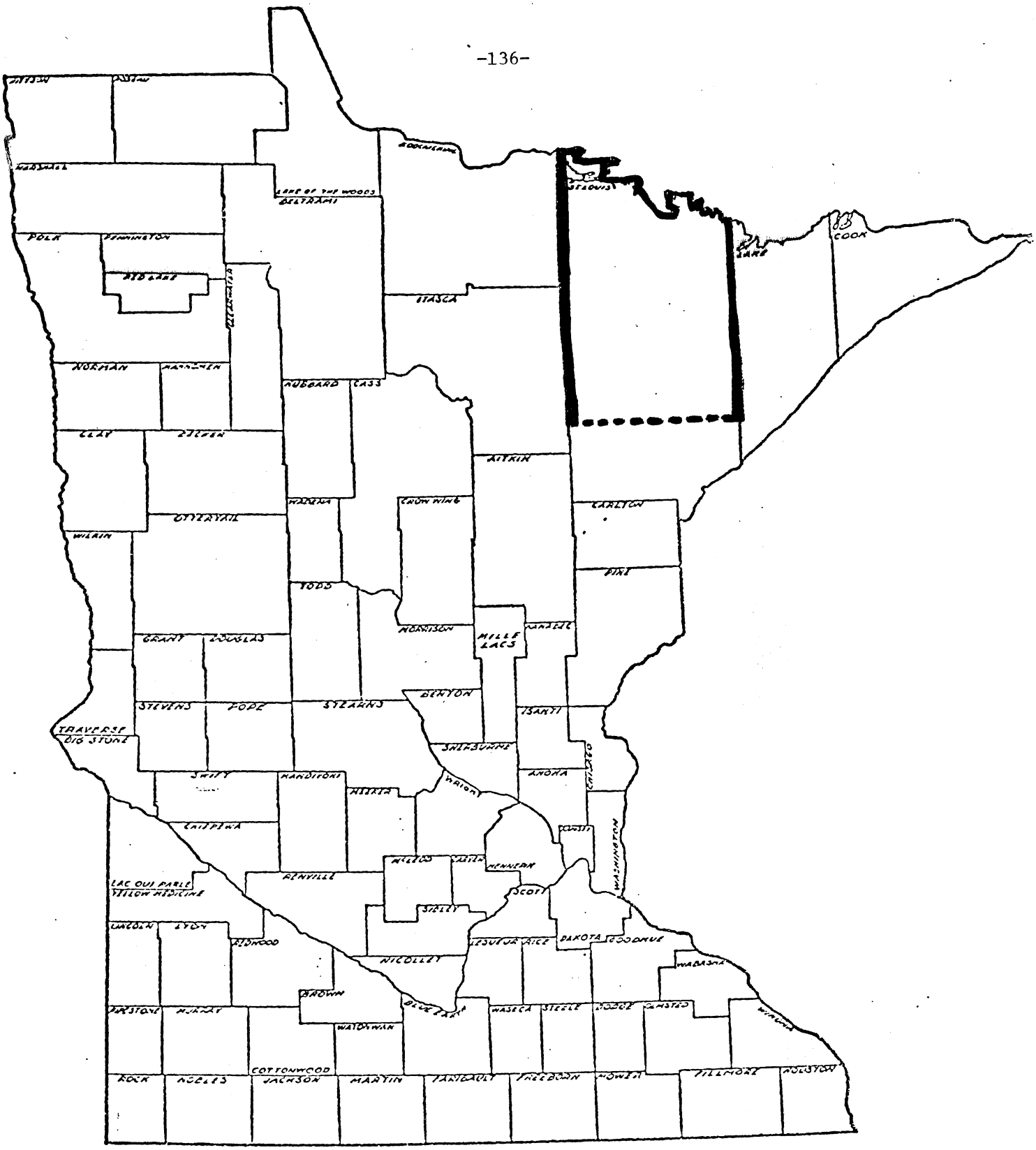
Halfway houses

*Alcohol services

*Drug treatment services

Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



RANGE AREA HUMAN RESOURCES BOARD, INC.

*Main office: Virginia, Minnesota

Region 3
HSA-2
Priority Rank 18

RANGE AREA HUMAN RESOURCE BOARD
Virginia

This catchment area includes the northern two-thirds of St. Louis County, located in the central part of Northeastern Minnesota and bordering Canada on the north. The area is 80 miles long and 50 miles wide, covering a total of 3,871 square miles. The area is essentially rural, with 3.8 persons per square mile. The largest population centers are Hibbing (16,104) and Virginia (12,450). There were 87,763 people living there in 1970.

The area has more "melting pot" characteristics than any other rural area in the state. There are still second generation immigrants from the British Isles (primarily English), the Scandinavian countries, and Southern and East Central Europe. There continues to be a somewhat culturally isolated population of Finnish people. A small Chippewa Indian reservation is within the catchment area.

The major industry is iron mining and processing. The economy has been one of "boom or bust", depending on the current status of the mining industry. The area is currently experiencing a boom period. Unemployment is low, housing in certain areas is scarce, and the cost of living is relatively high.

The Range Area Human Resource Board has had an NIMH staffing grant, which has expired at the end of the eighth year of funding. Currently, it has a federal Consultation and Education grant, to carry on its nationally recognized work in this area.

Services available in this county through the mental health center and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

*Halfway houses

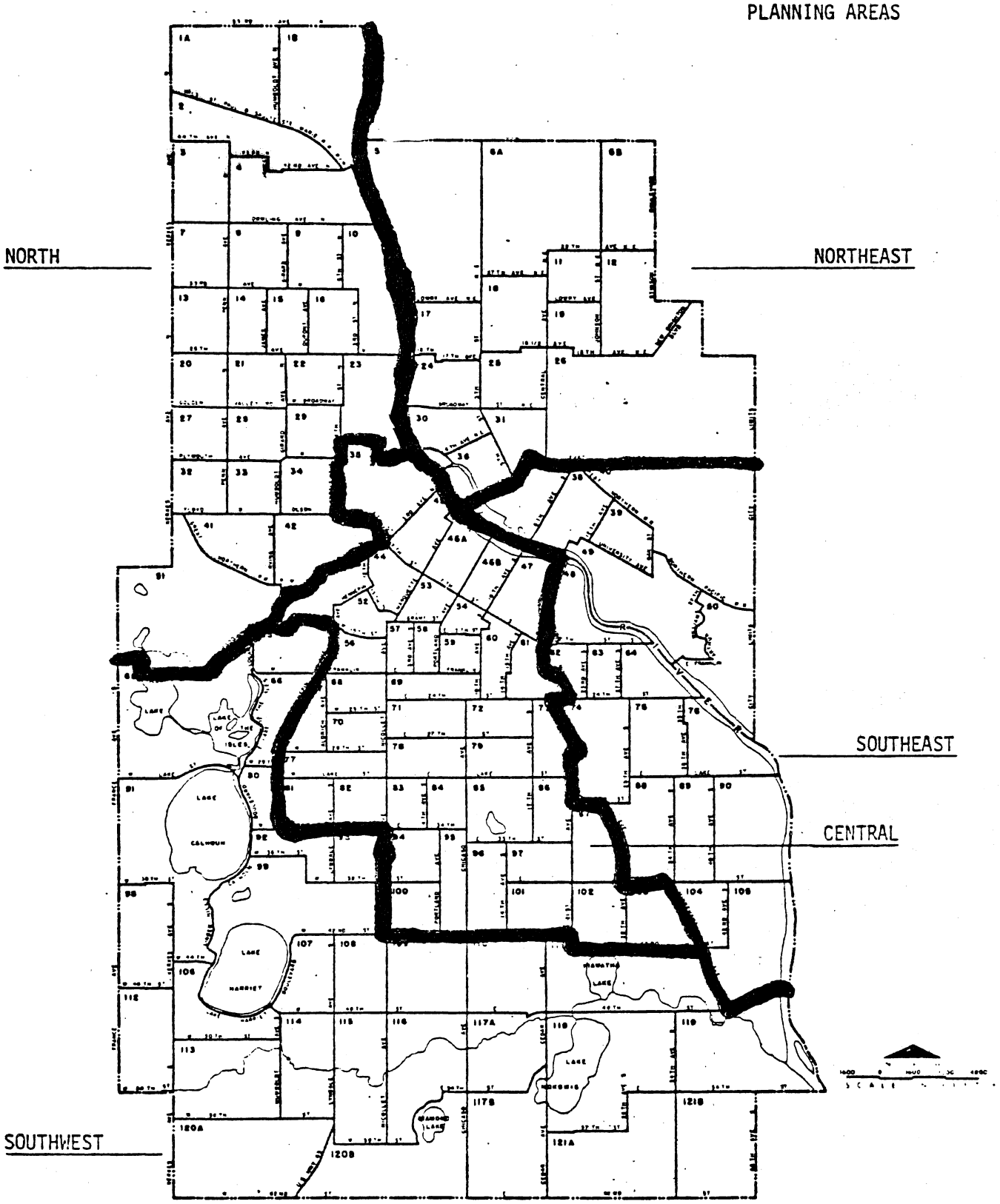
*Alcohol services

*Drug treatment services

*Community program planning and coordination for MH/MR/CD services

*Special services for elderly people

HENNEPIN COUNTY
CITY OF MINNEAPOLIS
MENTAL HEALTH AND MENTAL RETARDATION
PLANNING AREAS



Region 11
HSA-5
Priority Rank 19

HENNEPIN COUNTY
Northeast Area - Minneapolis

NORTHEAST AREA

The Northeast area covers Minneapolis' Northeast neighborhood, and the village of St. Anthony. The area has the second youngest population among planning areas in Minneapolis. It is about average among the Minneapolis areas with regard to most other demographic characteristics. The Census of 1970 reported 53,175 living here.

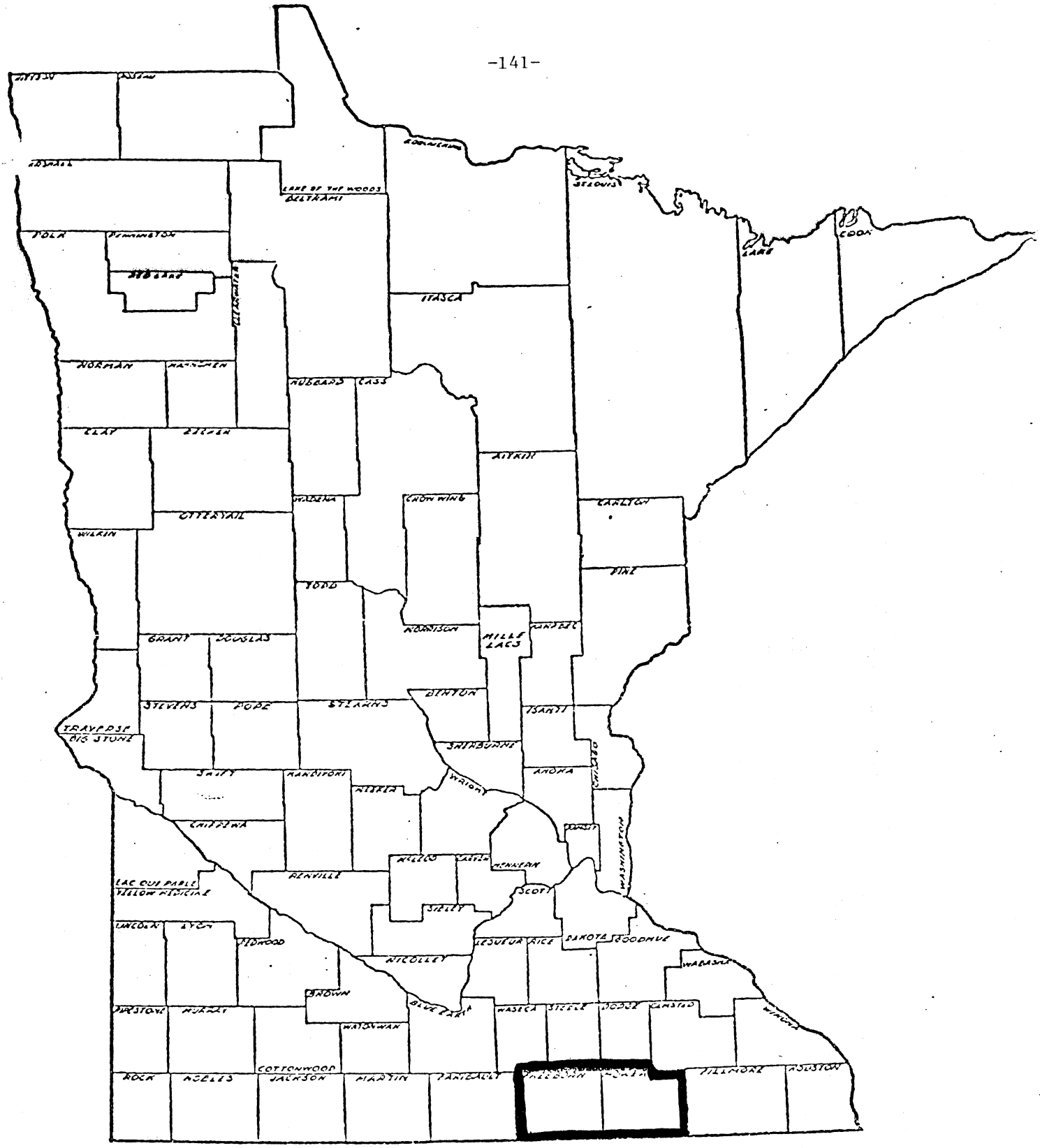
While residents of Northeast Minneapolis have free access to mental health centers and hospitals throughout the Metropolitan Twin City area, there are no such facilities available in this community. Residents of the area are currently working with the Hennepin County MH/MR/CD Department and the University of Minnesota to change this situation. The Department is in touch with the representatives of this planning effort and will assist in efforts to improve access to mental health services.

Income: The mean family income in Northeast is about $10,750. This is considerably less than each of the three suburban areas, but ranks second highest among the planning areas in Minneapolis. Northeast has the third highest percent of individuals in poverty, and is fourth in percent of families in poverty.

Unemployment: Northeast's 1970 unemployment rate is about average among planning areas in the city.

Educational Attainment: Northeast ranks second in proportion of persons age 25 and older with less than 12 years of education.

Age and Family Characteristics: Northeast ranks second among planning areas in Minneapolis in percent of families with children younger than 18, and in percent of population under 18. It ranks next to last among city areas in percent of persons 65 or older. Northeast's percent of persons age 14-54 who are widowed or divorced is about average.



FREEBORN-MOWER MENTAL HEALTH CENTER, INC.

*Main office: Austin, Minnesota

Region 10
HSA-7
Priority Rank 20

FREEBORN-MOWER HEALTH CENTER
Austin

The population of this catchment area was 107,743 in 1970 and the total number of square miles of these two counties is 1,404. Approximately 70% of Mower's population, or 30,000, live in Austin. The population of Freeborn County is about 38,000 and the county seat is Albert Lea, which has about 65-70% of that figure. The majority of the population in these two counties live in an urban setting.

The largest numbers of the people are of German, Swedish and Danish extraction. This is one of the most politically conservative areas in the state, particularly regarding governmental intervention. The per capita income is quite high. The meat packing plants in Albert Lea and Austin and the flat, rich farmland account of the general prosperity of the area.

Although this area has been traditionally a relatively high income area, this situation is threatened by a possible temporary closing of the Hormel Meat Packing plant while a new plant is being built.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

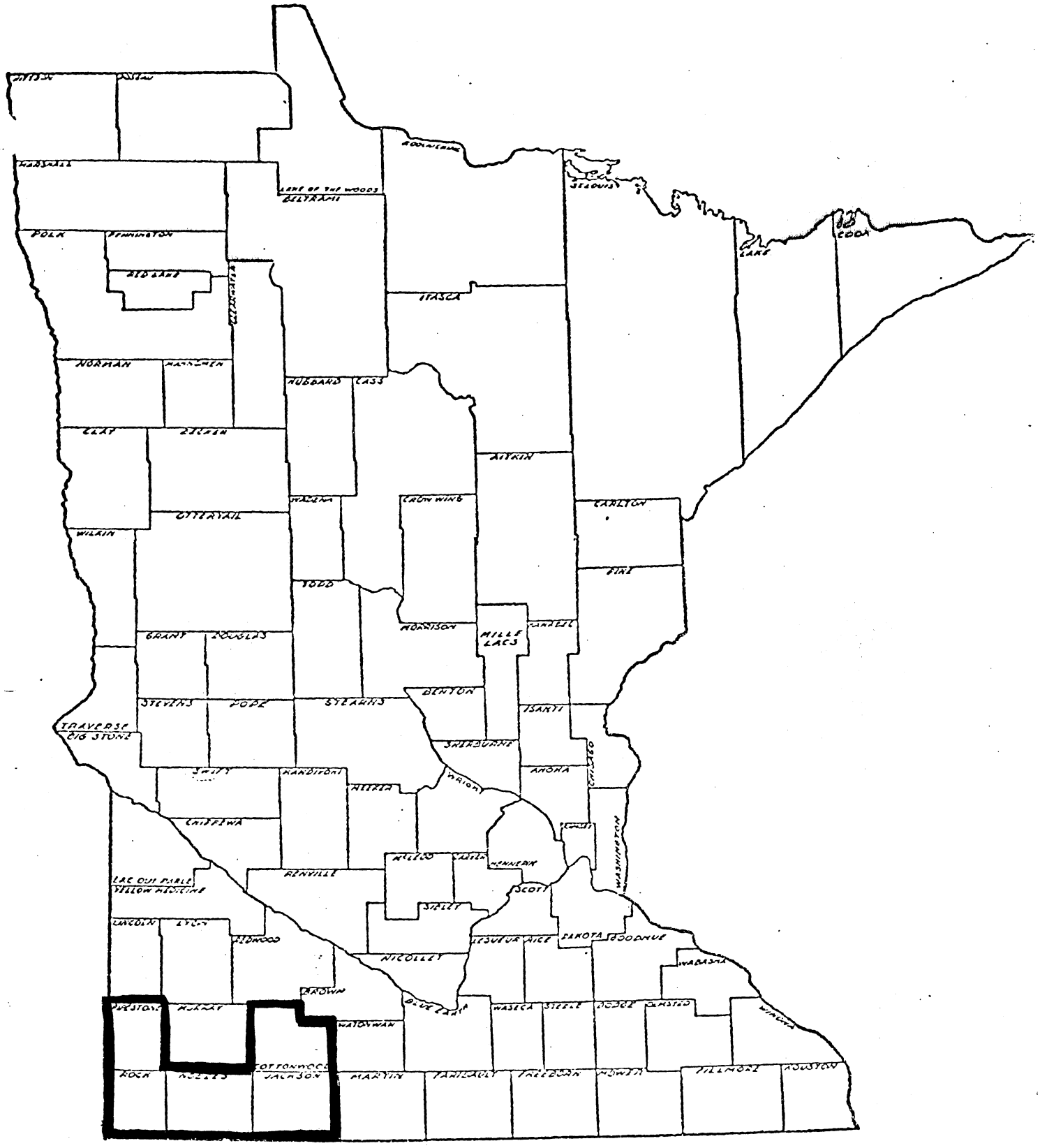
Halfway houses

*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



SOUTHWESTERN MENTAL HEALTH CENTER

*Main office: Luverne, Minnesota

Region 8
HSA-6
Priority Rank 21

SOUTHWESTERN MENTAL HEALTH CENTER
Luverne

This is a five-county area in the extreme southwestern corner of the state, bordering with South Dakota on the west and Iowa on the south. The area covers 2,993 square miles, with a 1970 Census population of 76,584 (1974 estimated 76,900). The counties served are Cottonwood, Nobles, Jackson, Pipestone and Rock. The major ethnic groups are Scandinavian, Dutch, German and Polish. The major industry is farming and agri-related businesses. The only true minority group is a small Native American settlement in Pipestone County.

Traditionally, the southern areas of the state have placed a high value on the work ethic, with the churches being the center of the social system. These characteristics have resulted in limited acceptance of deviant behaviors and, therefore, the community-based service system for the behaviorally disabled has been limited to the single MHC outpatient program and the county welfare departments.

The Southwest Mental Health Center and the Western Human Development Center, located in Marshall, are currently exploring the feasibility of jointly applying for a federal planning grant as a prelude to the establishment of a comprehensive community mental health center in the combined 10-county area. No final decision has been made on this question, as of June, 1977.

Residential treatment resources for the mentally ill remain a major unmet need, particularly when the area's state hospital resource at Willmar is approximately 125 miles from the area's population center of Worthington.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

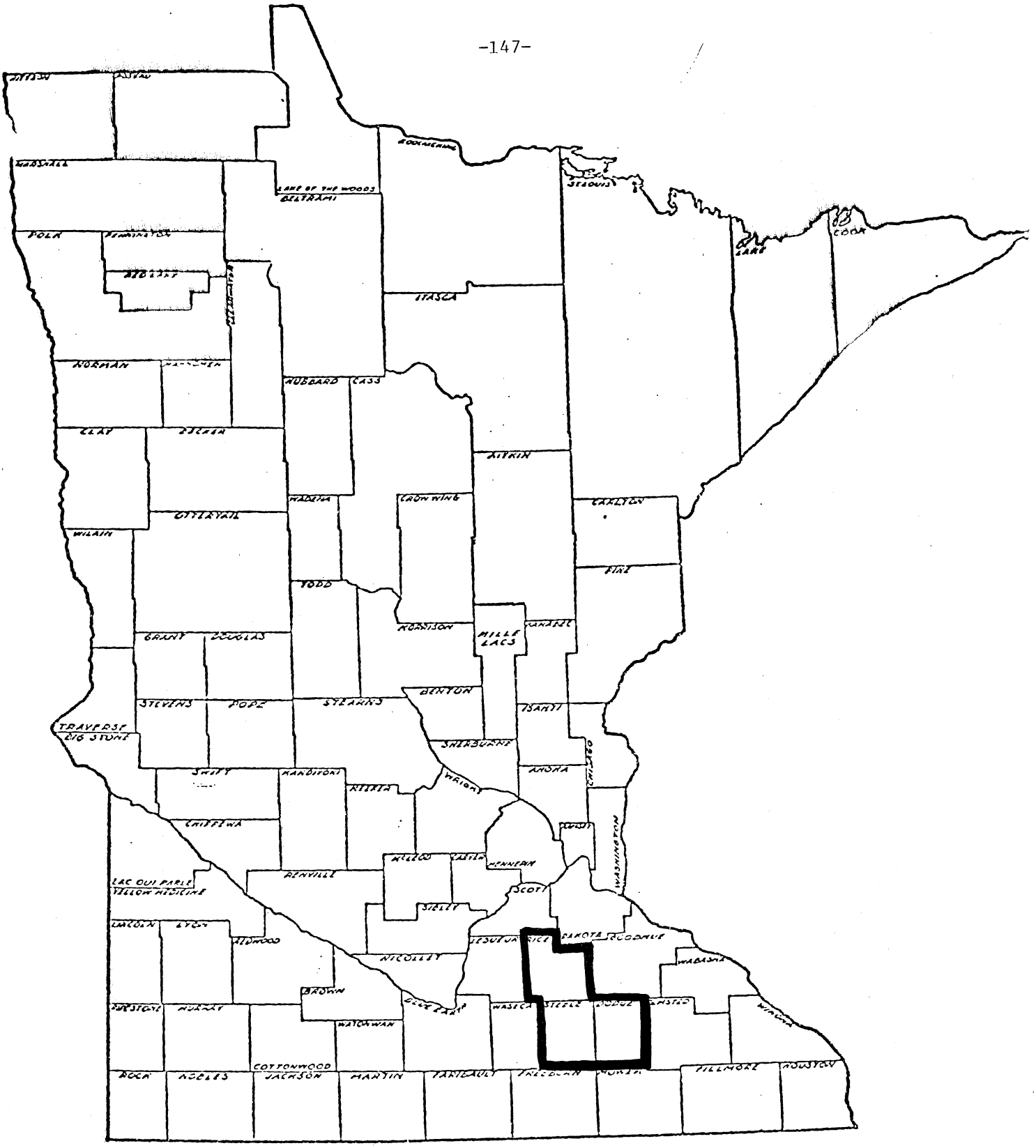
Halfway houses

*Alcohol services

*Drug treatment services

*Community program planning and coordination of MH/MR/CD services

Special services for elderly people



LUTHER W. YOUNGDAHL HUMAN RELATIONS CENTER

*Main office: Owatonna, Minnesota

Region 10
HSA-7
Priority Rank 22

LUTHER W. YOUNGDAHL HUMAN RELATIONS CENTER
Owatonna

There are three counties which make up the catchment area: they are, Dodge, Steele and Rice. The population for the three counties is 103,400 (98,213 in 1970) and the total number of square miles contained within this region is 1,771. Almost half of the population is located in Steele County and Owatonna, the county seat, is the center for industrial development and trade. Dodge County, located in the eastern portion of the catchment area, and Waseca County, located in the west, are rural-agricultural areas characterized by less population.

In general, the topography is flat and the major industry is farming, although Owatonna has a number of small industries. A major industry in Rice County is education. Northfield, the cultural and educational center of the area, has two colleges, Carleton and St. Olaf.

There are no large minority groups, although there are increasing numbers of Mexican-American migrant workers. The vast majority of the people tend to be Caucasian, and the most prevalent ethnic groups are German, Swedish and Czechoslovakian.

Waseca County, which was previously part of this catchment area, has withdrawn from the Blue Earth, LeSueur, Waseca Human Service Board. It will continue to purchase mental health services from the Youngdahl Center. The population figures given above include Waseca County.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

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Special services for elderly people

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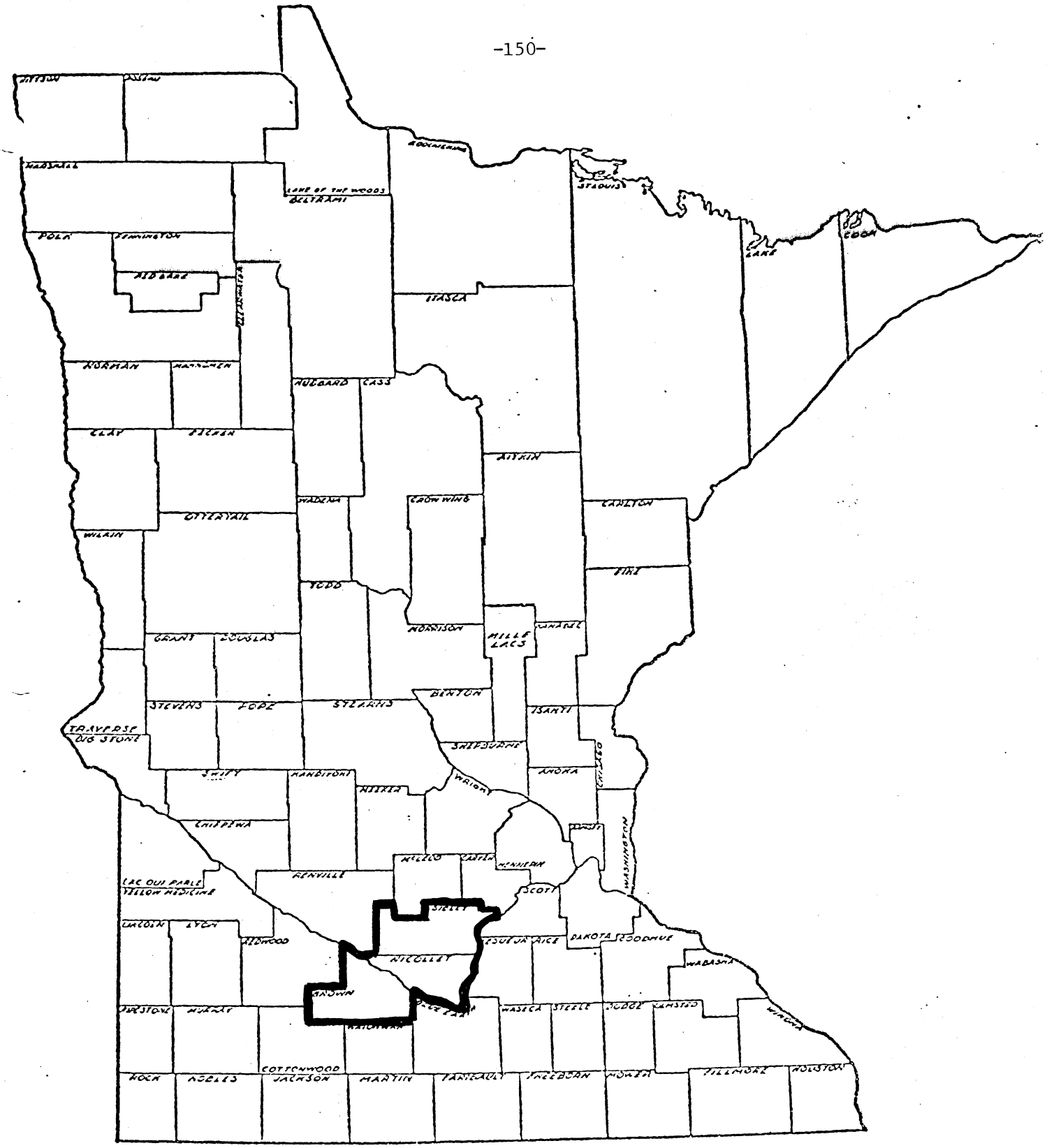


SIOUX TRAILS MENTAL HEALTH CENTER, INC.

Main Office: New Ulm, Minnesota

Region 9
HSA-6
Priority Rank 23

SIOUX TRAILS MENTAL HEALTH CENTER
New Ulm

The Sioux Trails Mental Health Center is based in New Ulm, Minnesota, which is located approximately 25 miles west of Mankato and 110 miles southwest of the Twin Cities. There currently are three counties located within this catchment area: they are, Brown, Nicollet and Sibley. The total population of these three counties in 1970 was 106,864 and the total square miles contained within is 2,761. New Ulm is the most central location in the three-county area, but is located approximately 40 miles from St. Peter, which is to the east boundary and about 60 miles from Fairmont, which is to the south boundary of the area. Many people in the three-county area tend to look at Mankato as their cultural, educational, shopping, etc., center.

Almost all industry in the area is either agricultural or agriculturally based. There are two colleges in the area: Martin Luther College at New Ulm and Gustavus Adolphus at St. Peter.

There are no large numbers of minorities in this area. Much of the New Ulm and Brown County and the surrounding area was settled by Germans. Fairmont was originally settled by the English, St. Peter by Swedish, and Eastern Watonwan County and Western Blue Earth County by Scandinavians. The people in this area of the state tend to be politically conservative and rather provincial in attitude and outlook.

Brown, Nicollet, and Sibley Counties agreed to form a human service board, but Sibley County has served notice of its intent to withdraw. The Brown/Nicollet Human Service Board contracts with Sioux Trails Mental Health Center for services for the residents of its two counties. Sibley County will be contracting directly with Sioux Trails. In addition, the Faribault-Martin-Watonwan Human Service Board contracts with Sioux Trails for services to Watonwan County.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

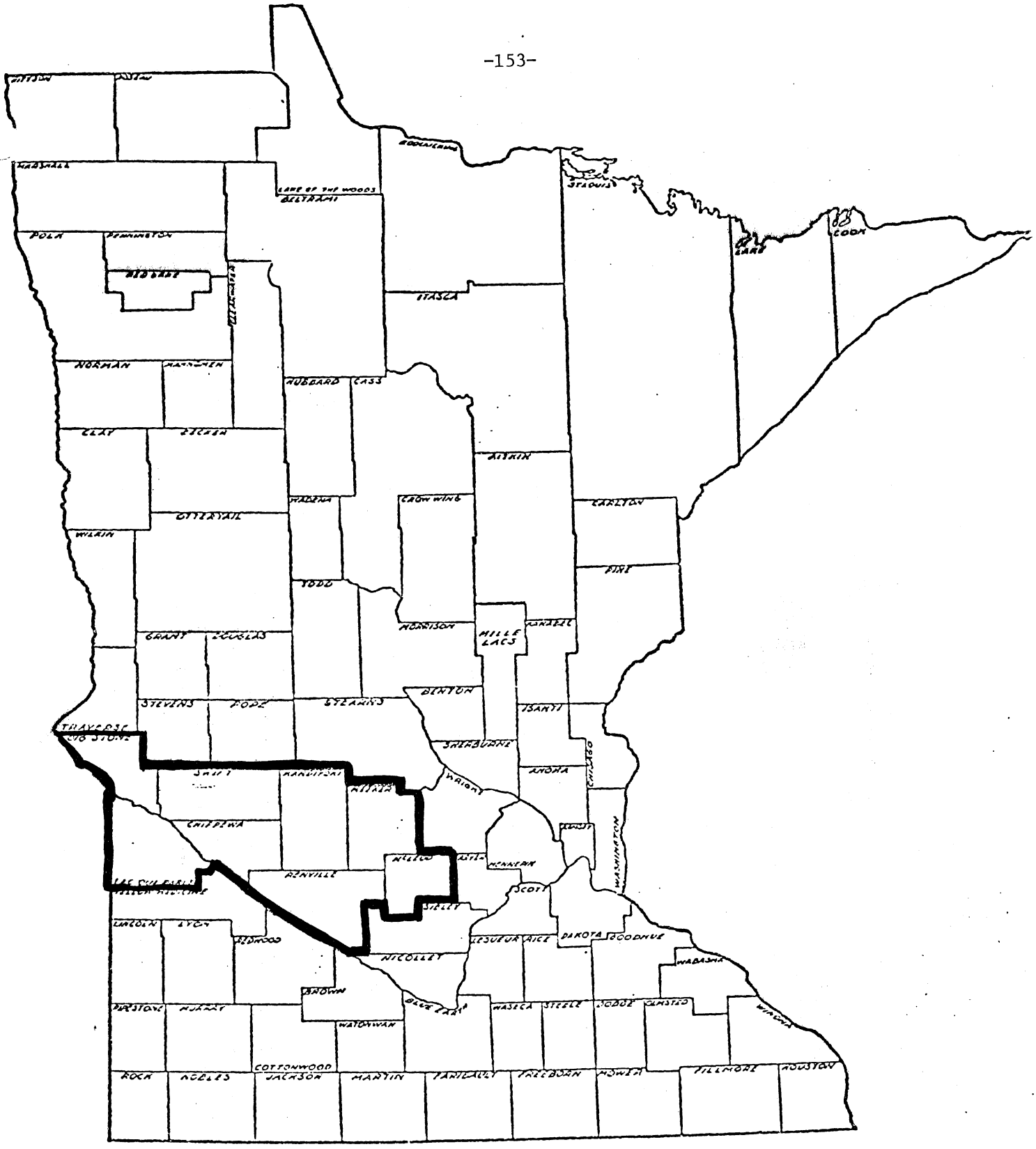
Halfway houses

*Alcohol services

*Drug treatment services

Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



WEST CENTRAL COMMUNITY SERVICES CENTER

*Main office: Willmar, Minnesota

Region 6
HSA-6
Priority Rank 24

WEST CENTRAL COMMUNITY SERVICES CENTER, INC.
Willmar

The eight counties that comprise the West Central Community Services Center area are all rural counties. In no county do communities with the population in excess of 2,500 constitute more than half the population of that county. The area begins about 50 miles west of the Twin Cities, and extends 120 miles from east to west. The north-south dimensions are within 60 miles at any one point. Willmar (population of approximately 15,000) is the central city of the area and the only community with a population in excess of 10,000. It is the major trade and professional center for the region. The 1970 population was 145,550.

There is great dependence upon personal transportation. The economy is largely agrarian based and, for the most part, industrial growth is related to agri-business efforts. Many farm families with low income supplement their incomes through employment in the new farm-related industries that are being developed.

The population is relatively homogeneous from a cultural and social-economic standpoint. The ethnic background is largely Northern European. The number of persons belonging to minority races is lower than in any mental health area in the state, with less than 1% of the population being nonwhite. There is a small Indian agency in the area with less than 40 families. While the people tend to be conservative in their lifestyle, there is support for community programs and services. Community pride is important, and civic organizations flourish.

Approximately 16.5% of the population of the area is over 65 years of age. This is significantly higher than the state percentage, which is under 11%. This catchment area has the third highest proportion of older people in the state. Mental health services to the aging population have lagged, and there has not been the concerted effort to meet the special needs of this group.

Alcoholism is another significant problem which is considerably higher than the state average. The area ranks sixth of the state catchment areas with respect to the prevalence of occurrence of this condition.

Violent death and infant mortality are also significantly higher than the state average. This is related, in part, to the special hazards in farming and the problems of safety which have not been approached in a coordinated way.

This is a comprehensive community mental health center. It has a Staffing Grant, which continues until 1978, and a growth grant which will be in effect until 1982.

Services available in this catchment area through the mental health center and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

Rape prevention and treatment

Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

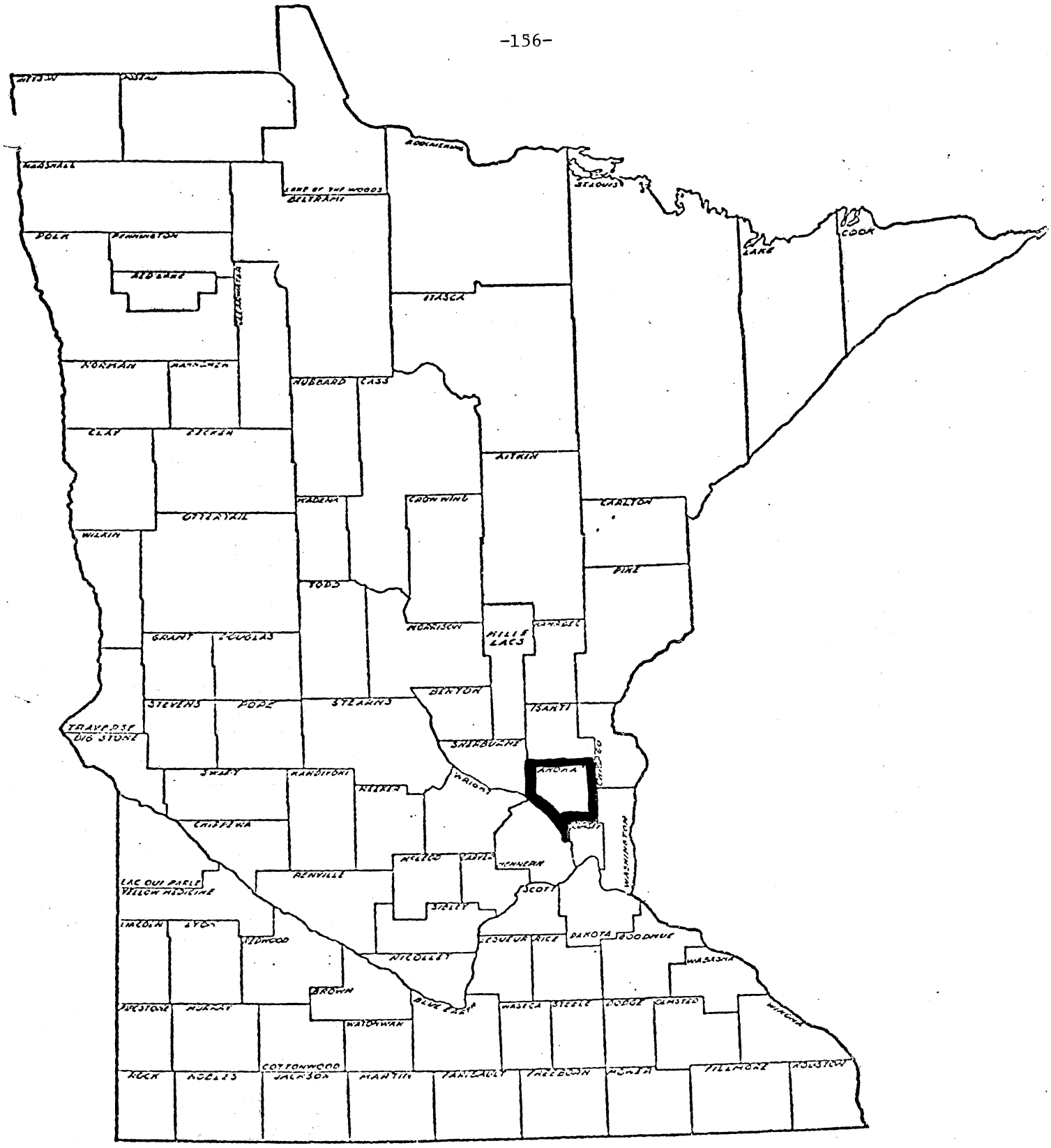
*Halfway houses

*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



ANOKA COUNTY COMPREHENSIVE HEALTH BOARD

*Main office: Anoka, Minnesota

Region 11
HSA-5
Priority Rank 25

COMPREHENSIVE HEALTH BOARD - OFFICE OF HUMAN RESOURCES
Anoka County

This area has a population of 185,000 (1975 estimate) residing in 424 square miles, up from 154,556 people in 1970. The southern half of the county is fairly densely settled, with 425 persons per square mile. The communities have been characterized as "bedroom communities", although commerce and light industry are infiltrating from the more urbanized counties to the south. This county is one of the five which surround the highly urban counties of Hennepin and Ramsey. Because of this, and the dynamic character of the area, it is subject to a great deal of population growth and of planning attention, generally initiated at the Metro Council or at the county level. The northern portion of the county is less densely settled and its political representation reflects this perspective. The City of Anoka is the seat of county government. It is here that most of the public social and health services are located.

There is not a significant number of minority persons (racial or ethnic) but, where there are minorities, they tend to be located in the south crescent, approximate to the urban counties.

There are no chief industries, although farming and agriculture are prevalent in the northern section of the county. In the south, there are a variety of light industries.

The county is a part of Region 11, which is estimated to have a 25% population increase over the next 25 years. This region contains approximately 50% of the state's population.

This is now an established suburban area. Major institutions located in the county include a state hospital (MH, CD) and a multi-county (Anoka-Ramsey) Vocational Technical School, serving approximately 1,600 students, and the Anoka-Ramsey Community College which serves approximately 2700 students.

Services available in this county through the mental health department, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening (by the County Department of Social Services)

*Aftercare follow-up (in conjunction with county social service agencies)

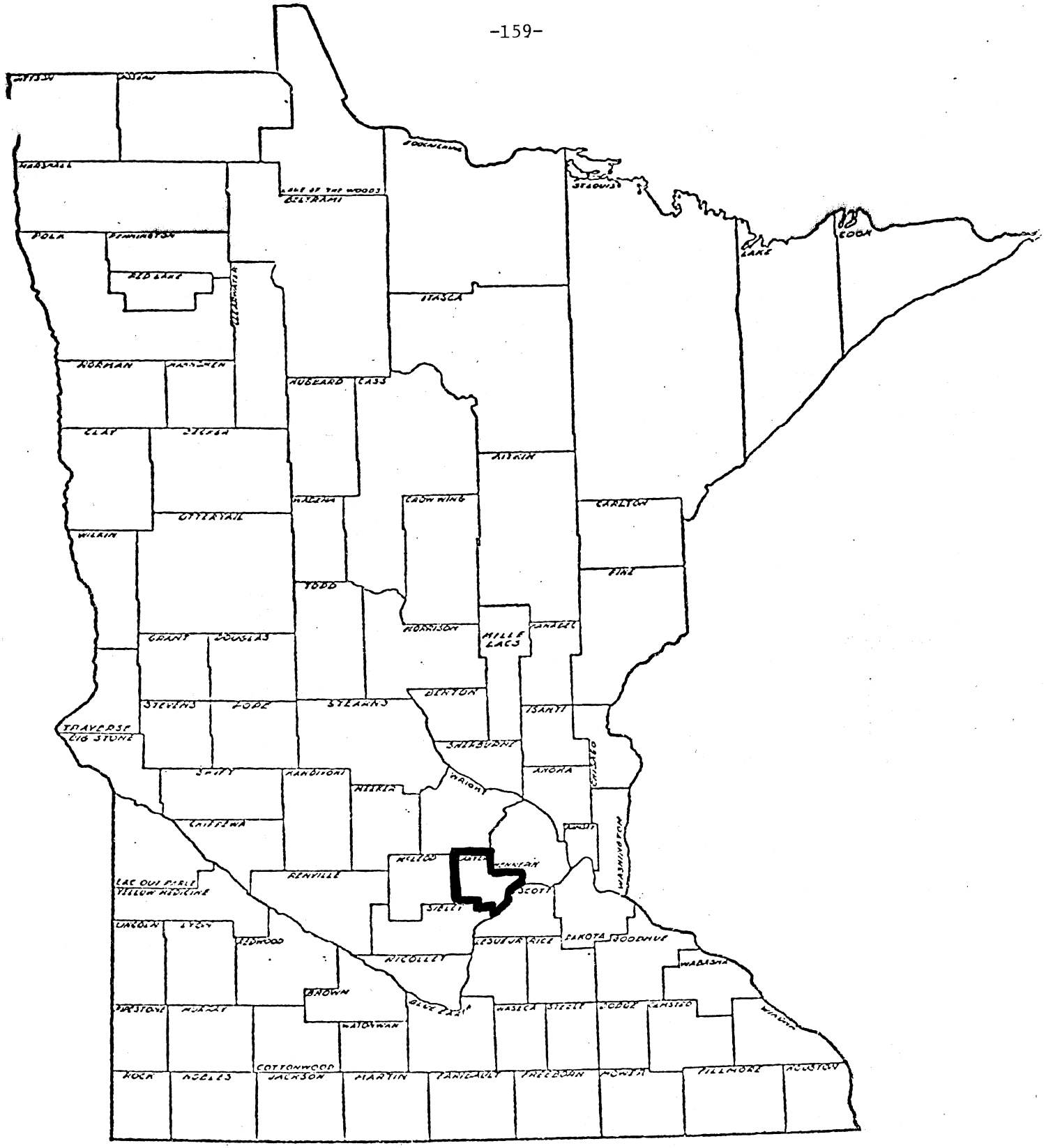
Halfway houses

*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



CARVER COUNTY MENTAL HEALTH PROGRAM BOARD

*Main office: Waconia, Minnesota

Region 11
HSA-5
Priority Rank 26

CARVER COUNTY MENTAL HEALTH CENTER
Waconia

Carver is one of the outlying counties of the Twin City metropolitan area that is in a transitional situation of change from predominately rural to a suburban environment. The southeastern portion of the county, which is closest to the Twin Cities, is essentially suburbanized, while the western portion remains a rural farm economy. As expected, the county is experiencing quite rapid population growth, with a 1974 estimate of 33,000, as compared to a 1967 estimate of 24,000, and a 1970 Census figure of 28,310. The county comprises an area of 359 square miles, which is the third smallest county in the state, but with a high population density of 91.9 persons per square mile. If the experimental city of Jonathan, being built near Chaska, should eventually become as successful as planned, the county would experience dramatic growth and possibly face major human service development needs.

It is interesting to note that while county government is essentially dominated by rural spokesmen, it is also a member of the Metropolitan Council and participates in the Council planning process.

Until 1974, Carver County's Community Mental Health Program was a joint Carver-Scott County operation. For various reasons, a decision was made to separate into two single county programs and Carver now is well along with rebuilding a comprehensive MH-MR-CD program. The program offices have just recently been relocated in a relatively new, adequate building in Waconia which they share with the Public Health Nursing Service. The County's proximity to the metropolitan area provides access to the available professional personnel.

Services available in this county through the mental health department, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

Halfway houses

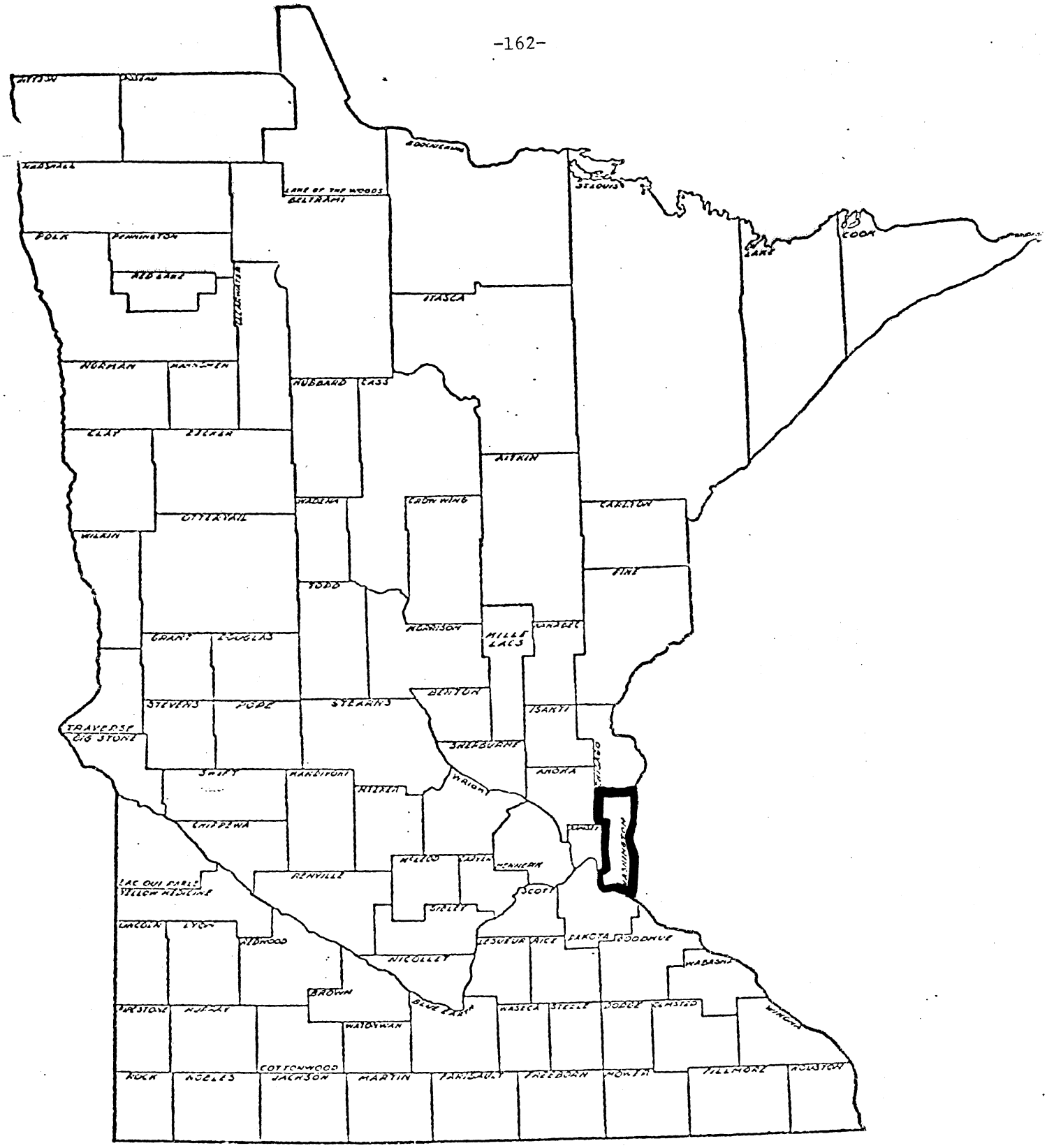
*Alcohol services

*Drug treatment services

Special services for elderly people

*On a time-limited basis, the program will have authorization to pay for any needed mental health care (including hospitalization): 1) which an individual resident needs, and 2) which is not available within the county.

*Community program planning and coordination of MH/MR/CD services



WASHINGTON COUNTY HUMAN SERVICES, INC.

*Main office: Lake Elmo, Minnesota

Region 11
HSA-5
Priority Rank 27

WASHINGTON COUNTY HUMAN SERVICES, INC.
Lake Elmo

Washington County is the eastern most county of the seven-county metropolitan area of Minneapolis-St. Paul. It is bordered on the east by the St. Croix River, which divides Minnesota and Wisconsin at that point. The county includes 386 square miles, with an estimated 1974 population of 99,700, compared with a 1970 Census figure of 82,948. It is the fastest growing county in the metropolitan area.

There is no substantial minority population in this county and no distinguishing ethnic features.

Although 40% of the land in Washington County is used for agriculture, the majority of the population commute to jobs outside the area. The per capita income of area residents is above both state and national averages.

The catchment area is in a transition from rural to rural-urban with a substantial increase in population. There is an increasing demand for social services. The community mental health center, established in 1969, is gradually increasing its staffing, services and financing.

Services available in this county through the mental health center and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

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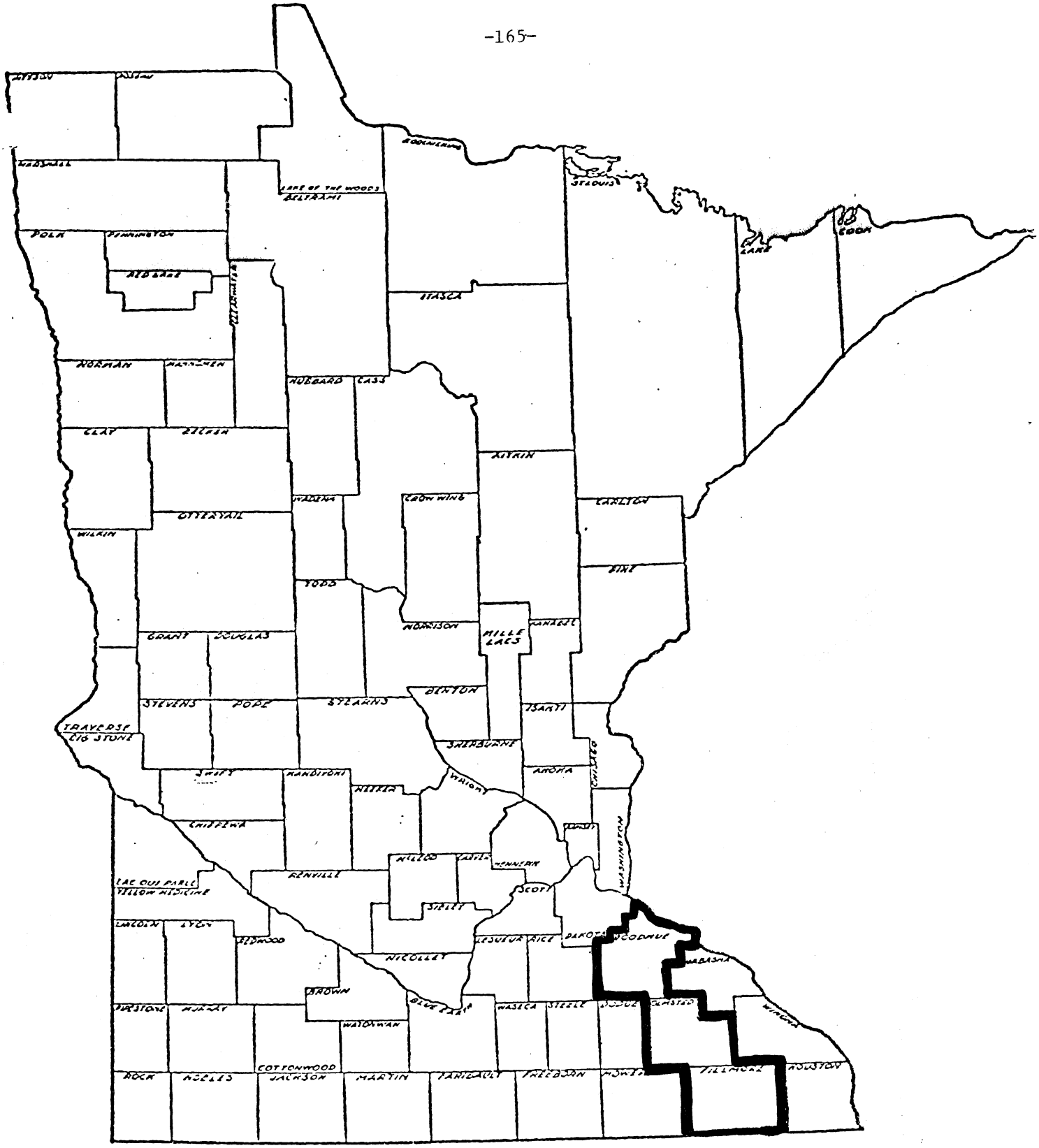
Halfway houses

*Alcohol services

*Drug treatment services

*Special services for elderly people

*Community program planning and coordination of MH/MR/CD services



ZUMBRO VALLEY MENTAL HEALTH CENTER, INC.

*Main office: Rochester, Minnesota

Region 10
HSA-7
Priority Rank 28

ZUMBRO VALLEY MENTAL HEALTH CENTER
Rochester

The population of this three-county area is approximately 145,820 (140,783 in 1970) with the specific population by county as follows: Olmsted--90,074, Goodhue--34,772 and Fillmore--20,974. The total number of square miles for the three-county area is 2,268.

Eighty percent (80%) of the residents of Olmsted County are considered urban, whereas 68% of Goodhue and 38% in Fillmore are considered urban.

The City of Rochester dominates the area; it is a city of 50,000 with perhaps one of the best medical centers in the world. Another distinguishing feature is the fact that female residents over age 14 outnumber males of a similar age by a ratio of 2 to 1. In the three-county area, there is no appreciable number of minorities. The ethnic groups are primarily Norwegian and German.

Chief industries in the area are IBM, Medical-Health Care (Mayo Clinic) and agriculture. The median income for Olmsted County is $10,000, whereas the median is $9,000 for Goodhue and $6,000 for Fillmore County.

The diversity of the area requires a diversified and flexible program for mental health services. Although Mayo Medical Center is the most significant institution in the area, it offers few services to area residents, who receive mental health services from the Zumbro Valley Mental Health Center and Rochester State Hospital.

Zumbro Valley MHC has a Staffing Grant which expired on 9/30/75. The board has decided not to pursue any more federal funding.

Services available in this catchment area through the mental health center, and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, and treatment

*Inpatient hospitalization

*Partial hospitalization (day/night)

*Emergency/crisis services (including nights and weekends)

*Consultation and education

*Specialized services for children

*Planning and coordination

Rape prevention and treatment

*Pre-petition screening

*Aftercare follow-up (in conjunction with county social service agencies)

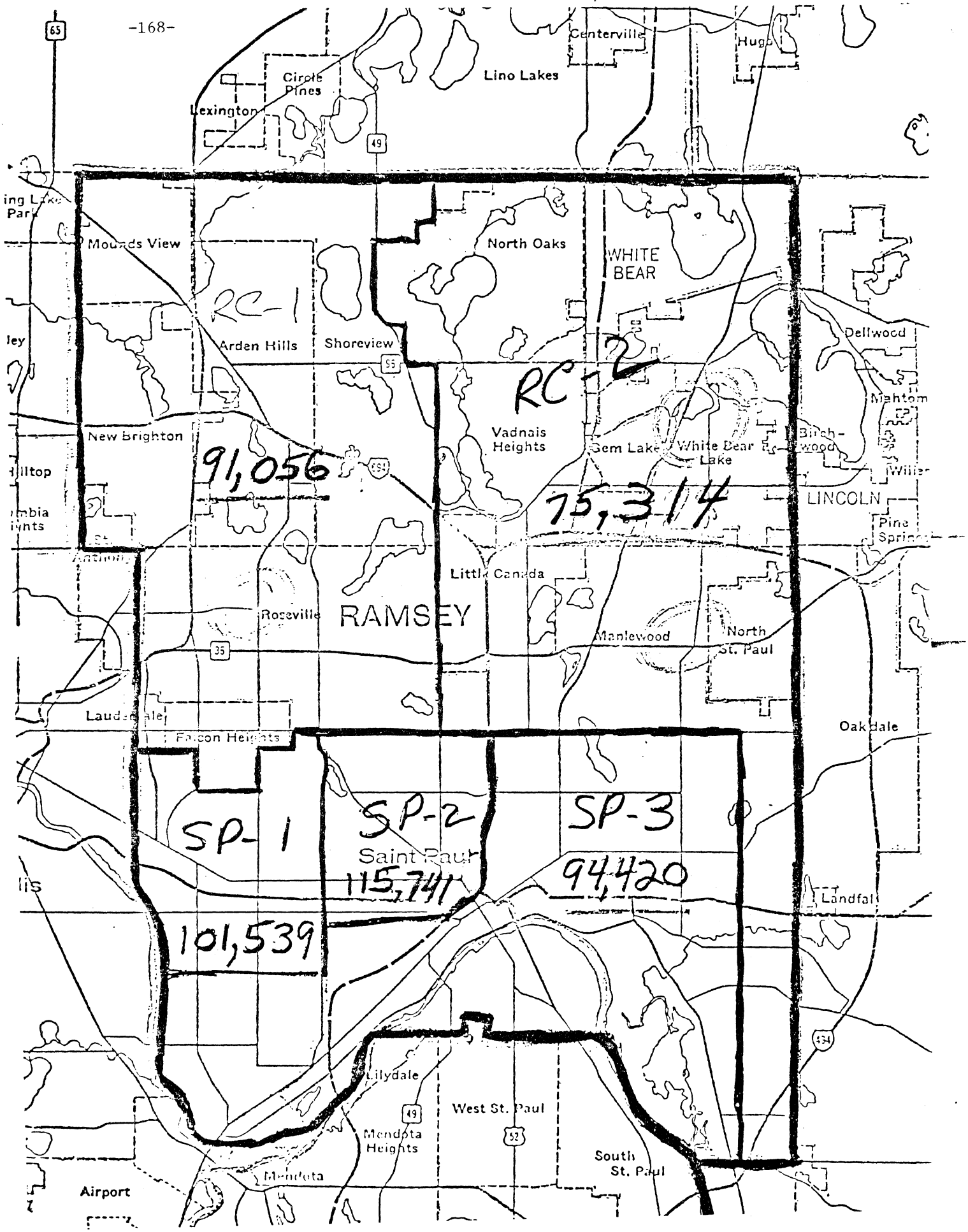
Halfway houses

*Alcohol services

*Drug treatment services

Special services for elderly people

*Community program planning and coordination of MH/MR/CD services


Centerville
Hugo
Lino Lakes
Circle Pines
Lexington
Mounds View
North Oaks
WHITE BEAR
RC-1
Arden Hills
Shoreview
RC-2
Dellwood
Mahtom
New Brighton
Vadnais Heights
Gem Lake
White Bear Lake
Birch-wood
91,056
75,314
LINCOLN
Pine Spring
Little Canada
Roseville
RAMSEY
Manlewood
North St. Paul
Oakdale
Falcon Heights
SP-1
SP-2
SP-3
Saint Paul
115,741
94,420
101,539
Landfall
Lilydale
West St. Paul
Mendota Heights
Mendota
South St. Paul
Airport

Region 11
HSA-5
Priority Rank 29

ST. PAUL-1

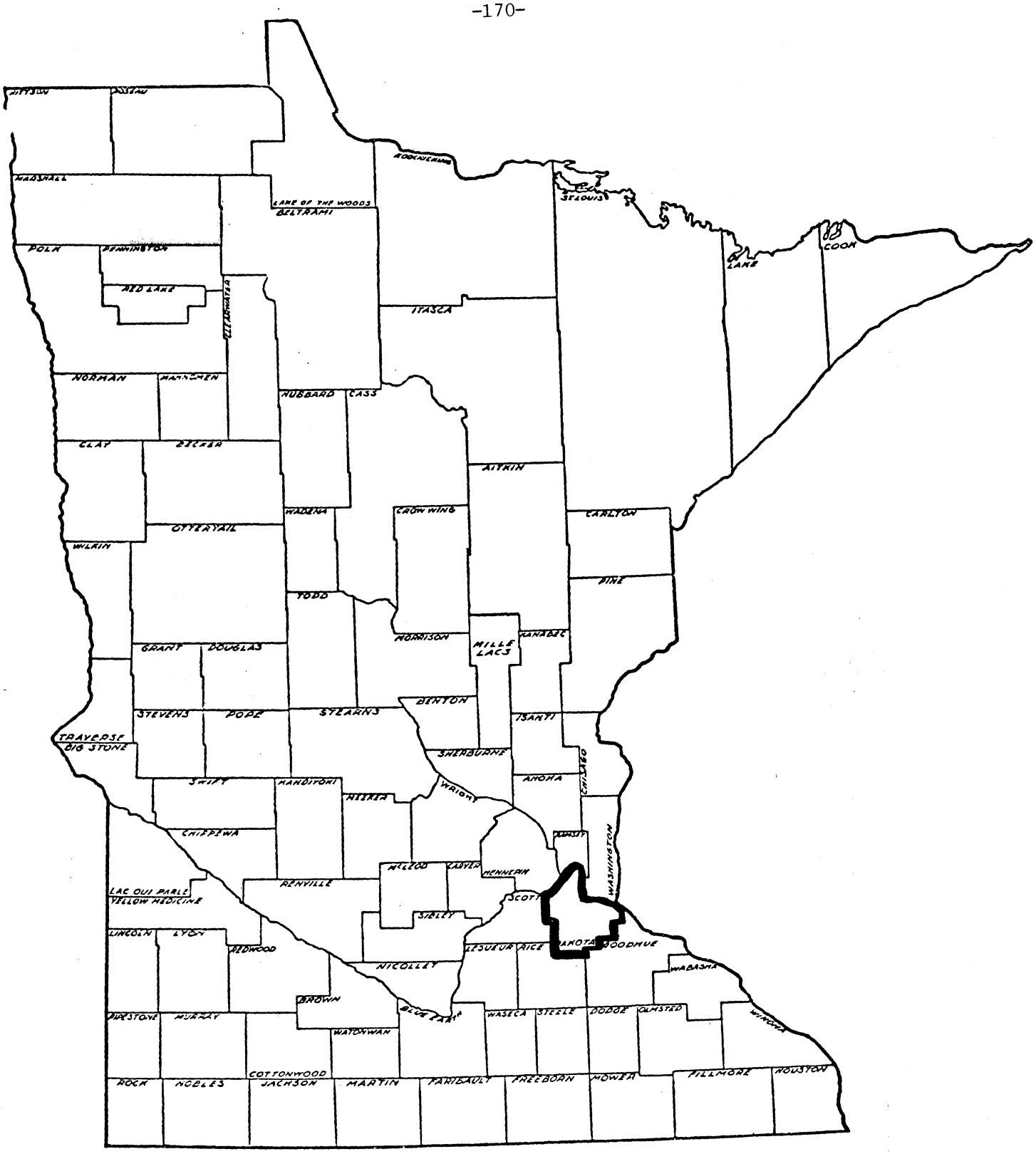
The St. Paul catchment area covers the western one-third of the City of St. Paul. The neighborhoods that compose this area range from the high economic area of Highland Park, which is primarily the Jewish community of St. Paul, to the low income, unskilled labor areas. The area contains the majority of older persons in the county. There is a relatively major drug and alcohol problem in this catchment area.

Population: St. Paul-1 ranks second in total population, with 101,589 people. (1970 Census)

Income: The mean family income is $9,071. This figure is the second lowest average within the catchment areas, and ranks in the middle of the three St. Paul areas. It has the third highest percentage total of individuals in poverty, but contains the lowest percentage total of the three St. Paul areas.

Education: St. Paul-1 ranks third in proportion of persons age 25 and over who are high school graduates.

Age and Family Characteristics: St. Paul-1 ranks last among areas in percentage of families with children under 18, and in percentage of population under 18. It ranks first in the percentage of persons over 65, and it contains the third largest percentage of persons divorced.



Dakota County Mental Health Center
Main Office: South St. Paul

Region 11
HSA-5
Priority Rank 30

DAKOTA COUNTY MENTAL HEALTH CENTER, INC.
South St. Paul

The total square miles in Dakota County are 576. The 1970 population census was 139,808, 1974 estimated population was 167,000 and the 1976 population estimate is 183,900. Dakota is a part of the southeastern portion of the metropolitan area and currently is the fastest growing county in Minnesota. Dakota is a mixture of urban, semi-urban and rural areas. It tends to be politically conservative, as well as very affluent and highly educated.

It is estimated that approximately 1% of the population is Native American and Black, with the balance being Caucasian. In southern Dakota County, there are large numbers of Germans, who are primarily involved in agriculture. In northern Dakota County, which is heavily influenced by the metropolitan area, there appears to be no one particular ethnic group which is predominant. The population in the southern end of the county is generally quite stable, whereas the northern end is growing fast and is characterized by a young and somewhat upward mobile population.

For the people in the northern part of the county, there is no one major industry, although Blue Cross, Univac, meat packing and an oil refinery have a significant economic influence. Agriculture is the major industry in the southern rural part of the county. Overall, of the 55,000 employed persons in the county, over half (34,000) work outside the county (1970).

Services available in this county throuth the Mental Health Center and its affiliates, include (indicated by *):

*Outpatient diagnosis, evaluation, treatment and drug management for MH, MR and CD

Inpatient hospitalization

*Community MH Outreach Program 24 hours/day, 7 days/week (SLIC)
Partial hospitalization (day/night)

*Emergency/crisis services (48 hours/week with 24-hour, 7 day/week Emergency ON CALL through Sheriff's Department)

*Preventive Education - In-service Training Program in MH and CD

*Consultation and education

*Specialized services for children including child abuse team

*Planning and coordination for MH, MR and CD

Rape prevention and treatment

*Pre-petition screening - provided through welfare department with consultation available from MHC as needed

*Aftercare follow-up (in conjunction with county social service agencies)

Halfway houses

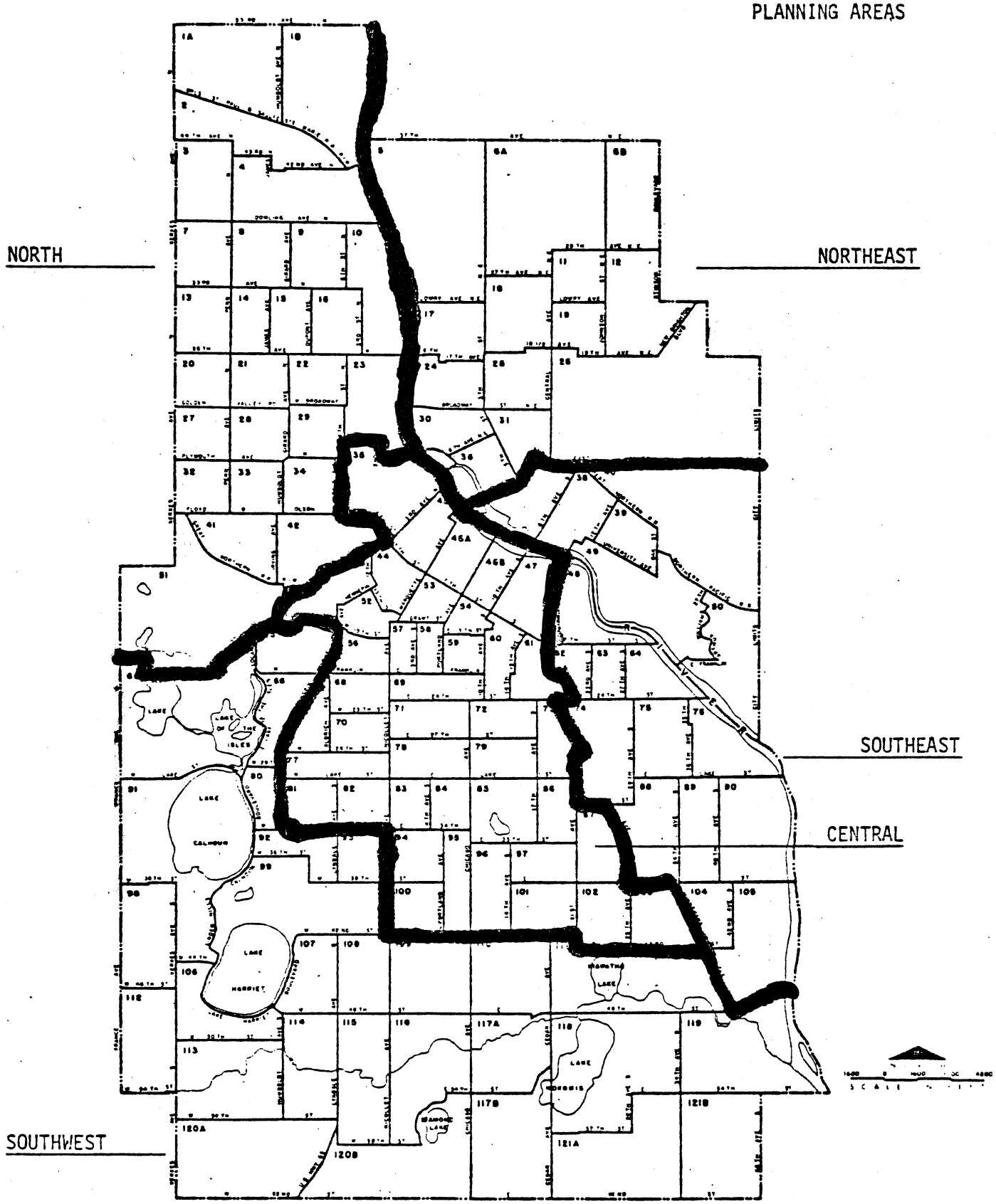
*Alcohol services (detoxification, outpatient, education and consultation)

*Drug treatment services

*Special services for elderly people - In-service training available to nursing home staff

*Community program planning and coordination of MH/MR/CD services

HENNEPIN COUNTY
CITY OF MINNEAPOLIS
MENTAL HEALTH AND MENTAL RETARDATION
PLANNING AREAS



Region 11
HSA-5
Priority Rank 31

HENNEPIN COUNTY

SOUTHWEST AREA

The Southwest area covers the three Minneapolis neighborhoods of Calhoun-Isles, Southwest and Nokomis. These neighborhoods have mean incomes of $14,000, $15,000, and $12,000, respectively. Calhoun-Isles differs from Southwest and Nokomis in that a much higher proportion of its residences are multiple dwellings, and a much smaller percent of its population is under age 18. As a whole, Southwest is comparable to the suburban areas in terms of income and poverty rates. It had a population of 131,603 in 1970.

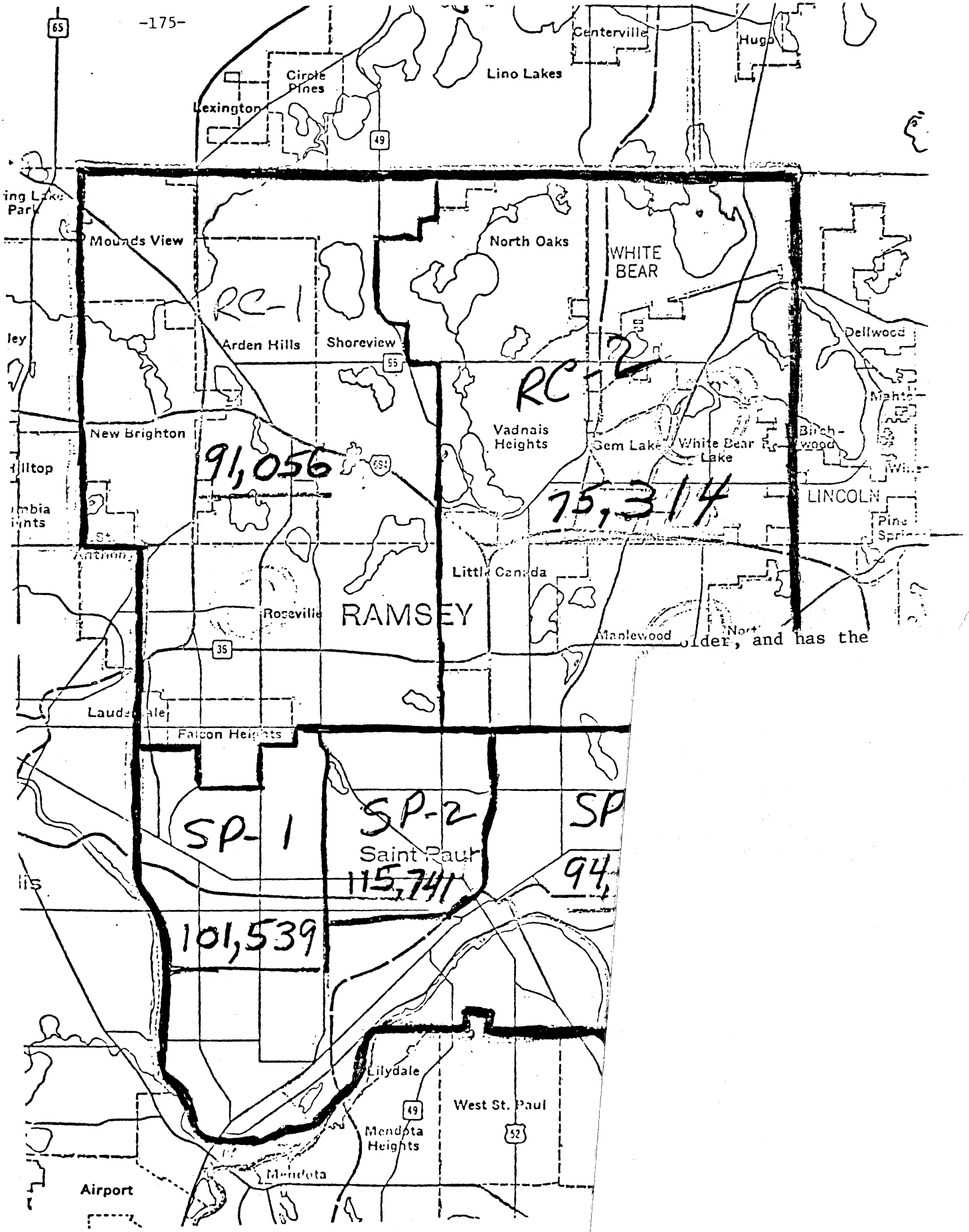
Income: Southwest ranks third among all county planning areas in income with a mean family income of $14,050. Its poverty rates for individuals and families are the lowest among planning areas in Minneapolis.

Unemployment: Southwest has the second lowest 1970 unemployment rate among Minneapolis planning areas.

Educational Attainment: Thirty-six percent (36%) of persons 25 or older have less than 12 years of education. Only the three suburban areas have smaller percentages in this category.

Age and Family Characteristics: Among planning areas in the city, Southwest ranks third both in percent of families with children under 18 and in percent of population under 18. The area ranks second among all planning areas in percent of residents age 65 and older. It ranks fourth among all planning areas in percent of persons age 14-54 who are widowed or divorced.

There are no mental health centers or hospitals in this catchment area. Residents use those facilities located in other parts of the county and the Twin City metropolitan area. A number of them can also afford to use the services of private practitioners.



older, and has the

Region 11
HSA-5
Priority Rank 32

RAMSEY COUNTY-2

The Ramsey County-2 area has the highest density of professional workers in Ramsey County. There are very identifiable areas of poverty. The housing conditions are good, which relates to the highest per capita income area in the county. The area has the least density of population, but the highest percent of school-age children. There is a high incidence of juvenile delinquency and drug abuse in the area. There are municipalities which have a "small" town atmosphere, but the northern portion is basically suburban. Both Ramsey County-1 and Ramsey County-2 areas relate to both Minneapolis and St. Paul for their service and shopping needs, as well as for mental health services.

Population: Ramsey County-2 has the lowest population of all five catchment areas, with 66,097 people. (1970 Census)

Income: The mean family income is $15,606, which ranks it first in this category. It contains the second lowest percentage of people whose income falls below the poverty level.

Education: Approximately 71% of the population are high school graduates, which is the second highest percentage.

Age and Family Characteristics: Ramsey County-2 has the highest percentage number of persons under 18, and also families with children under 18. It contains the second lowest percentage of people 65 or older, while having the lowest percentage divorce rate.

Region 11
HSA-5
Priority Rank 33

RAMSEY COUNTY-1

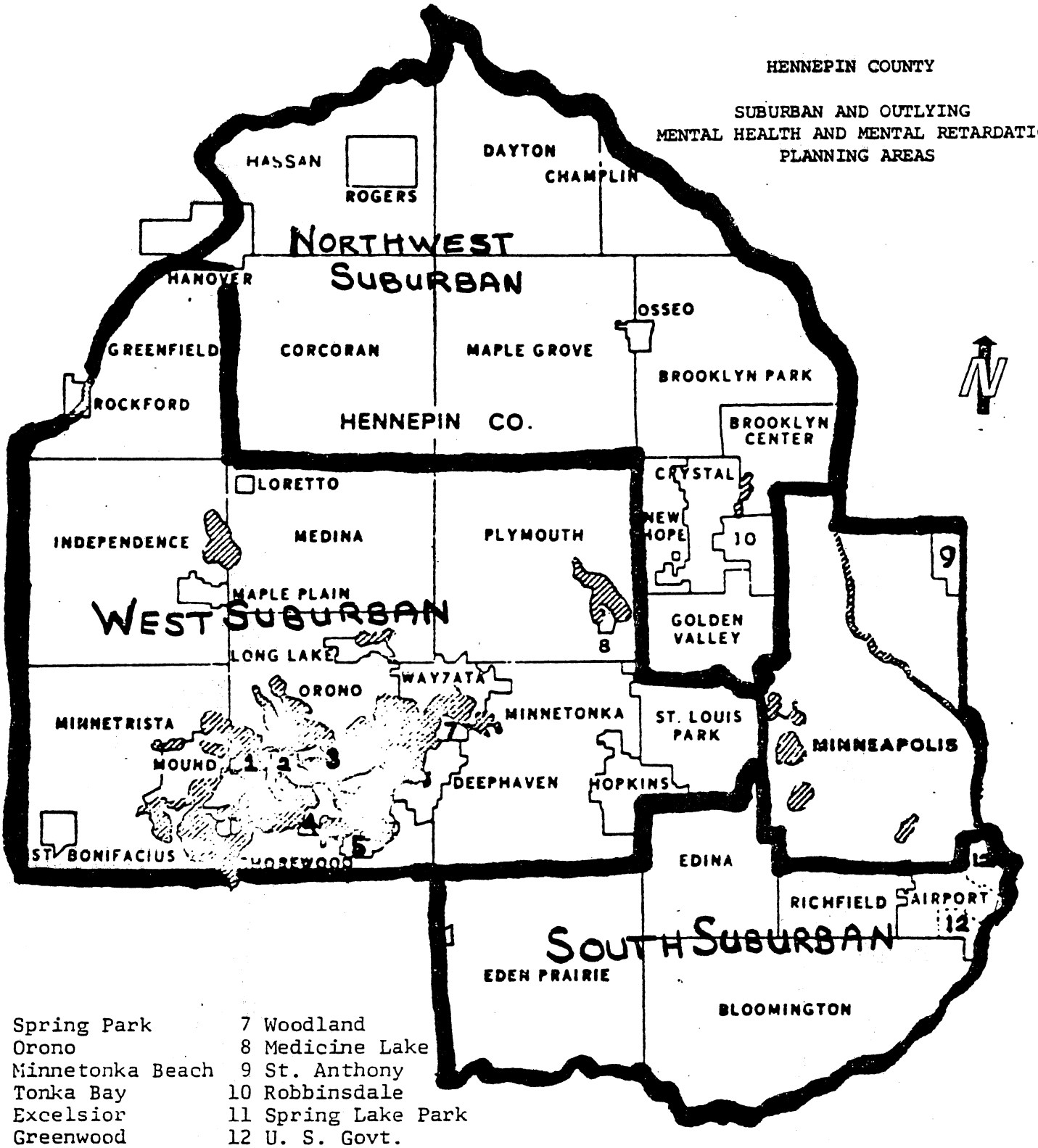
The Ramsey County-1 catchment area contains the basic suburban family types of neighborhoods. This area has a high percentage of the middle management and professional persons. This area does not have the high drug and alcohol problems of St. Paul-1 or Ramsey County-2, but there is a large juvenile population, and a large juvenile problem. There are "pockets of poverty" located in this area which present identical problems related to St. Paul-2. Residents use mental health and hospital facilities throughout the metropolitan Twin City area.

Population: Ramsey County-1 has the second lowest population total, with 91,057 people. (1970 Census)

Income: The mean family income is $12,110, which is the second highest total. It contains the lowest percentage of people whose income falls below the poverty level.

Education: Approximately 76% of its population are high school graduates, which places it first in this category.

Age and Family Characteristics: Ramsey County-1 has the second highest number of persons under 18, and also families with children under 18. It contains the lowest percentage of people who are 65 or older, and has the second lowest divorce percentage.



1 Spring Park
2 Orono
3 Minnetonka Beach
4 Tonka Bay
5 Excelsior
6 Greenwood
7 Woodland
8 Medicine Lake
9 St. Anthony
10 Robbinsdale
11 Spring Lake Park
12 U. S. Govt.

Region 11
HSA-5
Priority Rank 34

HENNEPIN COUNTY

NORTHWEST SUBURBAN AREA

The Northwest suburban area is comprised of 14 suburban communities to the Northwest of Minneapolis. The area is the least affluent of the three suburban areas. It has the youngest population of any of the county planning areas. In 1970, it had a population of 174,674. No mental health centers are currently located in the area, but a local planning group is active with assistance from the University of Minnesota. Residents use resources located in other parts of the county.

The largest private psychiatric group, the Minneapolis Clinic of Psychiatry and Neurology, has its main office in Golden Valley, within this catchment area. Minneapolis Clinic psychiatrists staff most of the private hospital psychiatric units in Hennepin County. Glenwood Hills Hospital, which has a large psychiatric unit, is adjacent to the offices of the Minneapolis Clinic.

Income: Mean family income in the Northwest area is about $13,200. This is substantially higher than four of the five city areas. Northwest has a smaller percent of individuals and families below the poverty level than any of the city areas, but ranks about average among the three suburban areas (2.7% of individuals and 2.9% of families).

Unemployment: Northwest's 1970 unemployment rate of 3.1% is the highest of the three suburban areas.

Educational Attainment: Northwest has the highest percent of persons who have not compelted high school (25%) among the suburban areas.

Age and Family Characteristics: Northwest ranks first among all planning areas both in percent of families with children under 18 and in percent of population under age 18. It ranks last among planning areas in percent over age 65. It is average among suburban areas in percent of persons age 14-54 who are widowed or divorced.

Region 11
HSA-5
Priority Rank 35

HENNEPIN COUNTY

WEST SUBURBAN AREA

The West suburban planning area includes 22 communities located to the west of Minneapolis. This planning area covers the largest geographic area of all county planning areas. The West area has an older population than the other two suburban areas. In 1970, there were 163,271 people living in this catchment area. The area is served by the Lake Minnetonka Mental Health Center in Wayzata. Many residents are also able to afford private practitioners.

Income: The West suburban area has the second highest mean family income among all planning areas ($16,524). At the same time, the poverty rates for individuals and for families are higher than those of the two other suburban areas.

Unemployment: The West area has the second lowest percentage of persons who have not completed 12 years of education.

Age and Family Characteristics: The West area ranked lowest among suburban areas both in percent of families with children under age 18, and in percent of population under age 18. It ranks third lowest among all planning areas in percent of population over age 65. It is also second lowest in percent of persons age 14-54 who are widowed or divorced.

Region 11
HSA-5
Priority Rank 36

HENNEPIN COUNTY

SOUTH SUBURBAN AREA

Four suburban communities, plus Fort Snelling, are included in the South suburban planning area. As a whole, this area is the most affluent among county planning areas. It is also the most densely populated suburban area. The 1970 population was 180,849.

The South Suburban Planning Council, which has its office in Bloomington, has received NIMH approval for a planning grant. Funds have not yet been made available to carry out this grant proposal. Once these funds have become available, specific planning for mental health services will begin.

Currently, residents use mental health services from throughout the metropolitan Twin City area. Many of them can afford the services of private practitioners, of whom a significant number are located within the catchment area.

The South Suburban Counseling Center, an affiliate of the Hennepin County MH-MR-CD Department is located in Edina, within this catchment area.

Income: The South area has the highest mean family income (about $17,300), and the lowest poverty rates (1.7% for individuals and 1.9% for families) among all planning areas. The City of Edina has one of the highest per capita incomes in the nation.

Unemployment: The area has the lowest rate of 1970 unemployment.

Education: The percent of persons in the area who have not completed 12 years of education is smallest among all planning areas.

Age and Family Characteristics: The South area ranks second highest both in percent of families with children under age 18 and in percent of population under age 18. It ranks second lowest in percent older than 65. The South area has the smallest percent of persons age 14-54 who are widowed or divorced.

A P P E N D I C E S

APPENDIX A

THE STATE MENTAL HEALTH PROGRAM - FY 1977

PROGRESS REPORT

A. Goals and Objectives

As the state's responsibility for continuation of mental health programs supported by state, federal and local funds, the following Goals and Objectives are set forth to identify the major operational directions of the Department of Public Welfare. These goals are those of the Department of Public Welfare. Many, but not all of the, are the result of input from the general public, consumers, and providers. They provide a mechanism for monitoring the progress of the Minnesota Mental Health System.

GOAL I:	Results to Date
Mentally ill adults who need residential treatment shall have access to such treatment with out regard to their ability or inability to pay for it by the end of the 1977-79 biennium, in both hospital and nonhospital settings, whichever is the least restrictive for the individual.	Goal I: Significant progress to report; see below.
Subgoal I: The Department of Public Welfare shall propose to the 1977 session of the Legislature that community-based nonhospital residential treatment be made available by providing reliable funding for it.	Subgoal I: Proposals introduced; over $1 million in state funds appropriated for FY 1978.
OBJECTIVES:	
1-A. The Department shall propose to the 1977 session of the Legislature that nonhospital treatment be provided, both as an alternative to psychiatric hospitalization and as a transitional step in treatment and reintegration, through expansion of group health insurance coverage to include reimbursement of such costs. (January, 1977)	1-A: Legislation introduced in 1977; will be acted on in 1978.
1-B. The Department shall propose to the 1977 session of the Legislature that nonhospital treatment be provided, both as an alternative to psychiatric hospitalization and as a transitional step in treatment and reintegration through reimbursement from a state subsidy, for those persons not covered by a group health insurance policy and for those persons needing additional residential treatment beyond the duration of their group health insurance coverage. (January, 1977)	1-B: See report on Subgoal I

1-C. The Department shall recommend to the 1977 session of the Legislature that such reimbursement for residential treatment, through either insurance or state appropriations, be made available only to facilities qualifying for program licensure under DPW Rule 36 (see attachment C-2). (January, 1977)	1-C: To be done administratively in rule revision.
1-D. The Department shall complete, by October 15, 1976, the work of a committee to establish an operational definition of mental illness as it pertains to nonhospital residential treatment. Such definition shall contain descriptors of behavioral characteristics that will be used to determine admission of individuals into such treatment facilities.	1-D: Work substantially completed; report pending.
1-E. The Department shall, by September 14, 1976, submit a training proposal to the Paraprofessional Branch of NIMH. This proposal would provide a program of certified training to paraprofessional staff of community residential facilities to 1) enhance their competence, 2) make reintegration (deinstitutionalization) more effective, and 3) provide career mobility for paraprofessionals.	Approved, but not yet funded. Effective date for funding not yet established.

GOAL II:

The Department shall, by June, 1978, clarify its expectations, establish its standards, and put into effect its monitoring/evaluation mechanisms to assure a unified public mental health delivery system for the citizens of Minnesota.

OBJECTIVE I: By January, 1977, the Department will have revised and reissued Policy Bulletin #5 (dated January, 1975) further clarifying the roles and responsibilities of the state hospitals, mental health centers, and county social service agencies.	I: Still in process.
OBJECTIVE II: By June, 1977, all state hospital mental illness units shall have program licensure under DPW Rule 36, or shall have been reviewed for licensure and have been informed of conditions needing change in order to become licensed.	II: See FY 1978 Goals.

OBJECTIVE III: By November, 1976, the Department will have established standards for community mental health centers which will become a requirement for continuing state support.

III: Revision of DPW Rule 28 is continuing; see FY 1978 Goals.

OBJECTIVE IV: By January, 1977, the Department's Office of Evaluation will have completed a survey instrument for monitoring county social service agencies, which will include standards for mental health services, particularly mandatory aftercare case management services for ex-mental patients.

GOAL III:

There shall be established, for and with the community mental health centers, an information system that meets local, state, and federal reporting requirements; provides baseline data on areas of activity from which projections and expectations can be derived; and which has optimum compatibility with other related systems.

Subgoal I: The Department, in conjunction with the Association of Community Programs, shall identify the local, state and federal information needs to be addressed, and the cost of developing and implementing such a system, by January, 1977. This proposal will be submitted to the 1977 Legislature.

I: Work progressing; legislative request turned down. Applications being developed for submission.

OBJECTIVES:

1-A. The Department and the Association shall apply for federal and state funds sufficient to develop and have operating this system by June, 1979.

1-B. The Department shall see to it that when this system is developed, optimum compatability is established with related systems in this state: social services (Title XX), the Patient-Oriented Information System (state hospitals), and the Alcohol and Drug Management Information System.

Continuing

APPENDIX B

COMMUNITY MENTAL HEALTH SERVICES ACT

From: Minnesota Statutes 1974, Chapter 245; and including 1975 amendments, from Minnesota Statutes 1975. Amendments changed the following sections: 245.62, 245.63, 245.66, and 245.69.

COMMUNITY MENTAL HEALTH SERVICES

245.61 COMMISSIONER OF PUBLIC WELFARE MAY MAKE GRANTS FOR LOCAL MENTAL HEALTH PROGRAMS. The commissioner of public welfare is hereby authorized to make grants to assist cities, counties, towns or any combinations thereof, or non-profit corporations in the establishment and operation of local mental health programs to provide the following services: (a) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation, alcoholism, and other psychiatric disabilities; (b) informational and educational services to the general public, and lay and professional groups; (c) consultative services to schools, courts and health and welfare agencies, both public and private; (d) outpatient diagnostic and treatment services; (e) rehabilitative services for patients suffering from mental or emotional disorders, mental retardation, alcoholism, and other psychiatric conditions particularly those who have received prior treatment in an inpatient facility/ (f) detoxification and alcoholism evaluation and service facilities.

245.62 COMMUNITY MENTAL HALTH PROGRAM; TAX LEVY. Any city, county, town, or any combination thereof, of over 50,000 population, and upon consent of the commissioner of public welfare, any city, county, town, or combination thereof with less than 50,000 population, may establish a community mental health services program and may establish clinics and staff same with persons specially trained in psychiatry and related fields. Such programs and clinics may be administered by a city, county, town, or non-profit corporation or a community mental health board established pursuant to sections 245.61 to 245.69. After June 30, 1977, each community mental health services program must be contained completely within the boundaries of one Minnesota economic development region except that a community mental health board may encompass completely two Minnesota economic development regions.

In order to provide the necessary funds to establish and operate a mental health services program and to establish and maintain a clinic, the governing body of any city, county or town may levy annually upon all taxable property in such city, county or town a special tax in excess of any statutory or charter limitation but except when levied by a county, such levy shall not exceed two-thirds of one mill. The governing body of any city, county or town may make such a levy, where necessary, separate from the general levy and at any time of the year. Nothing contained herein shall in any way preclude the use of funds available for this purpose under any existing statute or charter provision relating to cities, towns or counties.

245.63 ASSISTANCE OR GRANT. Any city, county, town non-profit corporation or community mental health board administering a mental health services program may apply for the assistance provided by sections 245.61 to 245.69 by

submitting annually to the commissioner of public welfare its plan and budget for the next fiscal year together with the recommendations of the community mental health board thereon. No programs shall be eligible for a grant hereunder unless its plan and budget have been approved by the commissioner. After June 30, 1977, no program shall be eligible for a grant hereunder unless it is contained completely within the boundaries of one Minnesota economic development region except that a community mental health board may encompass completely two Minnesota economic development regions.

245.64 FUNDS ALLOCATED. At the beginning of each fiscal year the commissioner of public welfare shall allocate available funds to the mental health programs for disbursement during the fiscal year in accordance with such approved plans and budgets. The commissioner shall, from time to time during the fiscal year, review the budgets and expenditures of the various programs and if funds are not needed for a program to which they were allocated, he may, after reasonable notice and opportunity for hearing, withdraw such funds as are unencumbered and reallocate them to other programs. He may withdraw funds from any program which is not being administered in accordance with its approved plan and budget.

245.65 LIMITATION ON GRANTS. Subdivision 1. Except as hereinafter provided, grants for any program shall not exceed 50 per cent of the total expenditures for (a) salaries, (b) contract facilities and services, (c) operation, maintenance, rental and service costs, (d) per diem and travel expense of members of community mental health boards, (e) mortgage or other financial costs specifically approved by the commissioner of public welfare for buildings and facilities constructed under the auspices of community mental health centers construction programs sponsored by the government of the United States, (f) mortgage or other financial costs specifically approved by the commissioner of public welfare for buildings and facilities which are not constructed under the auspices of community mental health centers construction programs sponsored by the government of the United States, providing such grants do not exceed 25 per cent of total construction costs, and (g) other expenditures specifically approved and authorized by the commissioner of public welfare. Where any county served by a program hereunder has an assessed valuation of real and personal property of less than $13,000,000 and the required total mill levy for all costs, including administrative costs, for all forms of public assistance exceeds by 50 per cent or more the average required mill levy for such costs in all counties of the state, grants hereunder, attributable to such county's proportionate share of the total expenditures based on the ratio of such county's population to the total population of the area served by the program, may exceed 50 per cent of the total expenditures but shall not exceed 75 per cent of the total expenditure for the mental health program of such county. No grants shall be made for capital expenditures, except as herein provided. Grants may be made for expenditures for mental health services whether provided by operation of a local facility or through contract with other public or private agencies.

Subd. 2. Where local funds from any source other than the department of public welfare are being used to finance community mental health services prior to the effective date of sections 245.61 to 245.69, such funds shall not be used for matching state funds hereunder except that such local funds

may be used for matching state funds for expansion of the existing services if such existing and expanded services conform to the provisions of sections 245.61 to 245.69.

Subd. 3. Existing local out-patient psychiatric clinic services now 100 per cent state supported shall continue to receive such support until local funds are secured to provide 50 per cent of such support but in no event beyond four years from the effective date hereof. Nothing in sections 245.61 to 245.69 shall be construed to limit the power of the commissioner of public welfare to establish clinics pursuant to section 246.014(10).

245.66 COMMUNITY MENTAL HEALTH BOARDS. Every city, county or town or combination thereof establishing a community mental health services program shall, before it may come within the provisions of sections 245.61 to 245.69, establish a community mental health board. When a combination of six or less political subdivisions establish a program, the board shall consist of at least nine members, but not more than twelve members, at the option of the selection committee. When seven or more political subdivisions establish a program the board shall consist of at least nine members, but not more than fifteen members, at the option of the selecting committee. When any city, county or town singly establishes a program, the board shall be appointed by the chief executive officer of the city or the chairman of the governing body of the county or town. When a non-profit corporation is the administrator of a program not established by a city, county or town, the corporation shall select a community mental health board which shall be representative of the groups herein enumerated, but the number of members need not be nine. When any combination of the political subdivisions herein enumerated establishes a community mental health services program, the chief executive officer of each participating city and the chairman of the governing body of each participating county or town shall appoint two members to a selecting committee, which shall select the members of the board. Membership of the community mental health boards shall include at least one county commissioner representative from each participating county and shall also be representative of local health departments, medical societies, county welfare boards, hospital boards, lay associations concerned with mental health, mental retardation and chemical dependency, labor, agriculture, business, civic and professional groups and the general public. Membership may include a representative from any county which purchases substantial services from the community mental health board. Nothing in Laws 1975, Chapter 69 shall prevent a county or community mental health board from purchasing services from an agency outside the boundaries of the Minnesota economic development region.

245.67 MEMBERS OF COMMUNITY MENTAL HEALTH BOARDS; TERMS, VACANCIES, REMOVAL. Except for boards appointed by non-profit corporations, the term of office of each member of the community mental health board shall be for three years measured from the first day of the year of appointment except that of the members first appointed, one-third shall be appointed for a term of one year, one-third for a term of two years, and one-third for a term of three years if there is a nine, twelve, or fifteen member board. Any remaining members first appointed shall serve the three year term. Vacancies shall be filled

for the unexpired term in the same manner as original appointments. Any member of a board may be removed by the appointing authority for neglect of duty, misconduct or malfeasance in office, after being given a written statement of charges and an opportunity to be heard thereon.

245.68 DUTIES OF COMMUNITY HEALTH BOARDS. Subject to the provisions of this section and the rules and regulations of the commissioner of public welfare, each community mental health board shall:

(a) Facilitate and implement programs in mental health, mental retardation and inebriacy so as to assure delivery of services;
(b) Review and evaluate community mental health service provided pursuant to sections 245.61 to 245.69, and report thereon to the commissioner of public welfare, the administrator of the program, and, when indicated, the public, together with recommendations for additional services and facilities;
(c) Recruit and promote local financial support for the program from private sources such as community chests, business, industrial and private foundations, voluntary agencies and other lawful sources, and promote public support for municipal and county appropriations;
(d) Promote, arrange and implement working agreements with other social service agencies, both public and private, and with other educational and judicial agencies;
(e) Advise the administrator of the community mental health program on the adoption and implementation of policies to stimulate effective community relations;
(f) Review the annual plan and budget and make recommendations thereon;
(g) When so determined by the authority establishing the program, act as the administrator of the program;
(h) Approve applications for grants made pursuant to section 245.693;
(i) Establish and operate a detoxification center;
(j) Encourage and assist innovative private treatment programs;
(k) Provide services for drug dependent persons; and
(l) Appoint advisory committees in at least the areas of mental health, mental retardation and inebriacy. A committee shall consist of residents of the area served who are interested and knowledgeable in the area governed by such committee. These advisory committees shall report regularly to the board.

245.69 ADDITIONAL DUTIES OF COMMISSIONER. In addition to the powers and duties already conferred upon him by law the commissioner of public welfare shall:

(a) Promulgate rules and regulations governing eligibility of community mental health programs to receive state grants, prescribing standards for qualification of personnel and quality of professional service and for in-service training and educational leave programs for personnel, governing eligibility for service so that no person will be denied service on the basis of race, color or creed, or inability to pay, providing for establishment, subject to the approval of the commissioner, of fee schedules which shall be based upon ability to pay and the guiding principle of which shall be that no one who can afford to pay for his own treatment at the rate customarily charged

in private practice shall be treated in the community mental health services clinic except as hereinafter provided, regulating fees for consultation and diagnostic services which services may be provided to anyone without regard to his financial status when referred by the courts, schools, or health or welfare agencies whether public or private, and such other rules and regulations as he deems necessary to carry out the purposes of sections 245.61 to 245.69.

(b) Review and evaluate local programs and the performance of administrative and psychiatric personnel and make recommendations thereon to community mental health boards and program administrators;

(c) Provide consultative staff service to communities to assist in ascertaining local needs and in planning and establishing community mental health programs; and

(d) Employ qualified personnel to implement sections 245.61 to 245.69.

DPW RULE 28: COMMUNITY MENTAL HEALTH SERVICES

This Rule hereby repeals the existing Minnesota Rule, DPW Rule 28, effective March 10, 1961.

(a) This rule provides methods and procedures relating to the establishment and operation of area-wide comprehensive community-based, mental health-mental retardation-chemical dependency programs under state grant-in-aid as provided under Minn. Stat. 245.61 - 245.69. (Minn. Stat. 245.61 - 245.69 is entitled, The Community Mental Health Services Act. For purposes of this Rule, Community Mental Health Services includes services to persons who have mental or emotional disorders or other psychiatric disabilities, mental retardation, and chemical dependency, including drug abuse and alcoholism.)

The Community Mental Health Board has the responsibility for ensuring the planning, development, implementation, coordination and evaluation of the community comprehensive mental health program for the mentally ill/behaviorally disabled, mentally retarded and chemically dependent populations in the geographic area it serves. It also has the responsibility for ensuring delivery of services designated by statute.

Rule 28 also sets forth definitions of Community Mental Health Centers and Community Mental Health Clinics. The definitions of Centers and Clinics constitutes the standards for the Commissioner's "approval" of a program for purposes of Minn. Laws 1975, Chapter 89, which requires certain group insurance policies and plans to provide benefits to nonhospitalized persons for mental health diagnosis, treatment and consultation services.

(b) A Community Mental Health Center means an agency which includes all of the following:

(1) Established under the provision of Minn. Stat. 245.61 - 245.69.

(2) Provide as a minimum the following services for individuals having mental or emotional disorders, mental retardation, alcoholism, drug abuse, and other psychiatric conditions. The extent of each service to be provided by the center shall be indicated in the program plan, which is to reflect the problems, needs and resources of the community served.

(aa) collaborative and cooperative services with public health and other groups for programs of prevention of mental illness, mental retardation, alcoholism, drug abuse and other psychiatric disorders.

(bb) informational and educational services to schools, courts, health and welfare agencies, both public and private.

(cc) informational and educational services to the general public, lay and professional groups.

(dd) consultative services to schools, courts, and health and welfare agencies, both public and private.

(ee) out-patient diagnostic and treatment services.

(ff) rehabilitative services, particularly for those who have received prior treatment in an in-patient facility.

(3) Provides or contracts for detoxification, evaluation and referral for chemical dependency services (Minn. Stat. 254A.08).

(4) Provides specific coordination for mentally ill/behaviorally disabled, mentally retarded, and chemical dependency programs. (Minn. Stat. 254A.07 and 245.61).

(5) Has a competent multidisciplinary mental health/mental retardation/chemical dependency professional team whose members meet the professional standards in their respective fields.

(6) The professional mental health team is qualified by specific mental health training and experience and shall include as a minimum, the services of each of the following:

(aa) a licensed physician, who has completed an approved residency program in psychiatry;

and

(bb) a doctoral clinical, counseling, or health care psychologist, who is licensed under Minn. Stat. 148.87 - 148.99.

and one or both of the following

(cc) a clinical social worker with a Masters degree in Social Work from an accredited college or university;

and/or

(dd) a clinical psychiatric nurse with a Masters degree from an accredited college or university and is registered under Minn. Stat. 148.171. (The Masters degree shall be in psychiatric nursing or a related psychiatric nursing program such as Public Health Nursing with mental health major, Maternal and Child Health with mental health major, etc.)

(7) The multidisciplinary staff shall be sufficient in number to implement and operate the described program of the center. In addition to the above,

this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the Commissioner. If any of the minimum required professional staff are not immediately available, the Commissioner may approve and make grants for the operation of the center, provided that the board and director can show evidence acceptable to the Commissioner that they are making sincere, reasonable and ongoing efforts to acquire such staff and show evidence of how the specialized functions of the required professionals are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

(c) A Community Mental Health Clinic is an agency which devotes, as its major service, at least two-thirds (2/3) of its resources for outpatient mental health diagnosis, treatment and consultation by a multidisciplinary professional mental health team. The multidisciplinary professional mental health team is qualified by special mental health training and experience and shall include as a minimum the services of each of the following:

(1) A licensed physician, who has completed an approved residency program in psychiatry;

and

(2) A doctoral clinical, or counseling or health care psychologist who is licensed under Minn. Stat. 148.87 - 148.99.

and one or both of the following

(3) A clinical social worker with a Masters degree in Social Work from an accredited college or university;

and/ or

(4) A clinical psychiatric nurse with a Masters degree from an accredited college or university and is registered under Minn. Stat. 148.171. (The Masters degree shall be in Psychiatric Nursing or a related psychiatric nursing program such as Public Health with a mental health major, Maternal and Child Health with a mental health major.)

The multidisciplinary team shall be sufficient in number to implement and operate the described program of the clinic. In addition to the above, this team should include other professionals, paraprofessionals and disciplines, particularly in the preventive and rehabilitative components of the program, subject to review and approval of job descriptions and qualifications by the Commissioner.

If any of the minimum required professional staff are not immediately available, the Commissioner may approve and make grants for the operation of the

clinic, provided that the board and director can show evidence acceptable to the Commissioner that they are making sincere, reasonable and ongoing efforts to acquire such staff and evidence of how the specialized functions of the required professional positions are being met. The services being rendered by employed personnel shall be consistent with their professional discipline.

(d) On or before the date designated by the Commissioner, each year the chairman of the Community Mental Health Board or Director of the Community Mental Health Program, provided for in Minnesota Statutes, Section 245.62, shall submit an annual plan identifying program priorities in accordance with state grant-in-aid guidelines, and a budget on prescribed report forms for the next state fiscal year, together with the recommendations of the Community Mental Health Board, to the Commissioner of Public Welfare for approval as provided under Minn. Stat. 245.63.

(e) Other providers of Community Mental Health Services may affiliate with the Community Mental Health Center and may be approved and eligible for state grant-in-aid funds. The state funding for other Community Mental Health Services shall be contingent upon appropriate inclusion in the Center's Community Mental Health Plan for the continuum of Community Mental Health Services and conformity with the state's appropriate disability plan for Mental Health, Mental Retardation or Chemical Dependency. Fiscal affiliates (funded contracting agencies) providing specialized services under contract must meet all regulations and standards that apply to the services they are providing.

(f) The Program Director of the Community Mental Health Program shall provide the Commissioner of Public Welfare with such reports of program activities as the Commissioner may require.

(g) All state Community Mental Health funding shall go directly to the Community Mental Health Board or to a Human Service Board established pursuant to Minn. Laws 1975, Chapter 402, which itself provides or contracts with another agency to provide the Community Mental Health Program. Such programs must meet the standards and regulations for Community Mental Health Programs as enunciated in this Rule in accordance with Chapter 402.

(h) When the governing authority of the Community Mental Health Program operates other programs, services or activities, only the Community Mental Health Center Program shall be subject to the regulations in this rule.

(i) New applications for state assistance or applications for renewal of support must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid must be assured in writing on DPW forms by the local funding authority(ies).

(j) Funds utilized by the Director as authorized by the Community Mental Health Board to match a state grant-in-aid must be available to that director for expenditures for the same general purpose as the state grant-in-aid funds.

(k) The director of the Community Mental Health Program shall, within 20 days after the end of the quarter, submit quarterly prescribed reports to the Commissioner of Public Welfare (Controller's Office), containing all receipts, expenditures, and cash balance, subject to an annual audit by the Commissioner or his/her designee.

(l) Payments on approved grants will be made subsequest to the Department's receipt of the program's quarterly reporting forms, unless the Commissioner of Public Welfare has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount of at least equal to the quarterly allocation minus any unexpended balance from the previous quarter providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the Department will withhold the process of the program's payment until the next quarterly cycle.

(m) No fees shall be charged until the director with approval of the Community Mental Health Board has established fee schedules for the services rendered and they have been submitted to the Commissioner of Public Welfare at least two months prior to the effective date thereof and have been approved by him/her. All fees shall conform to the approved schedules, which are accessible to the public.

(n) The Commissioner of Public Welfare may make supplemental awards to the Community Mental Health Boards.

(o) The Commissioner of Public Welfare may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the director and Community Mental Health Board. Opportunity for hearing before the Commissioner or his/her designee shall be provided.

(p) Community Mental Health Boards may make budget transfers within specified limits during any fiscal year without prior approval of the Department. The specified limit which can be transferred in any fiscal year between program activity budgets, shall be up to 10% or up to $5,000 whichever is less. Transfers within an activity can be made into or out of line items with a specified limit of up to 10% or up to $5,000 whichever is less. No line item can be increased or decreased by more than $5,000 or 10% in a fiscal year without prior approval of the Commissioner. Transfers above the specified limits can be made with prior approval from the Commissioner. All transfers within and into program budget activities and/or line items must have prior approval by the Community Mental Health Board and this approval must be reflected in the minutes of its meeting, it must be reported to the Commissioner with the reasons therefore, including a statement of how the transfer will affect program objectives.

(q) Budget adjustments made necessary by funding limitations shall be made by the Commissioner and provided in writing to the director and board of the Community Mental Health Center.

(r) Every Community Mental Health Board receiving state funds for a Community Mental Health Program shall have a Center Director, who is the full-time qualified professional staff member who serves as the executive officer. To be considered qualified, the individual must have professional training to at least the level of graduate degree in his/her clinical and/or administrative discipline, which is relevant to MH-MR-CD and a minimum of two years experience in Community Mental Health Programs. The Center Director is responsible for the planning/design, development, coordination, and evaluation of a comprehensive, area-wide program and for the overall administration of services operated by the board.

The Center Director shall be appointed by the Community Mental Health Board and shall be approved by the Commissioner of Public Welfare.

(s) Within 30 days of receipt of an application for "approval status" as a Center or Clinic, under Minn. Law 1975, Chapter 89, the Commissioner shall approve or deny the request.

The Commissioner shall approve or deny, in whole or in part, an application for state financial assistance within 90 days of receipt of the grant-in-aid application or by the beginning of the state fiscal year, whichever is the later.

(t) An appeal of the Commissioner's denial of grant application or "approval" status as Community Mental Health Center or Community Mental Health Clinic under Minn. Law 1975, Chapter 89, is available under the procedures set forth in the state Administrative Procedures Act, Minnesota Statute 15.01 et seq.

(u) To assist the Community Mental Health Board in meeting its responsibilities as described in Minnesota Statute 245.68 and to provide opportunity for broad community representation necessary for effective comprehensive mental health, mental retardation and chemical dependency program planning, each Community Mental Health Board shall appoint a separate advisory committee in at least the three disability areas of mental health, mental retardation and chemical dependency.

(1) The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the area governed by such committee.

(2) Nominations for appointments as members of the advisory committees are to be made to the community mental health board from agencies, organizations, groups, and individuals within the area served by the community mental health center. Appointments to the advisory committees are made by the Community Mental Health Board.

(3) One Community Mental Health Board member should serve on each advisory committee.

(4) Each advisory committee shall have at least one-half of its membership composed of individuals who are not providers of services to the three disability groups.

(5) Membership of each advisory committee shall generally reflect the population distribution of the service delivery area of the community mental health center.

(6) The Community Mental Health Board shall appoint a chairperson for each advisory committee. The chairperson shall not be a Community Mental Health Board member nor a staff member. The power to appoint the chairperson may be delegated by the Community Mental Health Board to the individual advisory committee.

(7) Each advisory committee shall be directly responsible to the Community Mental Health Board. Direct communication shall be effected and maintained through contact between the chairperson of the particular advisory committee, or his/her designee, and the chairperson of the Community Mental Health Board, or his/her designee.

(8) Staff shall be assigned by the Director to serve the staffing needs of each advisory committee.

(9) Each advisory committee may appoint study groups and task forces upon consultation with the Community Mental Health Board. It is strongly recommended that specific attention be given to the aging and children and youth populations.

(10) Each advisory committee shall meet at least quarterly.

(11) Each advisory committee must make a formal written and oral report on its work to the Community Mental Health Board at least annually.

(12) Each advisory committee shall submit copies of minutes of their meetings to the Community Mental Health Board and to the Department of Public Welfare (respective disability group program divisions).

(13) The advisory committees shall be charged by the Community Mental Health Board with assisting in the identification of the community's needs for mentally ill/behaviorally disabled, mental retardation and chemical dependency programs. The advisory committee also assists the Community Mental Health Board in determining priorities for the community programs. Based on the priorities, each advisory committee shall recommend to the Community Mental Health Board ways in which the limited available community resources (manpower, facilities and finances) can be put to maximum and optimal use.

(14) The advisory committee recommendations made to the Community Mental Health Board shall be included as a separate section in the grant-in-aid request submitted to the Department of Public Welfare by the Community Mental Health Board.

(15) The advisory committees shall assist the Community Mental Health Board in assessing the programs carried on by the Community Mental Health Board, and make recommendations regarding the reordering of priorities and modifying of programs where necessary.

ES/gir

APPENDIX D

DRAFT - FOR DISCUSSION PURPOSES ONLY 12/13/77

Rule #28

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MINNESOTA RULE DPW 28: Community Mental Health Board or Human Service Board Responsibility for Mentally Ill, Mentally Retarded and Chemically Dependent Target Populations and Individuals.

This Rule hereby repeals the existing Minnesota Rule, DPW 28, which was effective April 16, 1976.

A. Statutory Authority

Minnesota Statutes, Sections 245.61-245.69 and 254A.07, and 254A.08, establish the authority of the Commissioner of Public Welfare to make grants to assist cities, counties, towns or any combination thereof, or nonprofit corporation, in the establishment of community mental illness, mental retardation and chemical dependency programs.

The Human Services Act, Minnesota Statutes, Sections 402.02-402.10, mandates that, where human service boards have been established, the Commissioner may make grants only to human service boards for community mental illness, mental retardation and chemical dependency programs.

Minnesota Statutes 62A.149 and 62A.152 also requires state approval of programs seeking insurance payments for nonresidential services to mentally ill, alcoholic and drug dependent persons.

Approval of new applications for state assistance, applications for renewal of assistance, or approval for insurance payments will be contingent upon compliance with the provisions of this Rule and the applicable statutes.

B. Mission and Purpose

Minnesota's community mental illness, mental retardation and chemical dependency program is designed to provide a variety of specialized services to all citizens of Minnesota with problems of mental illness, mental retardation, chemical dependency, and other psychiatric disabilities. These specialized services are based on the premise that people with these problems can be helped, and can learn to help themselves. Programs must be designed to intervene at the earliest time in order to minimize the human misery that comes with these problems. Programs and services must also be designed to meet specialized needs of different geographical areas and individualized needs of the troubled person and his/her family.

Minnesota's program is a cooperative endeavor between state and local authorities. The role of the state is to establish minimum required program elements and standards, evaluate the effectiveness of programs and provide financial assistance for delivery of these services. The state shall also make clear the lines of authority and responsibility for program planning, development, implementation, coordination and evaluation by the local authority.

C. Definition of Terms Used in This Rule

For the purposes of this Rule, the following terms shall mean:

1. Commissioner - The Commissioner of the Minnesota Department of Public Welfare.

2. Local Board - An area mental health board or human service board which is the governing authority and which has responsibility for assessing need, planning, facilitating, providing and assuring comprehensive areawide services for mentally ill, mentally retarded and chemically dependent individuals and groups and which receives grant-in-aid from the Minnesota Department of Public Welfare.

3. Program - A formal, coordinated combination of services, with clear goals and measurable objectives which provide assistance to identified target populations and to individuals within those populations.

4. Services - A specific, identifiable, time-limited, goal-oriented activity designed to provide assistance to groups, individuals, or organizations, having certain common needs or characteristics.

5. Areawide Comprehensive Program - The combination of services, which are either provided or purchased by the local board, according to state requirements and local determination, available to mentally ill, mentally retarded and chemically dependent disability groups residing within the official catchment area.

6. Continuum of Care - The structured formation within the local board catchment area of all specialized disability-directed programs, both residential and nonresidential, into an interfacing relationship, in order to allow the individual entry based on individual need and maximum program benefits. Further, it means that individuals and their records can move readily between the service components in the continuum, as needed.

7. Fee Income - Those revenues, as delineated by the Commissioner, received primarily for provision of direct services to individuals, with a fee payment being made on behalf of or by the individuals served, or by reimbursement under either public or private insurance coverage.

8. Affiliate - An affiliate is any agency or organization with which the local board enters into an agreement or contract for the purposes of providing a portion of the coordinated continuum of care program for its catchment area.

9. Catchment Area - The geographic area, usually delineated by the boundaries of local governmental units officially providing financial support, for which the local board has overall program provision and program monitoring and evaluation responsibility.

10. Disability Program Budget - The separate income and expenditures plan established for each distinct disability program, as differenciated by the legislative appropriation.

D. This Rule Applies to the Following:

1. Community Mental Health Services - Programs for mental retardation, chemical dependency, mental illness and other psychiatric conditions.

a. Is a program established under the provisions of Minnesota Statutes, Section 245.61-245.69 or 402.01-402.10.

b. Is an areawide comprehensive program that is responsible for planning, development, coordination, liaison and needs assessment; that either directly provides, or contracts for, services for individuals with mental or emotional disorders, mental retardation, chemical dependency, and other psychiatric conditions.

c. That employs a multidisciplinary staff, as described in Section G of this Rule, and in sufficient number to implement and operate a program of required services, as described in Section E of this Rule.

2. Community mental health centers or clinics and alcohol and drug outpatient treatment programs that request approval of the Commissioner of Public Welfare, for the purposes of receiving private insurance payments, as defined by Minnesota Statutes, Section 62A.149 or Section 62A.152, or for approval to receive payments for other publicly financed insurance program, shall meet the program requirements as described in Section E, 4, of this Rule. Staff requirements for community mental health centers shall be the same as those described in Section G of this Rule. The requirements of community mental health clinics and outpatient alcohol and drug programs are as follows:

a. Mental Health Clinic

(1) Is a program that contractually affiliates with a local board and receives state financial assistance for the provision of mental health clinical services as defined in Minnesota Statutes, Section 62A.152, or a program which does not receive state financial assistance but which substantially meets the provisions of this Rule and is approved by the Commissioner for purposes of insurance reimbursement, and

(2) Is a program that provides identifiable mental illness outpatient treatment, diagnosis and consultation services as its primary function, and

(3) Employs a multidisciplinary staff team that is qualified by specific mental health training and experience, and meets the staffing requirements below.

(a) A physician licensed to practice in Minnesota who has completed an approved residency program in psychiatry shall be employed by the mental health clinic a minimum of 16 hours per month.

(b) A doctoral clinical, counseling, or health care psychologist.

(c) A clinical social worker with a Master's Degree from an accredited graduate school of social work.

b. Outpatient Alcohol and Drug Treatment Program

(1) Is a program that provides nonresidential alcohol and drug treatment program as identified by Minnesota Statutes, Section 62A.149.

(2) Employs a professional staff team that has specific chemical dependency training or experience and whose qualifications have been approved by the Department of Public Welfare.

E. Required Services

This section of the Rule establishes standards for the provision of services (M.S. 245.61) in order to carry out programs for the target populations of mentally ill, mentally retarded and chemically dependent persons, as provided in M.S. 245.68. Other program standards in Rule 185, or its successor, are applicable.

All of the following are baseline services which must be identified and available to the citizens of Minnesota, and are required prior to the Commissioner of Public Welfare making any grants of financial assistance to the local board.

1. COLLABORATIVE AND COOPERATIVE SERVICES WITH PUBLIC HEALTH AND OTHER COMMUNITY GROUPS FOR THE PURPOSES OF PREVENTION OF MENTAL ILLNESS, MENTAL RETARDATION, DRUG ABUSE, ALCOHOLISM AND OTHER PSYCHIATRIC DISABILITIES.

a. Minimum Service Requirements

(1) The local board shall serve as a coordinating and convening authority of all appropriate public and private community agencies and facilities involved with the development of preventive programs for mental illness, mental retardation, chemical dependency, or other psychiatric disabilities.

(2) The local board shall provide a continuum of care to serve the needs of the mental illness, mental retardation and chemical dependency disability groups.

b. Minimum Service Standards

(1) There shall be identified assigned staff responsible for meeting the service requirements.

(2) There shall be documentation of efforts and results of the coordinating and convening of community agencies and facilities.

2. INFORMATIONAL AND EDUCATIONAL SERVICES TO THE GENERAL PUBLIC AND LAY AND PROFESSIONAL GROUPS.

a. Minimum Service Requirements

(1) The local board shall provide informational and education programs and services to prevent and reduce problems of mental illness, mental retardation, chemical dependency, and other psychiatric disabilities.

(2) The local board shall provide informational and education programs to assist the general public in its understanding and attitudes toward mental illness, mental retardation, chemical dependency, and other psychiatric disabilities.

b. Minimum Service Standards

(1) There shall be identified assigned staff responsible for meeting the service requirements.

(2) There shall be informational and educational services with identified objectives.

(3) There shall be documentation of dissemination of information pertaining to mental illness, mental retardation, chemical dependency, and other psychiatric disabilities.

(4) There shall be available informational and educational materials on mental illness, mental retardation, chemical dependency, and other psychiatric disabilities.

(5) There shall be structured, formal educational, or training opportunities for voluntary association and professional groups.

3. CONSULTATION SERVICE TO SCHOOLS, COURTS AND HEALTH AND WELFARE AGENCIES, BOTH PUBLIC AND PRIVATE.

a. Minimum Service Requirements

The local board shall make available consultation services by qualified personnel to schools, courts, health and welfare agencies, and other service providers, both public and private, for assistance in dealing with problems of mental illness, mental retardation, chemical dependency, and other psychiatric disabilities.

b. Minimum Service Standards

(1) There shall be identified assigned staff responsible for meeting the service requirements.

(2) There shall be consultation services with identified objectives.

(3) There shall be collaborative consultation with community providers to help them in their work with particular clients (see consultation).

(4) There shall be consultation on the planning and development of programs and services (program consultation).

4. OUTPATIENT DIAGNOSTIC AND TREATMENT SERVICES

a. Minimum Service Requirements

(1) The local board shall provide diagnostic and treatment services to area residents in need.

(2) The local board shall provide varied therapy programs, such as crisis intervention, emergency services, family counseling, and ongoing treatment programs to meet the needs of persons with mental illness, mental retardation, chemical dependency and other psychiatric disabilities.

b. Minimum Service Standards

(1) There shall be identified assigned staff responsible for meeting the service requirements.

(2) There shall be diagnostic and treatment services with identified objectives.

(3) There shall be available a variety of diagnostic and treatment methods designed to meet the needs of the individual or family.

(4) There shall be accessibility to direct services either through satellite facilities or extended scheduling, or both.

(5) There shall be emergency services available to residents of the catchment area.

(6) There shall be a plan for coordination of outpatient services with other services in the community continuum of care.

5. REHABILITATIVE SERVICES FOR PATIENTS SUFFERING FROM MENTAL OR EMOTIONAL DISORDERS, MENTAL RETARDATION, DRUG ABUSE, ALCOHOLISM AND OTHER PSYCHIATRIC CONDITIONS, PARTICULARLY THOSE WHO HAVE RECEIVED TREATMENT IN AN INPATIENT FACILITY.

a. Minimum Service Requirements

(1) The local board shall provide rehabilitative services generic to mental illness, mental retardation and chemical dependency expertise in cooperation with the county social service agencies, both of which have statutory aftercare responsibilities.

(2) The local board shall provide screening and evaluation services for persons being considered for voluntary or involuntary admission to residential treatment facilities.

b. Minimum Service Standards

(1) There shall be identified assigned staff responsible for meeting the service requirements.

(2) There shall be rehabilitative services with identified objectives.

(3) There shall be evidence of an effort of liaison and coordination with state and other residential programs, county social service staff, and other service providers to assist in appropriate planning for individuals.

(4) There shall be follow-up services to individuals who have been in residential care.

6. DETOXIFICATION SERVICES

a. Minimum Service Requirements

(1) The local board shall provide for one or more subacute detoxification program for the purpose of detoxifying and evaluating persons physically present within its area and providing entrance into a treatment program.

(2) Detoxification center units must be separate from other chemical dependency units or hospital units; although they may be in the same building, entrance to the unit should not cause disruption to other units.

b. Minimum Service Standards

(1) These facilities shall meet the appropriate DPW program licensure standards, i.e., DPW Rule 32, or shall be an approved vendor as determined by the Commissioner.

(2) Subacute detoxification programs shall follow a social rehabilitation model.

(a) Safe detoxification, including triage, surveillance, room and board.

(b) Administration of medication and physician visit only if triage process requires this.

(c) Chemical abuse/addiction assessment by a qualified chemical dependency professional.

(d) Appropriate referral.

(e) Aftercare planning in preparation for discharge of all patients as appropriate to patient needs.

(f) Follow-up contacts for patients determined by the individual discharge plan.

(g) Transportation to and from the detoxification center, as well as 24-hour emergency transportation support system, as needed.

(3) Services which may be available at detoxification centers, but which are not eligible for state detoxification center funding support:

(a) Routine physical examinations.
(b) Routine laboratory tests.
(c) Emergency room charges.
(d) Routine psychological or psychiatric evaluations.
(e) Vocational rehabilitation services.
(f) Educational or employment services.
(g) Research projects.

(4) The length of stay for patients shall average 72 hours or less.

(5) There shall be a staff review and justification for clients who stay in the center over 96 hours. The review and justification shall be documented in the client record and on information system forms.

(6) There shall be a system to identify frequent users of detoxification center services. For those individuals, there shall be a plan to address the problem of recidivism. For purpose of this Rule, frequent use is defined as admission five or more times during the previous 12 months.

F. Recommended Optional Services for Which State Reimbursement May Be Available.

When the required services are provided throughout the catchment area, the local boards are encouraged to initiate services complementary to variations in local population needs and to improve and enhance programs and services for the mentally ill, mentally retarded and chemically dependent. Any or all of the following services may be provided, and receive state financial assistance to the extent that state funds have been appropriated.

If the local board chooses to provide directly or indirectly an optional service, and receives state funding for this service, the minimum service requirements and standards shall be followed. When applicable, programs and services shall also comply with DPW Rules.

1. PARTIAL CARE PROGRAMS

a. Minimum Service Requirements

The local board may provide a range of services between standard outpatient and standard inpatient care, such as day treatment, night care, weekend care, or respite care.

b. Minimum Service Standards

(1) There shall be identified assigned staff responsible for delivery of the service.

(2) There shall be coordination of this service with both inpatient and outpatient service.

2. TRANSITIONAL CARE AND HALFWAY HOUSE PROGRAMS

a. Minimum Service Requirements

(1) The local board may provide short-term residential services which emphasize movement towards independent living, or prevention of long-term residential placements. These programs and services are to be separate from other disability treatment program units, although these may be housed in the same building.

(2) The local board may provide support services for transitional care residents apart from the facility.

b. Minimum Service Standards

(1) These programs and facilities shall meet the appropriate DPW program licensure standards, such as DPW Rule 35 or 36, or be an approved vendor as determined by the Commissioner, if appropriate.

(2) There shall be identified staff responsible for delivery of these services.

(3) There shall be coordination of various levels of residential care programs with the outpatient and acute inpatient service.

(4) There shall be an individualized treatment program for people in transitional care programs.

(5) There shall be collaboration and coordination with other community resources for support services, such as sheltered work, vocational counseling, outpatient treatment, day treatment and schools.

(6) For halfway house programs for the chemically dependent, the following are special mandatory service requirements:

(a) Room and board in a constructive living environment.

(b) One-to-one counseling with individualized treatment plan performed by qualified counselor.

(c) Employment and educational counseling and referral.

(d) Group meetings, group therapy and family therapy.

(e) Individualized aftercare plan, which shall include arrangements for participation in growth groups and follow-up contacts after discharge.

(7) For halfway house programs for the chemically dependent, the following optional services may be provided, but for which state halfway house funding will not be available:

(a) Medical services.

(b) Intensive therapy.

(c) Routine psychological or psychiatric evaluation.

(8) There shall be monthly review and justification by staff and client for each client whose stay in the program exceeds six months.

(9) There shall be an evaluation system as recommended by the Commissioner of Public Welfare.

3. COMMUNITY SHORT-TERM INTENSIVE RESIDENTIAL TREATMENT PROGRAMS

a. Minimum Service Requirements

The local board may provide short-term intensive care residential treatment programs.

b. Minimum Service Standards

(1) There shall be identified assigned staff responsible for delivery of the service.

(2) In the event that the local board contracts with individuals or families to provide short-term intensive care in their own homes for people experiencing crises, the board shall assure that there is available to the home, professional staff on a 7-day-a-week, 24-hour-a-day basis.

(3) There may be a residential short-term intensive care program with specialized staffing, including psychiatric services.

4. PROTECTIVE LIVING SERVICES

a. Minimum Service Requirements

The local board may provide protective living facilities for persons with chronic problems who have not responded to varied and numerous therapeutic efforts.

b. Minimum Service Standards

(1) Room and board shall be provided to the residents.

(2) There shall be identified assigned staff responsible for managing the facility.

(3) There shall be an annual review and evaluation of the residents.

G. Staffing Requirements

The local board shall employ, or contract with fiscal affiliates which employ, multidisciplinary staff in sufficient number to implement and provide the required mental illness, mental retardation and chemical dependency programs and services. The staff team shall include professionals and, where indicated, paraprofessionals representing a variety of disciplines. Fiscal affiliates providing identified services shall employ appropriate multidisciplinary staff that meet the same training and experience requirements.

1. The professional mental illness, mental retardation and chemical dependency team is to be qualified by training and experience, and shall include, as a minimum, the services of each of the following:

a. A physician licensed to practice in Minnesota who has completed an approved residency program in psychiatry and who shall be employed by the local board or fiscal affiliate and be available on a regularly scheduled basis a minimum of 16 hours per month.

b. A doctoral clinical, doctoral counseling or doctoral health care psychologist.

c. A clinical social worker with a Master's Degree from an accredited graduate school of social work.

d. Professional mental illness staff qualified by formal education and experience to provide direct services and indirect services of planning, coordination, liaison, needs assessment and program consultation in the mental health/mental illness field.

e. Professional mental retardation staff qualified by formal education and experience to provide direct services and indirect services of planning, coordination, liaison, needs assessment and program consultation in the mental retardation/developmental disabilities field.

f. Professional chemical dependency staff qualified by formal education and experience to provide direct services and indirect services of planning, coordination, liaison, needs assessment and program consultation in the chemical dependency field.

2. The services being rendered by employed personnel shall be consistent with their professional discipline.

3. If any of the minimum required professional staff are not immediately available, the Commissioner may approve the program, provided that the local board can show evidence acceptable to the Commissioner that it is making sincere and reasonable efforts to acquire such staff and show evidence of how the functions of the required professionals are being met.

H. Governing Board

1. There shall be designated a local governing board, established in compliance with the provisions of Minnesota Statutes, 245.66 or 402.02.

2. Any city, county, town, or combination thereof, which does not satisfy the population requirements of Minnesota Statutes, Section 245.62, may apply to the Commissioner for approval to establish a single or multi-county mental health board. Such approval shall be given under the following conditions (with the addition of such other conditions as the Commissioner may deem appropriate):

a. A determination has been made by the Commissioner that no other alternatives are feasible.

b. All services, activities and staffing requirements of Minnesota Statutes, Sections 245.61-245.69, and this Rule shall be provided by the board.

c. State grant-in-aid funds shall not be used by the local board to replace existing funding for existing services.

d. Application for grant-in-aid shall be submitted by the board in accord with procedures for all other local boards; these applications will be reviewed specifically for cost efficiency; that part of budgets which is identified to be in excess of statewide norms shall not be eligible for state matching funds.

3. To assist the local board in meeting its responsibilities, as required in Minnesota Statutes, Section 245.68, and to provide opportunity for broad community representation, the local board shall appoint separate advisory committees in at least the three disability areas of mental illness, mental retardation and chemical dependency. These committees shall report regularly to the local board.

a. The advisory committees shall consist of residents of the geographic area served who are interested and knowledgeable in the disability assigned to each committee.

b. Appointments to the advisory committees are made by the local board. Memberships shall include at least one nonidentified consumer of the services for which the committee is responsible.

c. The advisory committees shall be charged by the local board to assist with the program review and identification of the community's needs for the mental illness, mental retardation and chemical dependency programs. The advisory committees shall also advise the local board in determining priorities for the program.

d. The advisory committees shall meet at least four times a year, preferably on a quarterly basis. The program director shall assign staff to serve the functional, administrative needs of each advisory committee.

e. Matchable expenses for advisory committee members shall be limited to reimbursement for official travel.

4. When the governing authority of the mental illness, mental retardation and chemical dependency program operates other programs, services or activities, only those programs and services authorized under Minnesota Statutes, Sections 245.61-245.69, 254A.07, and 254A.08, shall be subject to this Rule.

5. Matchable expenses of local board members, when involved in official business, shall be limited to a reasonable per diem and reimbursement for travel.

6. All minutes of meetings of the local board and the required advisory committees shall be sent to the Commissioner. The board shall also provide the Commissioner with such reports of program activities as may be required.

7. Every local board receiving state funds for community mental illness, mental retardation and chemical dependency programming shall appoint an administrative program director who is the full-time qualified professional staff member who serves as the organization's executive director. To be considered qualified, the individual shall have professional training to at least the level of a graduate degree in his/her clinical or administrative discipline which is relevant to community mental illness, mental retardation or chemical dependency programming, and a minimum of two years' experience in a relevant community setting. Minnesota Merit System requirements will apply to the program directors position for those programs operated by human service boards.

a. The program director is responsible for providing leadership to the local board for planning, design, development and evaluation of a comprehensive areawide program and for the overall administration of services and programs operated by the local board.

b. Prior to appointing the program director, the local board shall document to the Commissioner that the appointee meets all the training and experience qualifications for this position.

8. Every local board shall adopt an official written policy relevant to private practice activities allowed paid staff personnel of the organization.

9. Other providers of community mental illness, mental retardation and chemical dependency services may affiliate with the local board and may be approved and eligible for state grant-in-aid funds. The state funding for affiliate programs shall be contingent upon appropriate inclusion in the local board's plan for the continuum of community services and be in conformity with the state's plan for mental illness, mental retardation and chemical dependency. Fiscal affiliates receiving state grant-in-aid funds under contractual arrangements with the local board must also meet all applicable statutory or licensing approval requirements and staffing requirements as described by this Rule. Any state funds awarded fiscal affiliate programs, under provisions of Minnesota Statutes, Section 245.61-245.69, shall be included in the overall state grant to the local board and flow of state funds will be to and through the local boards, except where there are conflicting statutes.

10. Every local board, and its fiscal affiliates, shall meet applicable Affirmative Action and Civil Rights provisions of state and federal laws.

11. Every local board, and its fiscal affiliates, shall comply with the Official Records-Collection, Security and Dissemination of Data Law, Minnesota Statutes, Sections 15.161-15.169, and the Rules pertaining thereto, and the applicable federal laws.

12. The salary and fringe benefits plan for staff of the local board and its fiscal affiliates shall comply with the provisions of Minnesota Statutes, Section 245.65. Documentation of compliance shall be maintained by the board and be available for audit inspection.

13. The local board, and its fiscal affiliates, shall adopt a written policy on eligibility for services that complies with the provisions of Minnesota Statutes, Section 245.69 (a).

14. The local board, and its fiscal affiliates, shall adopt a written policy on fee for services and a fee schedule that, as a minimum, complies with the provisions of Minnesota Statutes, Section 245.69 (a).

I. Applications for State Financial Assistance

1. In accordance with application guidelines prescribed by the Commissioner, the local board shall submit for review and approval, an annual plan and budget that identifies priorities for nonresidential services and residential services.

2. Applications for state assistance must be accompanied by an agreement executed by designated signatories on behalf of the participating counties that specifies the involved counties, the amount and source of local funds in each case, and the period of support. The local funds to be used to match state grant-in-aid for nonresidential services must be assured in writing on DPW forms by the local funding authority(ies).

a. State nonresidential funds for mental illness, mental retardation, or chemical dependency programs and services shall not be used by the local board, or its fiscal affiliates, to fulfill more than 50% of requirements for federal funds.

b. Federal funds shall not be used as local match for state nonresidential mental health, mental retardation and chemical dependency programs and services.

3. State financial support for local board programs and services will be awarded according to a formula and/or a per diem rate determined annually by the Commissioner.

4. The Commissioner may withdraw funds from any program that is not administered in accordance with its approved plan and budget. Written notice of such intended action will be provided to the local board. Opportunity for hearing before the Commissioner on such action shall be provided.

5. The Commissioner may make supplemental awards to the local board, upon receipt of an application and information documenting such need.

6. The Commissioner shall approve or deny a completed application for state financial assistance within 90 days of receipt of an application, or by the beginning of the state fiscal year, whichever is the later.

7. An appeal of the Commissioner's denial of approval of applications for financial assistance is available under the procedures set forth in the State Administrative Procedures Act, Minnesota Statute 15.01 et seq.

J. Local Board Grant-in-Aid Management

1. The local board shall, within the time period established by the Commissioner, submit prescribed certified quarterly expenditure or other reports to the Commissioner, reporting all receipts, expenditures, and cash balance, subject to an annual audit by the Commissioner.

2. Payments on approved grants will be made subsequent to the Department's receipt of the program's certified quarterly reporting forms, unless the Commissioner has determined that funds allocated to a program are not needed for that program. Payments shall be in an amount at least equal to the quarterly allocation, minus any unexpended balance or funds owed the state from the previous quarter, providing this payment does not exceed the program grant award. In the event the program does not report within the prescribed time, the Department may withhold the processing of the payment until the next quarterly cycle.

3. The local board shall provide the Commissioner with such other reports of program and budget activities as may be required.

K. Local Board Budget Transfers

1. After the Commissioner has approved a grant-in-aid application and made awards, the local board shall submit revised budgets for itself and its fiscal affiliates to reflect the actual amounts of the awards. Second quarter funds will not be released until the revised budgets have been received and approved by the Commissioner.

2. The local board or fiscal affiliate line-item transfers between the state approved disability program budgets shall be submitted for approval in advance to the Commissioner.

3. The local board, or its fiscal affiliates, may make line-item transfers within the state approved budget for a disability program budget without prior approval of the Commissioner. Any such transfers shall be acted on by the responsible board, with the reasons for the actions recorded in the minutes of that board meeting.

4. After the Commissioner has approved a grant-in-aid application and funded the local board, and after revised budgets have been received and approved by the Commissioner, the amount of state funds designated for fiscal affiliate programs shall not be changed or transferred to other programs without prior approval of the Commissioner.

L. State Fee Policies

The local board, and its fiscal affiliates, shall adopt a policy governing the utilization of income from fees for service, which conforms with the following provisions:

1. Boards which are receiving state funds for nonresidential programs at a rate of 50% of the state approved disability program budget shall retain fee income of up to 10% of the approved budget. Fee income collected by the board in excess of 10% of the approved budget shall equally reduce local and state funding.

2. Boards which are receiving state funds for nonresidential programs at a rate of less than 50% of the state approved disability program budget shall retain fee income amounting to the difference between the state funding received and the amount the board would have received had the state share been 50% of the approved budget. When the deficiency level of funding has been made up from local fee income, additional fee collections, exceeding 10% of the approved budget, shall equally reduce local and state funding.

3. Programs which are receiving state funds for detoxification services at a rate of 75% of the state approved budget shall retain fee income of up to 25% of the approved budget. Fee income collected by the program in excess of 25% of the approved budget shall reduce the state funding.

4. Programs which are receiving state funds for detoxification services at a rate of less than 75% of the state approved budget, shall retain income amounting to the difference between the state funding received and the amount the program would have received had the state share been 75% of the approved budget. When the deficiency level of funding has been made up from local fee income, additional fee collections, exceeding 25% of the approved budget, shall reduce the state funding.

5. Programs which are receiving state funds for halfway house services, at a rate of 30% of the state approved per diem, shall be permitted to retain fee income of up to 70% of the approved budget. Additional fee collections, exceeding 70% of the approved budget, shall reduce the state funding.

M. Exceptions to This Rule

If compliance with this Rule is found to cause excessive hardship, to the extent that services will be curtailed or terminated, the local board may apply to the Commissioner for an exception. Such as exception may not exceed one year, and its granting will not be considered a precedent for other local boards.

APPENDIX E

STANDARDS FOR A MERIT SYSTEM OF PERSONNEL ADMINISTRATION

These standards are promulgated by the Departments of Health, Education, and Welfare, Labor, and Defense to implement statutory and regulatory provisions requiring the establishment and maintenance of personnel standards on a merit basis in the administration of various grant-in-aid programs.[1]

The development of proper and efficient administration of the grant-in-aid programs is a mutual concern of the federal, state, and local agencies cooperating in the programs. Proper and efficient administration requires clear definition of functions, employment of the most competent available personnel, and development of staff morale and individual efficiency. The cooperative efforts of merit system and program agency personnel offices in providing comprehensive personnel programs are essential. Such programs provide for analyzing and classifying jobs; establishing adequate and equitable salary, fringe benefit, and retirement plans; projecting manpower needs and planning to meet them; developing effective recruitment, selection, placement, training, employee evaluation, and promotion programs; assuring equal opportunity and providing affirmative action programs to achieve that end; protecting employees from discrimination, arbitrary removal, and political pressures; conducting positive employee-management relations and communications; and providing research to improve personnel methods. Personnel programs must be planned and administered in a timely, expeditious manner to meet effectively program and merit system objectives.

An integral part of the grant-in-aid programs is the maintenance by the state and local governments of a merit system of personnel administration for the grant-aided agencies. The federal agencies are interested in the development and continued improvement of state and local merit systems but exercise no authority over the selection, tenure of office, or compensation of any individual employed in conformity with the provisions of such systems.

Laws, rules, regulations, and policy statements to effectuate a merit system in accordance with these standards are a necessary part of the approved state plans required as a condition of federal grants. Such laws, rules, regulations, policy statements, and amendments thereto, will be reviewed for substantial conformity to these standards. The administration of the merit system will likewise be subject to review for compliance in operation.

Continuing application of these standards will give reasonable assurance of a proper basis for personnel administration, promote a career service, and result in increased operating efficiency and program effectiveness. Within these standards, means are provided for the effectuation of national policies for structuring jobs and the training and employment of the disadvantaged.

In order to assist state and local jurisdictions in maintaining their merit systems under these standards, technical consultative service will be made available.

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[1]See the appendix for a list of the grant-in-aid programs to which these standards are applicable.

JURISDICTION

These standards are applicable to all personnel, both state and local, except those exempted in this section, engaged in the administration of grant-in-aid programs under federal laws and regulations requiring the establishment and maintenance of personnel standards on a merit basis. The standards apply to personnel engaged in the administration of the federally aided programs, irrespective of the source of funds for their individual salaries. The following positions may be exempted from application of these standards: Members of policy, advisory, review, and appeals boards or similar bodies who do not perform administrative duties as individuals; officials serving ex officio and performing incidental administrative duties; the executive head and a deputy or deputies to the executive head of each state agency as warranted by the size and complexity of the organization, scope of programs, and nature of the positions; one confidential assistant or secretary to any of the foregoing exempted officials; attorneys serving as legal counsel; the executive head of an independent local public health or civil defense agency; part-time professional health and related personnel; time-limited positions established for the purpose of conducting a special study or investigation; and unskilled labor.

MERIT SYSTEM ORGANIZATION

Any one of a variety of types of merit system organizations covering substantially all employees in a state or local government would meet the requirements of this section if it adequately provides for impartial administration and the system and its administration are in substantial conformity with these standards. The system will be administered by a qualified merit system executive who may be responsible to the chief executive, a top level official, or a board or commission.

In the absence of such a system, a state may establish a cooperative interagency merit system for the grant-aided agencies covered by the standards. In the interest of economy, efficiency, and effectiveness, a single cooperative merit system will be established for all of these grant-aided agencies. The cooperative merit system will be administered by a qualified executive and adequate staff appointed on the basis of merit and serving in accordance with the provisions of the merit system. An impartial citizens' merit system council will be established to assure that in accordance with merit principles public employment is based on the public interest, including management effectiveness and sound employee relations. The members of this council or board will be appointed by the chief executive or by the administrative agencies, as determined by the state, and will serve overlapping terms. No member will be employed in any other capacity in any of the agencies covered by the merit system.

A local government may elect, at the option of the state, to cover grant-aided programs under a merit system serving other grant-aided agencies covered by the standards, such as a system serving state agencies, another city or county, or a group of local jurisdictions.

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EQUAL EMPLOYMENT OPPORTUNITY

Equal employment opportunity will be assured in the state system and affirmative action provided in its administration. Discrimination against any person in recruitment, examination; appointment, training, promotion, retention, discipline or any other aspect of personnel administration because of political or religious opinions or affiliations or because of race, national origin, or other nonmerit factors will be prohibited. Discrimination on the basis of age or sex or physical disability will be prohibited except where specific age, sex, or physical requirements constitute a bona fide occupational qualification necessary to proper and efficient administration. The regulations will include provisions for appeals in cases of alleged discrimination to an impartial body whose determination shall be binding upon a finding of discrimination.

EMPLOYEE-MANAGEMENT RELATIONS

The rights of public employees to organize and join or refrain from joining an organization for purpose of representation and the matters on which they may negotiate or on which management agrees to meet and confer should be delineated, along with other employee rights and obligations and management rights and obligations. Means should be established for resolution of impasses. The maintenance of a system of personnel administration based on merit principles must be assured.

POLITICAL ACTIVITY

Every employee will have the right freely to express his views as a citizen and to cast his vote. Coercion for political purposes of and by employees of federally aided programs and use of their positions for political purposes will be prohibited. Participation in partisan political activity by any employee subject to these standards will be prohibited with respect to activity prohibited in federally grant-aided programs under the Federal Hatch Political Activities Act, as amended, 5 U.S.C. 150.-1503. (Individuals whose principal employment is in a federally grant-aided program are subject to the prohibitions in the Hatch Act, administered by the U. S. Civil Service Commission, regardless of whether their employment is covered by these standards.)

CLASSIFICATION

A position classification plan based upon analysis of the duties and responsibilities of each position will be established and maintained on a current basis. The classification plan will include an appropriate title for each class of position, a description of the duties and responsibilities of positions in the class, and minimum requirements of training, experience, skills, knowledges, abilities, and other qualifications necessary for entry into the class.

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COMPENSATION

A plan of compensation for all classes of positions will be established and maintained on a current basis. The plan will include salary rates adjusted to the responsibility and difficulty of the work and will take into account the prevailing compensation for comparable positions in the recruiting areas and in other agencies of the government and other relevant factors. It will provide for salary advancement for full-time permanent employees based upon quality and length of service and for other salary adjustments.

Compensation in a local agency will be governed by a compensation plan which, at the option of the state, is established by: a local government and covers other local agencies; the state and covers local grant-aided agencies; or the state and covers the agency responsible for state administration of federal grants.

RECRUITMENT

An active recruiting program will be conducted, based upon a plan to meet current and projected manpower needs. The recruiting efforts of the merit system and program agencies will be coordinated and carried out in a timely manner. Recruitment will be tailored to the various classes of positions to be filled and will be directed to all appropriate sources of applicants in order to attract an adequate number of candidates for consideration and to permit successful competition with other employers. Recruiting publicity will be carried out through all appropriate media for a sufficient period to assure open opportunity for the public to apply and be considered for public employment on the basis of abilities and potential. Such publicity will indicate that the agency is an equal opportunity employer.

SELECTION

Selection for entrance to the career service will be through open competition. The selection process will maximize reliability, objectivity, and validity through a practical and normally multipart assessment of applicant attributes necessary for successful job performance and career development. Applicants will meet the minimum requirements of the job class. The parts of the total examination will consist, in various combinations as appropriate to the class and to available manpower resources, of such devices as work-sample and performance tests, practical written tests, individual and group oral examinations, ratings of training and experience, physical examinations, and background and reference inquiries. In determining ranking of candidates, the examination parts will be appropriately weighted.

To facilitate employment of disadvantaged persons in aide or similar positions, competition may be limited to such individuals.

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APPOINTMENT

Appointments to positions not herein exempted will be made on the basis of merit by selection from among the highest available eligibles on appropriate registers established in accordance with the above provisions on recruitment and selection. Permanent appointment will be based upon satisfactory performance of employees during a fixed probationary period.

In the absence of an appropriate register, individuals appointed to temporary or other nonstatus positions or given provisional appointments to permanent positions pending establishment of a register will be certified by the merit system executive as meeting at least the minimum qualifications established for the class of position. Such appointments will be time-limited. Provisional appointments will not be continued beyond the established time limit unless compelling extenuating circumstances exist and are a matter of record. Provisional appointments will be terminated within a specified reasonable period following establishment of an appropriate list of eligibles.

Emergency appointments may be made for a specified limited period to provide for maintenance of essential services in an emergency situation where normal employment procedures are impracticable.

CAREER ADVANCEMENT

Employee performance and potential should be evaluated systematically in order to improve individual effectiveness, to assess training needs and plan training opportunities, and to provide a basis for decisions on placements, promotion, separations, salary advancements and other personnel actions.

When in the best interest of the service it is determined to fill a position by promotion, consideration will be given to the eligible permanent employees in the agency or in the career service and the selection will be based upon demonstrated capacity, and quality and length of service. Promotions will require certification of eligibility by the merit system executive.

LAYOFFS AND SEPARATIONS

Employees who have acquired permanent status will not be subject to separation or suspension except for cause or reasons of curtailment of work or lack of funds. Retention of employees in classes affected by reduction in force will be based upon systematic consideration of type of appointment, length of service and relative efficiency. In the event of separation, permanent employees will have the right to appeal to an impartial body through an established procedure.

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COOPERATION BETWEEN MERIT SYSTEMS

To facilitate public service mobility and maximum utilization of manpower provision should be made for: cooperative interjurisdictional recruiting, examining, certifying, training and other personnel functions; adding to registers of eligibles applicants with eligibility on comparable examinations in other jurisdictions; appointing employees on the basis of their permanent merit system status in another jurisdiction, with maximum protection of their retirement and other benefits.

EXTENSION OF MERIT SYSTEM

As determined by the state, upon the initial extension of the merit system to a program, an incumbent may obtain permanent status through an open competitive examination; or if he has a specified period of service in the agency, at its discretion he may attain permanent status if he passes a noncompetitive qualifying examination. If he does not pass, such an employee may be retained in the position in which he has incumbency preference without acquiring the rights of merit system status.

An employee with permanent status under a merit system meeting these standards will retain comparable status if the employing agency is placed under the jurisdiction of another merit system.

PERSONNEL RECORDS AND REPORTS

Such personnel records as are necessary for the proper administration of a merit system and related agency personnel programs will be maintained. Periodic reports will be prepared as necessary to indicate compliance with applicable state and local requirements and these standards.

Dated: 2/19/71

Secretary
Department of Health, Education, and Welfare

Dated: 3/2/71

Secretary
Department of Labor

Dated: 3/3/71

Secretary
Department of Defense

Effective Date: March 6, 1971

APPENDIX

Following is a list of those programs covered by statutes or regulations relating to a merit system or personnel administration:

Program	Statute or Regulation
Comprehensive Health Planning	42 U.S.C. 246 (a)(2)(F)
Comprehensive Public Health Services	42 U.S.C. 246 (d)(7)(F)
Medical Facilities Construction and Modernization	42 U.S.C. 291(a)(B)
Old-Age Assistance	42 U.S.C. 382 (a)(5)(A)
Aid to Families with Dependent Children	42 U.S.C. 632 (a)(5)(A)
Maternal and Child Health Services/ Crippled Children's Services	42 U.S.C. 785 (a)(3)(A)
Aid to the Blind	42 U.S.C. 1282 (a)(5)(A)
Aid to the Permanently and Totally Disabled	42 U.S.C. 1382 (a)(5)(A)
Aid to the Aged, Blind, or Disabled	42 U.S.C. 1382 (a)(5)(A)
Medical Assistance	42 U.S.C. 1396a (x)(4)(A)
Developmental Disabilities Services and Facilities Construction	42 U.S.C. 2674 (a)(7)
Community Mental Health Centers Construction/Children's Mental Health Facilities Construction/Narcotic Addict Rehabilitation Facilities Construction	42 U.S.C. 2684(a)(6)
Older Americans	42 U.S.C. 3023 (a)(4)
Alcoholism Prevention, Treatment, and Rehabilitation	42 U.S.C. 4573 (a)(5)
Surplus Property Utilization	45 C.F.R. 145 (b)(3)(8)
Child Welfare Services	45 C.F.R. 220.49 (c)
*Disability Insurance Determination	SSA Disability Insurance State Manual, Part IV, Sec. 425.1
*Health Insurance for the Aged	SSA State Operations Manual, Part IV, Sec. 4618 (a)
*Vocational Rehabilitation Administration	29 U.S.C. 35 (a)(6)
*Vocational Evaluation and Work Adjustment	29 U.S.C. 424 (c)(5)
Food Stamp	7 U.S.C. 2019 (a)(2)
Unemployment Compensation	42 U.S.C. 503 (a)(1)
Employment Service	29 U.S.C. 49D (a)
Work Incentive Program	WIN Program Handbook, Sec. 8 and Exhibit 4, V-F
Civil Defense Financial Assistance	50 U.S.C. App. 2286 (a)(4)

*Federal requirements for personnel standards, which may be met by coverage under a state merit system.

retyped 3/9/76

I certify that:

Methods of personnel administration for merit system employees have been established and will be maintained in the State Agency and in local agencies administering the State plan in conformity with the Standards for a Merit System of Personnel Administration, 45 CFR Part 70, and any standards prescribed by the U.S. Civil Service Commission pursuant to the Intergovernmental Personnel Act of 1970. Laws, rules, regulations and policy statements, and amendments thereto, effectuating such methods of personnel administration are a part of the plan, and such documentation is attached. That this Department's regulations and policies meet the Federal Merit System Standards.

Further that any amendments to the above will be submitted whenever necessary.

Minnesota Statutes, Chapters 256 and 393 authorizes and charges the Minnesota Department of Public Welfare with establishing adequate standards and administration for personnel employed by the counties.

I certify that:

The Minnesota Merit System is an organizational unit within the Minnesota Department of Public Welfare.

DATE

William J. Daly, Assistant Supervisor
Minnesota Merit System
County Welfare Bureau

APPENDIX F

July 1, 1977

Ms. Barbara Sundquist
Personnel Director
Minnesota Department of Public Welfare
Centennial Building, 4th Floor
658 Cedar
St. Paul, Minnesota 55155

Dear Ms. Sundquist:

At the request of Donald O'Neal, Department of Public Welfare Affirmative Action Director, I have reviewed the proposed Affirmative Action Plan for the Minnesota Merit System.

During this review I made a number of suggestions, mostly related to clarification of wording, that have been incorporated into the final document. What changes remain relate to minor clarifications and do not effect the intent or impact of the document. For example, future plnas should repeat and re-affirm that the plan applies to human service agencies as well as welfare departments. This is stated in the Commissioner's policy statement but not re-affirmed in subsequent text.

We wish the Department of Public Welfare well in encouraging the development and monitoring of these individual county Affirmative Action Plans. We hope the county administrators will not respond in terms of another burden imposed by Federal law but rather desire to improve their capabilities to provide good personnel managment to their respective bodies through realistic and positive affirmative action goals and timetables.

As the respective plans are submitted by counties we would be interested in seeing the types of goals and timetables being proposed. Hopefully we can continue to work with you and your staff in this area.

Sincerely,

Donald Anderson
State Representative
Intergovernmental Personnel Programs
Division

CT:IPP:DAnderson:alt 8/30/77

APPENDIX G

NONDISCRIMINATION

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and the Regulation issued thereunder by the Department of Health, Education, and Welfare (45 CFR Part 80) no individual shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of or be otherwise subjected to discrimination under this plan.

The state agency will comply with all of the provisions for reporting its compliance with Part 80 of the regulations that are promulgated by the responsible Department official or his/her designee and will provide to him/her and to beneficiaries and participants access to sources of information in accordance with the requirements of 45 CFR Part 80.6.

The state agency has established and will maintain methods of administration to assure that each program or activity for which it received federal financial assistance will be operated in accordance with the first paragraph of this statement. Attachments E and F contain a description of these methods of administration. The state agency will amend its methods of administration from time to time as necessary to carry out the purposes for which this statement is given.

APPENDIX H

State Plan Administration Funds

In the fiscal year ending June 30, 1968, the State of Minnesota spent $159,719 in state funds in administering the state plan for community mental health centers, exclusive of grants-in-aid to the centers. This data was obtained from the 1969-70 314(d) plan.

The state does not intend to claim any reimbursement this year, under Section 227 of P.L. 94-63, for administration of the state plan, since no funds are available for this purpose. At the time that construction funds become available, the Minnesota Department of Public Welfare will request, under Section 227 of the Act, the allowable portion of the state's allotment for reimbursement of expenditures made in administering the state plan.

APPENDIX I

ASSURANCE OF COMPLIANCE WITH THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE REGULATION UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

Minnesota Department of Public Welfare (hereinafter called the "Applicant")
(Name of Applicant)

HEREBY AGREES THAT it will comply with title VI of the Civil Rights Act of 1964 (P.L. 88-352) and all requirements imposed by or pursuant to the Regulation of the Department of Health, Education, and Welfare (45 CFR Part 80) issued pursuant to that title, to the end that, in accordance with title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department; and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. In all other cases, this assurance shall obligate the Applicant for the period during which the Federal financial assistance is extended to it by the Department.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts or other Federal financial assistance extended after the date hereof to the Applicant by the Department, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The Applicant recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this assurance, and that the United States shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the Applicant, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Applicant.

DATED _____

Minnesota Department of Public Welfare
(Applicant)

BY Edward J. Dirkswager, Jr., Commissioner
(President, Chairperson of Board, or comparable authorized official)

Centennial Building
St. Paul, Minnesota 55155
(Applicant's mailing address)

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